Mr Michael Baldry

Ennis House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Ennis House on 19 and 20 February 2018, we returned on 21 February to give feedback to the provider and manager. On 2 March we went back again to check some improvements to the environment had been made.

At our previous inspection in March 2015 the service was rated 'good' in all areas.

Ennis House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ennis House provides personal care and accommodates up to 40 people in one adapted building. At the time of the inspection there were 33 people living at the home. People at the home were living with a range of complex mental health illnesses. Most people were independent and needed minimal assistance and others required some assistance related to their personal care and day to day support at the home.

The home is managed by a registered provider who was supported by a care manager. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found improvements were required to ensure the provider is meeting all of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was in need of maintenance and general redecoration throughout. The provider and staff were aware of what was required, however no or limited action had been taken. There was a lot of 'clutter' at the home. This had not been taken into account when assessing risks to people. Risks in relation to infection control and fire had not been safely managed.

Although there was a training programme in place not all staff had received the training in line with the provider's policy. Quality assurance systems were not always effective at identifying and addressing areas that needed to be improved in a timely way.

Care documentation did not always support individual and person centred care. It did not reflect the support people received and required. Improvements were needed to ensure people were able to access a variety of meaningful activities.

Despite these concerns there were also positive aspects of the service. People were supported by staff who knew them well. They understood people's individual needs and preferences. Staff were committed to ensuring people lived happy lives.

Medicines were managed appropriately and people received the medicines they had been prescribed.

People's nutritional needs were assessed and met and they were supported to enjoy a variety of food and drink of their choice.

There were enough staff on duty, who had been appropriately recruited, to meet the needs of people. Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse.

Staff had an understanding of the Mental Capacity Act 2005 and DoLS assessments had been made to determine peoples' capacity. Appropriate referrals were made to the local authority if people needed to be deprived of their liberty to ensure their safety and well-being.

There was a positive culture at the service. People spoke highly of the staff team. They told us staff were kind and caring. People were supported to maintain and develop relationships and friendships that were important to them. People's dignity and privacy was respected.

People were supported to attend healthcare services and maintain good health. A complaints procedure was in place and complaints were responded to appropriately.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of Ennis House were safe.

The provider had not ensured the home had been properly maintained. This meant risks to people in relation to infection control and fire had not been safely managed.

Individual risks associated with people's care and support needs were well managed.

There were enough staff on duty, who had been appropriately recruited, to meet the needs of people.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse.

Medicines were managed appropriately and people received the medicines they had been prescribed.

Is the service effective?

Good

Ennis House was not consistently effective.

Staff had a good knowledge of how to provide appropriate support to people.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were given choices about what they wanted to eat.

People were supported to attend healthcare services and maintain good health.

Is the service caring?

Good

Ennis House was caring.

People were supported by staff who were kind and caring staff.

People were supported to maintain relationships and friendships that were important to them.

People's dignity and privacy was respected.

Is the service responsive?

Requires Improvement

Ennis House was not consistently responsive.

Care documentation did not always support individual and person centred care.

Improvements were needed to ensure people were able to access a variety of meaningful activities.

A complaints procedure was in place and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Record keeping did not reflect the support people received and required.

Quality assurance systems were not always effective at identifying and addressing areas that need to be improved.

There was a positive culture at the service. People spoke highly of the staff team.

Ennis House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 February 2018 and was unannounced. The inspection was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home, this included four staff recruitment files, training and supervision records, medicine records, accidents and incidents, quality audits and policies and procedures along with information in regard to the upkeep of the premises. We looked at five people's support plans and risk assessments and other documentation related to their support.

During the inspection, we spoke with 12 people who lived at the home and 17 staff members, this included the provider. We also spoke with two visiting healthcare professionals. Following the inspection we contacted seven health and social care professionals who visit the service to ask for their feedback.

We spent time observing people in areas throughout the home and were able to see the interaction between people and staff. We watched how people were being cared for by staff in communal areas. This included the lunchtime meals.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Ennis House. One person said, "I feel safe because I can lock my door. I was worried once because someone rattled my door at night, I told the carers and they dealt with it and I don't worry anymore." Another told us, "I feel safe because there are no burglars and your belongings are safe, I have never seen anyone being bullied or shouted at here." A further person said, "I feel safe here because I am happy, well cared for and well fed, what else could I need?"

Despite the positive feedback we found areas of Ennis House that were not consistently safe.

The provider had not ensured the home had been properly maintained. There were maintenance staff at the home and day to day maintenance took place. However, the home was in need of maintenance and general redecoration throughout. The provider and staff were aware of what was required, however no or limited action had been taken. The provider told us they were aware work was needed. They said bedrooms were redecorated when they became empty and other work was addressed as time constraints allowed. The paintwork in the communal areas was chipped and the paint was flaking. There was evidence of staining to a ceiling. We were told this was water damage and related to a slipped tile on the roof. One shower room had been refurbished but other bathrooms required maintenance. Some bathrooms had chipped tiles and grouting between tiles was stained. Sealant around wash basins and baths was stained, in some areas it was black and lifting. Baths were stained with lime scale and appeared unclean. Housekeeping staff told us the home was cleaned each day. They were confident all areas were as clean as possible. However, the condition of some areas meant it was not possible to clean them fully.

These issues are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the home was not always clean and had not been properly maintained.

There was paint stored in the smoking lounge. This should have been stored securely under the Control of Substances Hazardous to Health Regulations (COSHH) 2002. COSHH products are products which can be considered harmful, if for example it was swallowed. We told the provider and manager about this and it was removed.

Some people at the home smoked, there was a separate smoking lounge and risk assessments to manage risks associated with smoking. The provider told us servicing checks of fire safety equipment such as fire extinguishers and the fire panel had taken place. However, they were not able to tell us when this had last taken place and servicing certificates were not available. There was a large amount of 'clutter' around the home and in the garden. This included furniture and walking aids that were no longer in use. Although this did not impede people moving around the home or prevent them leaving the building in an emergency this had not been taken into account within the risk assessments.

When we returned to the home on 2 March 2018 we saw a number of improvements had been made to the environment through the clearing of 'clutter.' Both in the home and in the garden. An external company had been at the home and were completing servicing checks and we were told a fire risk assessment would also

be completed. The local fire service had also visited the home to provide advice and guidance.

Protective Personal Equipment (PPE) such as aprons and gloves were available. We observed that staff used this appropriately during our inspection and it was available for staff to use throughout the service.

Regular fire checks had taken place and this included fire alarm tests. One person told us, "A fire alarm goes off once a month and we sit down and wait for it to finish." Staff were aware of the risks associated with people smoking at the home. Regular checks of the smoking lounge took place to ensure all cigarettes had been extinguished and waste bins did not contain paper. Staff told us about some people who did not always smoke in designated areas. Systems were in place to monitor this which, where appropriate included supervising people when they smoked. There was an odour of cigarette smoke throughout the home. We asked people and staff about this and nobody expressed any concerns. Staff told us if they did not wish to enter the smoking lounge this was supported, although all staff acknowledged they would enter in an emergency. We recommend the provider works to ensure the impact of passive smoking is minimised as far as possible.

Risk assessments helped to support people to stay safe and retain their independence. The risk assessments were individual to each person. They included areas such as personal hygiene, mobility, mental ill health and use of call bells. There was guidance in place, which along with good staff knowledge of people meant that individual risks to people were well managed. There were risk assessments in relation to alcohol and smoking cigarettes in the home. Agreements were in place to support people to do this safely and where appropriate keep a record of how much was consumed or smoked. To support some people, with their agreement, the alcohol and cigarettes were kept in the office. This had been agreed with individuals. Throughout the inspection people asked staff for cigarettes and these were provided on request.

Some people displayed behaviours that may challenge themselves and other people. Staff told us how they supported people during this time. They told us what actions they took to de-escalate the issues. This included distraction techniques such as asking the person to move to a quieter area. One staff member told us if this happened other colleagues would immediately offer support. One person told us, "You might get a difficult resident playing up now and again but they (staff) deal with it well."

Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs and the assistance required in the event of an emergency evacuation. There were servicing contracts in place, for example the gas, electrical appliances and water temperature and the lift. The provider had identified an electrical service was required and this had been booked at the time of the inspection.

Accidents and incidents had been recorded with the actions taken. There was information in care plans and daily notes which showed the incident had been followed up and any other actions taken which included reporting to other organisations if needed. This information was shared during handover to ensure all staff were aware of this incident and learnt from what had happened to prevent a reoccurrence.

People were protected against the risk of abuse because staff knew what steps to take if they believed someone was at risk of harm or discrimination. One person told us, "I feel safe because I know all the staff, they have been here a long time and you feel safer with people you know." Staff received safeguarding training and this was updated regularly. Staff described what action they would take if they suspected abuse had taken place and there was information displayed for staff to remind them what steps to take. Staff told us they would raise an issue with the manager if appropriate. They said they were able to talk to the provider or contact the local authority safeguarding team. Staff told us they were informed about any safeguarding

concerns during daily handover, on a one to one basis if required. This helped to ensure everyone was aware of issues and actions taken to maintain people's safety.

There were enough staff on duty to support people safely. There were seven staff in the morning and five in the afternoon. Care staff were responsible for cooking people's meals each day. There was a dedicated staff member working each day to do this. The manager worked at the home most days and a senior member of care staff had been assigned to complete paperwork and supervisions. They worked in addition to the core team. There was a housekeeping team every day and maintenance staff five days a week. A senior member of staff remained in the office or lounge area most of the day to ensure people were safe and were able to offer support and reassurance as needed. Two care staff worked each night. Due to the complexity of people's needs agency staff were not used. In the case of staff absence, regular staff covered by working extra shifts. Throughout the day we observed staff were busy but people's needs were attended to in a timely way. The manager told us extra staff would be deployed if people's needs increased.

People were supported by staff who had been safely recruited. Before starting work at the home checks had been completed to ensure, as far as possible, staff were suitable to work in the care sector. These checks included references and Disclosure and Barring Service checks (DBS). These checks took place before staff worked unsupervised with people. If areas of concern were identified then further actions were taken and risk assessments undertaken to demonstrate staff were suitable to work at the home.

There were systems to make sure medicines were stored, given and disposed of safely and to ensure people received their medicines when they needed them. One person told us, "I get my pills regularly and they watch me swallow them and write it down." This person went on to tell us about their medicines and what they were for. There had been a recent audit of the medicines by an external pharmacy team. They had identified areas that needed to be improved. Staff told us what these changes were and how they were working to implement them. This included more detailed guidance about medicines that people had been prescribed 'as required' (PRN). People took these medicines only if they needed them, for example if they were experiencing pain or anxiety. Although the guidance did not currently contain all the information staff may need they had a really clear understanding of why people may need these medicines. Where people required PRN medicines for anxiety staff told us people may not always recognise they needed the medicine. Staff described to us how people may present and what their individual symptoms may be which indicated they may need these medicines. One staff member told us people did not necessarily know they were anxious but when staff recognised symptoms or certain behaviours they then asked people if they would like their medicine and explained why. Staff told us people would usually recognise the need and take the medicine. Staff were also aware of other actions they should take before offering some people PRN medicines. Staff explained people were able to tell them when and why they needed pain relief and this was given appropriately. Some people had particular routines for their medicines and these were supported by staff.

People's medicines were reviewed regularly to ensure they remained appropriate. A recent review by a visiting pharmacist had identified some changes were required and these had been completed with people's own GP's. Staff told us they had identified changes in one person's mood since their medicines had been altered. They had contacted the person's GP to discuss and re-review this.

Good

Is the service effective?

Our findings

People were complimentary of the staff and their knowledge and skills. They told us staff were well trained. One person told us, "The quality of the carers is excellent, they are so well organised and always listen and have time for you."

Despite this positive feedback we found aspects of Ennis House that were not consistently effective.

There was an ongoing training programme. Staff completed essential training which included safeguarding, medicines, mental health awareness, moving and handling and infection control. Most training was via a workbook system which staff could access at any time if they wished to refresh their knowledge. The workbooks included links to further information and guidance. Training such as moving and handling and first aid which involved practical skills was provided face to face. The manager told us all training was updated every three years. However, from the training matrix we identified that staff had not received training in line with the provider's policy. Out of 25 staff we found 14 had not received training updates in the past three years in relation to fire. 11 staff had not received safeguarding training updates. We found similar shortfalls in all areas of the training matrix. Of the 15 staff who had completed medicine training 11 had not received updates in the last three years. The manager told us updates had taken place however these had not been recorded on the training matrix. However, staff had completed medicine competency assessments each year. This did not impact on people because staff had a good understanding about the support they provided.

When staff started work at the home they had a period of induction which included an introduction to people, the routines of the home and policies and procedures. Staff then spent time shadowing their colleagues until they were assessed as competent to work unsupervised. Staff told us the period of shadowing was usually between four and six weeks however, this could last longer if staff were not deemed competent or did not feel confident. One staff member told us they had asked for extra time shadowing and had been supported to do this.

Staff received regular supervision throughout the year. The manager had identified some staff supervisions were required and was working to address this. Staff told us they could talk to the manager at any time and discuss concerns. If concerns had been raised in relation to staff practice then supervision was undertaken to identify areas where the staff member needed to improve and support was provided to help them achieve this.

Staff were knowledgeable about how to support people to ensure their equality, diversity and human rights were protected. Policies were in place and some staff had received recent training. Staff told us they treated each person as an individual and respected their individual choices and decisions.

People's nutritional needs were assessed and met. Nutritional assessments detailed the type of diet people required. One person had been assessed as requiring a pureed diet and thickened fluids. This was provided appropriately. Staff were aware of how they prepared the thickened drinks. However, they told us the person

was independent and able to prepare their own drinks appropriately. People were weighed regularly and this helped to identify if anyone was at risk of malnutrition or dehydration. If any concerns were identified then appropriate advice was sought through the GP, dietician or speech and language therapist.

There was no dedicated cook at the home and staff were allocated to prepare and cook meals each day. They had a good understanding of people's individual dietary needs, likes and choices. There was a set main meal provided each day. This was based on people's likes if however they did not like what was on offer then alternatives were provided. Staff who were new to cooking, told us they were never asked to cook any meals they were not comfortable with. They were supported by their colleagues and one staff member told us cooking had been a good experience for them.

People told us they enjoyed the food and were provided with choices. Staff told us people regularly complimented the meals. One person said, "The food is excellent, the girls do the cooking." At mealtimes we saw people enjoyed their food and plates were returned empty.

Mealtimes were flexible, breakfast started at 7am until 11.30am. Cereal was left out all morning and milk for a limited period, after which people requested it from the kitchen. Every day there was a cooked breakfast available with additional food items also available for breakfast to give variety. Most people ate lunch at the home. They were supported to sit where they chose and people often sat within their own friendship groups which helped make mealtimes a sociable occasion. There was a choice of hot and cold drinks available. These were provided in flasks and people were seen to help themselves throughout the day. Snacks were available and one person told us, "I give out the biscuits at 3pm, they call me 'the biscuit man'." If people did not wish to eat their meal at lunchtime or were out then a meal would be kept for them to eat later. Where necessary food and fluid charts were kept if staff needed to monitor what people were eating and drinking. Staff were observant to people's intakes and concerns were reported to other staff during handover. We heard staff reminding one person they needed to have a drink and checking with other staff this had happened.

People were supported to maintain good physical and mental health and received on-going healthcare support. One person told us, "If I was ill they would send for a doctor," another said, "I have my own dentist my (relative) takes me. If they are working the staff would take me in a taxi." Some people managed their own health needs independently and would visit the GP or other appointments when they chose. Other's needed encouragement and reminding and some needed more support. Where appropriate, staff accompanied people to appointments. If people regularly declined then arrangements were made for the GP to visit people at home. Staff were attentive to changes in people's health and contacted healthcare professionals promptly. We saw in one person's daily notes that staff had identified their toenails needed attention. They told us the person had agreed to see the chiropodist and they visited during the inspection.

People were encouraged to attend well-person health checks, however their right to decline was respected. A number of people at the home smoked and steps were taken to encourage people to reduce the amount they smoked. Staff told us about people who had reduced the amount they smoked and another person who was now using an electronic cigarette.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The manager had supported one person through the best interest process to enable them to make a complex decision. This meant the person was able to maintain their independence through appropriate

decision making. It also ensured their individual and human rights were protected and upheld.

The manager told us if they identified changes in people's capacity they would contact appropriate professionals. This included the GP or mental health worker. The manager explained that changes in people's capacity may be related to their mental ill health therefore appropriate professional advice would always be sought.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. DoLS authorisations were in place for two people and applications had been submitted for people who did not have capacity and were under constant supervision, these had not yet been authorised.

Staff demonstrated an understanding of mental capacity and DoLS. Some had completed mental capacity training. They told us people were able to make their own choices and were supported to make their own decisions.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person told us they had lived at the home for just over a year. They said, "The manager showed my (relative) around, I can do as I like, I could really recommend this place to anyone. I get up and go to bed when I like there are lots of people to talk to and the carers listen to you. I watch TV and play darts." Another person told us, "Every carer is kind and will help if you have a problem."

People were supported to make their own choices. They chose when they got up and went to bed and what they did throughout the day. The provider and staff were clear that Ennis House was people's home. This was repeated to us throughout the inspection. The provider and staff told us it was up to people what happened during the day, staff were there for support but people were able to make their own decisions and choices. Staff knew people really well and discussed people's support needs and choices with them throughout the day.

One person had become distressed and at times angry. Staff listened to the person and allowed them to express their frustrations. They listened to the person, acknowledged how they were feeling and spent time exploring this with the person. When the person appeared calmer and more relaxed they offered distractions such as a cup of tea and a cigarette. Later the person became upset again. Staff reminded them of previous conversations and offered continual reassurance which included reminding the person that Ennis House was their home.

Peoples' equality and diversity was respected and people told us their dignity was respected. One person said, "I am always treated with dignity and concern. They (staff) help me with my personal care. I can do most things myself but like in the shower or bath they wash my back." We observed one person had left the door open whilst using the bathroom. The staff member called out to the person and asked if they were alright. They then informed them they were shutting the door as others could see them in the bathroom. People were supported to maintain their own hygiene and dress in a way that was individual to each person. Staff complimented people on what they were wearing. One person was wearing their nightclothes during the daytime. Staff asked the person if they were going to get dressed. This was done with humour and kindness but also prompted the person to consider if they were going to change their clothes. People told us they had a choice of male or female carer. One person said, "I don't mind a female or male carer" but another person told us, "I wouldn't want a male to help in the shower but it has never happened." Staff were mindful of ensuring people received support with person care from staff who they felt comfortable with and acknowledged people's choices could change from day to day.

People were supported to maintain their personal relationships and develop new ones. Some had developed friendships within the home and were able to spend time with each other during the day. Other people told us they had regular visitors to the home. They said they were able to go out or spend time at the home with them. Most people were able to go out when they chose to. This was encouraged and some people had developed friendships outside of the home. People's individual beliefs were respected and people were supported to maintain their spiritual beliefs. One person told us they were supported to go to church and attended with their relatives. Another person's care plans stated their religious beliefs but they

currently did not go to church. Staff told us the person would be supported to do so if they wished.

People's privacy was respected. People had the opportunity to spend time with their friends and family in private if they wished. They were able to spend time in their bedrooms plus there was a small quiet lounge which people could use in private. People had a key to their own bedrooms and staff only entered if people agreed. One person had a notice on their bedroom door which reminded staff not to enter. Housekeeping staff told us they were invited in when the person required support with cleaning the room. People's bedrooms were personalised, where people wished to, with their own belongings such as personal photographs and mementos. Some rooms had been redecorated and people had chosen the colours and soft furnishings. People were pleased to talk with us about their room and their possessions.

People's right to confidentiality was respected. People's care plans were stored in offices to ensure that their privacy was maintained. When staff were speaking with people they were mindful of other people who may be listening and offered people private space to chat.

Requires Improvement

Is the service responsive?

Our findings

People told us they were listened to; staff understood their needs and supported them appropriately. One person told us, "Everything is fine living here, it's like living in your own home without the 'aggro' of cooking, cleaning, and washing, clean sheets every week there's no worries at all."

Despite this positive feedback we found areas that impacted on how staff were supported to provide person centred care. Care documentation did not always provide clear information on the care and support needed or guidelines for staff to follow in order to provide this care. For example; one person was living with seizures. The care plan stated there were two possible reasons for the seizures. There was information in the care plan and a risk assessment but these did not provide detailed guidance for staff about what to do if a seizure occurred. There was no information about triggers or if there were any differences between the two types of seizure. Staff told us what they would do and that the support required and provided was the same for both types of seizures. A senior member of care staff told us they had identified a seizure may occur if the person became hot. This information was not in the care plan and therefore this information was not available for all staff. There was no evidence that all staff were aware of this information. This meant staff may not always take appropriate steps to help prevent a seizure occurring.

Most people told us they had enough to do each day. One person told us, "I am never bored or lonely, I like reading and TV. The Library Service comes in to change my books." Another said "I have music and TV in my room." Throughout the day we saw people coming and going in the home. Some liked to spend time in the town. One person said, "I go out for a beer everyday" another told us, "I go to the Arndale centre, the coffee is very good." However, one person said, "There's one thing not good and that's activities." Staff told us how they supported people to go out if they wished to. During the inspection we observed people watching television in the lounge and chatting with each other. There was limited information in the care plans to show what people did each day and what activities they liked to take part in. The provider had stated in the PIR that an activity programme was to be developed with people. Staff told us this had happened but people did not participate. One person said, "I don't think there is much point trying to get people together for an activity, I would not be interested in Bingo." Therefore the activity programme had discontinued. However, there had been nothing introduced in its place to ensure people were continually given opportunities to take part in a variety of meaningful activities. For example, as individuals or small groups. Supporting people to take part in a variety of stimulating activities helps them to maintain good mental and physical health.

One person had not received the person centred support they may like to have in relation to their activities. The person told us they enjoyed painting and shared their pictures with us. There was no information about this interest in the person's care plan. Staff told us that they were not aware of any discussions having taken place to explore whether this person would like to continue with this interest or support them to do so.

This meant the provider could not be assured that people received appropriate and responsive care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people moved into the home the manager completed an assessment to ensure the person's needs could be met at the home. They met with the person and reviewed information about their support needs. People were invited to spend time at the home to help ensure they would be happy there. Care plans and risk assessments were developed from the original assessment. These were developed with the person and if appropriate their relatives. Care plan reviews took place regularly and staff told us people were included in these if they wished to be but generally people did not. One person said, "My (relative) would deal with that." Another told us, "I don't need a care plan I can make my own mind up about anything. If necessary I would discuss my health."

Staff knew people well; they had a good understanding of them as individuals, their daily routine and likes and dislikes. Care plans contained information about people's needs in relation to their mental and physical health, personal care, communication, mobility and nutritional needs. There was information about people's preferences, and what was important to them. One person needed support with their continence. The care plan stated that being incontinent upset this person. There was guidance for staff about how to support this person and reference to the continence support was evident throughout all their care plans. Staff told us about individual goals people had achieved. This included reducing their alcohol intake and the amount they smoked. It also included improvements in people's moods, personal hygiene and engagement in the home. This had not been recorded. However, this did not impact on people because staff knew them well and had a good understanding of their support needs and choices.

A handover took place at each shift change to ensure key information on people's needs were shared and discussed. This ensured staff had up to date and accurate information on people in order to meet their changing needs.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Although staff had not received AIS training, peoples' communication needs had been assessed and met. This included ensuring people were supported to have regular eye tests and reminded to wear glasses. One person had a visual impairment. The manager had arranged for a local association to provide guidance and support to this person. This had resulted in the person now having access to other services which included audio books.

There was a complaint's policy in place. People told us they had no complaints but if they did they would raise them with staff. One person said, "I would tell the owner (name) if I had a serious problem." Another person told us, "I would tell the carer and she would sort it out." We saw complaints had been recorded in the complaints book. People were supported to make complaints. One person had asked staff to record their complaint and this had been written in detail, using the person's own words to describe the concern. Records showed complaints raised were responded to and addressed appropriately. Feedback was obtained daily through discussions with people and general conversation.

As far as possible, people were supported to remain at the home until the end of their lives. There were end of life care plans. However, these had not always been fully completed but there was evidence of discussions having taken place with people. People had generally chosen not to discuss this and their wishes were respected.

Requires Improvement

Is the service well-led?

Our findings

We found aspects of Ennis House were not well-led. The provider had overall responsibility for the home and visited most days. There was a care manager at the home who was responsible for the home on a day to day basis. They were supported by senior care staff.

Record keeping needed to be improved. People were involved in making decisions about their support needs but this had not been recorded and there was no evidence people were involved in reviews of their support needs with staff. Staff told us people chose not to be involved but this had not been recorded to demonstrate people had been offered the opportunity. People's care plans did not always reflect the care and support people required and received. Care plans had not always been updated in a timely way to make sure the information was current and correct. One person's diet had been changed to pureed, but this was not reflected in the care plan. Care plans did not contain all the detail to support staff. One person required thickener in their drinks. The amount needed was not written in the care plan. Another person needed support with their catheter. Whilst there was information in the care plan it had not been recorded the catheter bag would be changed by a district nurse. Staff told us, and we saw some people were supported with their cigarettes. This had been done in agreement with people. However, care plans did not reflect what the agreement was, how often people may like to have a cigarette and for example what staff should do if people chose not to stick to the agreement and would potentially run out of cigarettes. Some people had fluctuating capacity or DoLS authorisations and applications were in place. This information had not been included within care plans to demonstrate how people may lack capacity and how any restrictions should be minimised. Information about people had been recorded in their daily notes. This information had not always been transferred to people's care plans. Therefore, as time passed it was more difficult to find the relevant information and staff who were new to the team may not be aware of the information at all. This lack of information left people at risk of not receiving the support they needed or chose to have.

Staff told us about individual goals people had achieved. However, there were no care plans to guide staff to show individual goals. There was no information to show this had been explored with people to identify what they would like to achieve. Although staff were aware of people's goals the lack of guidance may result in people receiving inconsistent support.

Although there was a quality assurance system in place and audits and some checks had been completed these did not always identify areas for improvement. Where improvements had been identified actions had not always been taken in a timely way.

The provider had not identified training had not always been delivered in line with their policy. We were told staff training was updated every three years but this had not happened for all staff. For example, not all staff had received recent safeguarding training. There were a range of policies in place. However, the safeguarding policy had not been updated to reflect the new categories of abuse domestic violence, modern slavery, discriminatory and self-neglect as defined by The Care Act 2014. This had not been identified through the audit system. The provider could not be assured staff knowledge and skills were up to date.

Maintenance and cleaning checks were completed and where immediate work was required this was addressed. An annual audit of the home had been completed in December 2016 which identified areas that needed to be improved. However, there was no plan to show how this would be addressed and over what timescale. The provider and staff were aware improvements were required but these had not been addressed in a timely way. The audit had not identified the risks associated with the home, lack of fire servicing and the amount of 'clutter' and poor storage of COSHH products.

Although people told us they were happy with the home the provider had failed to recognise the potential impact the lack of upkeep and refurbishment to the home may have on people. Staff told us they were frustrated with the lack of improvements.

Feedback was obtained from people informally on a day to day basis. There had been no formal feedback from people, relatives, visiting professionals or staff. We were told people did not participate in formal feedback. For example residents meetings had stopped because people didn't attend. There was no evidence different ways of gaining feedback to improve and develop the service had been explored.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured good governance had been maintained.

People spoke highly of the provider and manager. They knew who they were and we observed people speaking with them throughout the inspection. One person told us, "All the staff are excellent, if I was unhappy I would talk to them directly they are good listeners." People told us the manager and provider responded to their concerns and they felt listened to. One person said, "They deal with these things." When we asked people if they would like anything to be different at the home comments included, "I like it as it is" and "I am happy with the way things are." The provider and manager were visible at the home. They knew people really well and understood their needs, choices and wishes.

Staff told us they felt well supported working at the home. One staff member said, "We talk to each other, we keep an eye on each other and we work as a team." Another said, "I can always talk to the manager, can always go to her." A further staff member said, "I love coming to work." All staff spoke about Ennis House being people's homes. Their emphasis was on ensuring people were supported to make their own choices and decisions.

There was a management structure and staff knew who to contact if they had any concerns. The provider was supported by the manager and senior care staff. There was a low staff turnover at the home which meant staff knew people well. Staff were updated about people's needs at regular handovers and throughout the day. There were no formal staff meetings. However, the manager attended handover at least three times a week to update staff about any changes or share other relevant information.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received support that met their needs and reflected their preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the home was clean and properly maintained. 15(1)(a)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1)(2)(a)(b)(c)(e)(f)