EBS Services Limited

Rodney House Care Home

Inspection report

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12 December 2016
16 December 2016
20 December 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This inspection took place on 8, 12, 16 and 20 December 2016. The first two days of the inspection were unannounced.

Rodney House is a large Georgian style building with a more recent extension over five floors in a city centre location. The home had 57 rooms all for single occupancy; nine of the rooms were en suite. For people living at the home there were three lounge areas and smaller sitting areas on different floors. There were also two dining areas, a smoking room and toilets, bathrooms and shower rooms on each floor. Each floor was accessible by staircases and a passenger lift.

The home was registered to provide care and accommodation for up to 57 people. At the time of our visit 57 people were living at the home. Rodney House supports people who may have a physical disability or require support with their mental health.

The home required and had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. 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.

During our inspection we found breaches of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It became clear during our inspection that at least 14 people living at the home were smoking in their bedrooms, this was against the home's smoking policy. There was a designated smoking room within the building that the home's policy highlighted was the only safe place to smoke within the building.

There was another specific fire risk that had not been adequately risk assessed and the risk had not been sufficiently reduced. Also we found that people's personal emergency evacuation plans (PEEP) did not contain sufficient detail.

There were aspects of the home's environment that were unsafe. A number of doors with signs on them saying 'keep locked' were open. These provided access to bulk storage of cleaning chemicals, personal documents and the home's loft space. These are areas that contained risks for people living at the home. French doors opening onto a balcony between the first and second floors were not secured and were accessible to people at the home. In the kitchen, food was not being stored safely. During our visit the registered manager addressed these concerns with regard to the environment. They had also started to address the issue of people not keeping to the smoking policy.

Some of the checks and audits of the home and its environment and reviews of people's care plans had not been effective. They had not addressed the concerns highlighted during our inspection.

We found the home to have a pleasant and relaxed atmosphere. We saw people being supported with kindness and respect during difficult times. The registered manager told us that "People who come here may have had very chaotic lives. We offer support that is non-judgemental in a family atmosphere". Many people we spoke with who lived at the home told us they were happy living there. One person said, "It's beautiful. It's the only place where I've settled". People told us that they were happy with the care staff. Visitors to the home told us they had seen good care. One visitor said, "The staff are always patient with people, never seen anyone be short".

We found that the service operated within the principles of the Mental Capacity Act 2005. Deprivation of Liberty Safeguard (DoLS) applications had been made for some people who would benefit from them. We saw that this had been done thoughtfully for specific reasons after the person's capacity to contribute to the decisions had been assessed. People's consent to care and treatment at the home was sought and if they wished people were involved in planning their care.

Feedback from people who lived at the home, staff and visitors about staff numbers was mixed. We saw times when care staff were very busy responding to call bells and caring for people. We fed this information back to the registered manager.

We saw, and visiting health professionals told us, that people's health needs were responded to and people were supported to access services as necessary.

We saw that staff received support to be effective in their role. This support included training, initial induction, supervision meetings, staff meetings and appraisals. Staff went to the manager or an assistant manager if they needed support. Staff told us they felt comfortable doing this.

Incidents that occurred at the home were dealt with and people were kept safe with appropriate support. We saw that the records relating to incidents had been reviewed at management team meetings and strategies and responses analysed. Staff told us they though this had led to a decrease in incidents at the home. Records showed that people were supported during incidents with respect and dignity and it wasn't the practice to restrain people if there was a physical incident.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The home's smoking policy was not adhered to. There was a fire risk from unsafe smoking practices in the building. Another fire risk was also not appropriately managed.

During our inspection we saw aspects of the home's environment and practices that were not safe.

Improvements were required in safe recruitment.

Checks of people's medication had not been effective.

Feedback about staffing levels was mixed. We saw that there were times of pressure on the care staff available and their ability to respond to people in a timely manner.

Is the service effective?

Good

The service was effective.

The majority of people we spoke with were not happy with the food and the way it was delivered.

On-going improvements were being made to people's rooms and the home's environment.

Staff received a thorough induction period and were supported through on-going supervision and appraisal. Staff received training appropriate to their role.

The service operated within the principles of the Mental Capacity Act 2005.

The service worked alongside health professionals in ensuring that people received appropriate healthcare.

Is the service caring?

Good

The service was caring.

There was a pleasant environment at the home and people told us they felt cared for.

Visitors told us that they thought people were well cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had personalised and person centred care plans that were respectful and gave staff guidance on mitigating risks.

There were some omissions in people's care files. We saw that care planning at the home was improving.

We saw a number of activities happening at the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager arranged for regular audits and checks of the home and reviews of people's care and records. Some of these had been effective and some had not highlighted areas requiring improvement.

The registered manager had positive relationships with people living at the home. Staff told us that she was very approachable and worked as part of the staff team at the home.

The home's polices were being reviewed. We saw appropriate policies were in place for whistleblowing and safeguarding vulnerable adults.

Rodney House Care Home

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 8, 12, 16 and 20 December 2016, the first days were unannounced. The inspection was completed by an adult social care inspector.

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 looked at information the Care Quality Commission (CQC) had received about the service including notifications received from the registered manager. A notification is information about important events which the provider is required to send us by law. We checked that we had received these in a timely manner.

We looked at the local authority's contract monitoring report from their visit in July 2016.

We spoke with many people who lived at the home and had more detailed conversations with 12 people. We also spoke with six visiting health and social care professional and other visitors who frequently visited the home to engage in activities.

We spoke with 12 members of staff including the registered manager and assistant managers, four day and two night carers, the business manager, kitchen porter, maintenance staff and the owner of Rodney House. We observed people's care and staff interactions with people who lived at the home. We looked at the care plans for eight people and tracked the care of five people to see if they received the support they needed. We also looked at the staff files for five members of staff and documents relating to people's medication administration, health and safety, staffing and the management of the home.

Inadequate

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at Rodney House.

Rodney House had a no smoking policy with the exception of a designated smoking room that was for the use of people living at Rodney House only. In people's care files we saw a 'residents smoking policy and agreement'. This document it stated, 'If you smoke we have provided you with a designated smoking room within our building… This is the only place that you can smoke inside our home'. The registered manager told us that the aim was to, "Keep people safe and stop them having to wander around the streets to have a smoke". We saw that the smoking room was clear of fire hazards, well ventilated and had heat sensors to detect a fire. There was a wall mounted cigarette lighter to help reduce the need for people to carry matches or a lighter.

During our visit we saw people using the smoking room. One person told us, "We have to use the smoking room. It's ok a lot of places don't have a smoking room". We also became aware that other people did not adhere to the smoking policy or agreement and that smoking in the building was a safety issue. From our observations during the inspection there was evidence that at least 14 people were not abiding by the policy and were smoking in their bedrooms.

During our inspection one person opened their bedroom door smoking, another person started smoking whilst talking with us. Some people's rooms smelt of smoke, people had ashtrays on tables with cigarette butts in them, some people had cigarette butts on the floor of their rooms, there was burn marks on bedding and on a number of floors. The registered manager told us that people were supplied with fire retardant carpets and bedding. However the evidence of people smoking against the home's policy was clear which should have been reported by staff and addressed by the management of Rodney House.

We saw from notes of the last four residents meetings going back to October 2015 that people were reminded that there was no smoking outside of the designated smoking room. We also saw documented 'room safety checks' that were completed monthly. We looked at room safety checks from August 2016 to November 2016. In August cigarette burns were found in four people's bedrooms during the checks, by November this had increased to nine people's bedrooms. In the notes from the September 2016 managers meeting it was noted that, 'some of the [cigarette] smoke detectors may not be working as they should be' and a 'smoking letter issued to all residents'.

In August 2016 one person had deliberately set fire to their belongings in their bedroom. People were evacuated from their rooms to an evacuation point, the registered manager told us the fire service commended the response of the staff and the home's systems. An incident form had been completed and a record of the details of the evacuation. However when we looked in the care file of the person who set the fire there was no reference to this recent event. There was no risk assessment to guide staff in order to mitigate the risk of this event happening again. The registered manager told us that the risk assessment had been completed and stored on their computer system. When we looked at this the actions listed in the risk

assessment were not adequate as they had not reduced the risk.

These are breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because care and treatment of people was not provided in a safe environment.

During our inspection the registered manager and the owner started installing a system which would detect cigarette smoke and alert staff. This would enable staff to support people to use the smoking facilities provided.

Each person's care file we looked at had a personal emergency evacuation plan (PEEP) in place. The PEEPs did not always give clear guidelines for staff on how to keep people safe in the event of an emergency. For example, the PEEPs did not mention the person's room number or location within the building and how they would use staircases. Some of the actions to be taken in the plans were not clear, for example if the person would require support from one or two staff members.

We saw that aspects of the home's environment were unsafe and highlighted this to the registered manager straight away. Access to the building's loft rooms was through a door which was marked 'keep locked – maintenance only'. This door was unlocked and access was available to people living in the home. We went into this area and found that there were holes in the floor, missing floorboards, unglazed windows and many discarded items about the floor. This area would be a very dangerous place if accessed by people living at the home.

We also found a store room marked 'keep locked', which was unlocked. This room contained people's archived care records, which included personal and financial information along with staff files. This information was available to everybody living in and visiting the home that chose to open the door. This meant that people's confidential information was not stored safely.

On a staircase accessible to people living at the home, we saw French doors between the first and second floors, that opened out over the street. These doors were not secured and had no working restrictors in place. This meant that people living at the home, who may have alcohol or mental health support needs had unsupervised access to an open balcony.

The storage of COSHH (care of substances hazardous to health) chemicals was unsafe and careless. One store room close to the kitchen marked 'keep locked shut' was open and contained more than 15 five litre containers of oven cleaner, kitchen cleaner, dishwasher fluid and sanitary rinse. The laundry and adjoining store room were open and also contained a bulk store of bleach and disinfectant. The door to the ground floor sluice marked, 'keep locked shut' was open. The sluice room contained disinfectant and toilet cleaner.

We visited the kitchen which had been awarded the highest aware of 5 stars by the local authority environmental health team. A kitchen staff member told us that the chef had not been in work for two weeks and they were managing the kitchen and preparing the food by themselves.

We found that food was not being stored safely. In the dry store, food was not being rotated properly and the 'use by' date of some items had expired. We saw an open bag of flour and two open bags of cheesecake mix had expired in November 2016. A bag of crumble mix which expired in August 2016 had been used the day before our visit.

In the fridges, food was not being stored safely. For example, we saw an open can of custard that was marked 'Thursday' and looked old. It was a Thursday which suggested that it was at least a week old. There

was an opened gateaux and corned beef with no use by or opened on date recorded. One fridge had uncooked meat wrapped in foil with no use by date. It was stored on a rack above drink bottles causing a risk of cross contamination.

Adequate records were not being kept of food handling in the kitchen. There were gaps in the recording of fridge and freezer temperatures and the kitchen staff member was unable to find recent records of food cooking temperatures.

These are also breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because care and treatment of people was not provided in a safe environment.

We brought our concerns about safety to the attention of the registered manager and she took immediate action to address the issues highlighted. By the second day of our visit many of these concerns had been addressed and ongoing action plans for improvements were provided for us.

Regular checks and audits were undertaken of the services and facilities provided at the home relating to the safe operating of lifting and handling equipment, the passenger lift, gas and electrical services and the fire alarm system. Periodic fire evacuation drills were undertaken and recorded with subsequent actions. The home was split into 14 fire zones, which included the attic space. This allowed staff to very quickly know the likely location of any fire and move people accordingly.

There was an on-call system manned by a senior member of staff 24 hours a day, available for advice or to attend at the home if necessary.

We asked the registered manager how they decided the appropriate numbers of staff needed to provide people's care safely. They told us that they didn't have a formula but based staffing levels on people's support needs and staff response time to people's call bells. We observed and the staffing rotas showed that there were five care staff on duty each day between 8am and 8pm. From 8am until 2pm an assistant care manager was also on duty. The registered manager and the business manager were on duty Monday to Friday. In addition to this there were four or five cleaning staff, kitchen staff and a laundry person present at times through the week. The registered manager told us this was so the care staff only needed to focus on people's care. Overnight four care staff were present.

Feedback about staffing levels was mixed. Out of five staff we discussed this with, three felt strongly that there were not enough care staff. Staff spoke of pressure points around mealtimes as some people needed support to eat, when people had appointments and times when people needed support with personal care. One staff member told us that at times 'Answering people's buzzers is hard'. Another told us, 'It's busy but manageable'. During our visit we did see times when the call buzzer system at reception was repeatedly sounding from numerous calls for extended periods of time. There were not always enough staff available to respond to people's needs in a timely manner.

The call bell system had two types of call, standard assistance and emergency assistance. We observed that emergency assistance calls were responded to very quickly by all available staff.

Other people told us that they felt safe because, "When I push my button the staff come". One person told us, "staff come quickly". Other people told us that at times it, "takes them a while". One visiting professional told us that they had witnessed, "scant staff late in the morning". They told us that on one recent occasion they were looking for a person to give feedback to. Another told us, "On the whole they seem a bit short

staffed". We asked a third visitor if there were enough staff and they said, "Definitely no. It's full on with staff running around".

We checked that new staff had been recruited safely. We looked at the recruitment records for five staff members and saw that staff photographic identification, proof of address and right to work in the UK had been checked. New staff had completed an application form outlining their skills, previous employment and experience before they attended an interview with a panel of at least two senior staff. Staff told us that their interview contained scenario based questions asking how they would respond to people in different situations, in order to gauge their skills.

The organisation sought two references for new staff members before they started; one of them was from the job applicant's previous employer. There were records to show that steps had been taken to verify references in four out of the five staff files. On one person's file the two references had not been verified in any way and one of them contained contradictory information. When we highlighted this to the registered manager she told us she was not involved in the recruitment of this person and would investigate this straight away.

For new staff the provider undertook a criminal record check using the Disclosure and Barring Service (DBS). The DBS carry out checks to help employers make safer recruitment decisions and help prevent unsuitable staff from working with people who use care and support services. We saw records of risk assessments that the registered manager had completed when a staff member had declared a conviction. The registered manager confirmed that they discussed the details of any conviction with the applicant and completed an assessment of any risks before making a safe recruitment decision. DBS checks were completed every three years for existing staff members.

There was a secure medication room which provided appropriate space and equipment for storing and organising people's medication. There were facilities for hand washing and the safe disposal of sharps. Medication requiring refrigeration was stored appropriately and the fridge temperature was regularly checked. There were records of medication received and returned to the pharmacy. We also saw records relating to the care of people with diabetes and records of blood sugar readings.

Controlled drugs were securely stored. We checked the administration records and stocks for all the controlled medication and these were accurate. The records were checked at each staff changeover. We also checked the general medication and as required medication (PRN) stocks and records from the previous week for seven people. For six people these were correct. For one person over two periods in the previous week four different medications had not been administered. When we checked the records these had been signed by staff as administered to the person.

The staff member administering the medication was surprised by this. A person's medication that was still present in the blister pack for five days had not prompted any incident to be recorded or was not investigated to see why a person had missed their medication. The staff member indicated that these types of checks didn't happen all the time. When we spoke with the registered manager about this she told us that medication records were audited every six months and that this would now be reviewed.

Good

Is the service effective?

Our findings

People spoke about the staff in a positive manner. One person told us, "The staff I find great". Another person said, "I think the staff are really nice and very helpful. The home is quite good". A third person said, "If I want anything, the staff get it for me".

New staff had an induction from various people within the home. We saw this covered health and safety, fire safety, safeguarding and people's support plans. We saw that there was a checklist that new staff went through with a senior member of staff. Also new staff initially had a 'support meeting' every two weeks. This helped new staff to fill any gaps in their knowledge during these meetings. One staff member told us the induction was good and "prepared me for people and their support needs". New staff we spoke with told us they had a shadow period. One staff member said, "I shadowed another staff member for two weeks. The result is that I felt comfortable".

We looked at five staff members' files and saw that staff received regular supervision. We saw that these were used as opportunities to offer staff praise for good work and gain their feedback about the role. We also saw that they were used as learning opportunities and to raise any concerns with the staff member. We also saw that staff had an annual appraisal which the staff member contributed to. This gave the staff member feedback on their performance. Staff had regular staff team meetings to update them on events in the home.

Staff told us they received regular training appropriate for their role. This included moving and handling, health and safety, safeguarding vulnerable adults, hygiene and behaviour awareness. Staff told us that training was provided in the building by face to face training, people told us they though this helped them to learn. Some staff told us they had received training in deescalating challenging situations that may arise.

Staff told us that it wasn't practice to restrain people if there was a physical incident. They used distraction and moved the person or others to a quieter place or a place of safety to diffuse situations. In certain situations, people required increased observation or were asked to use their bedrooms. This was documented in people's care plans. If necessary the staff called the police for assistance.

People had 24 hour access to tea and coffee making facilities; if people needed help making a drink we saw staff helping them. Some people had tea and coffee making facilities in their rooms.

There was a mix of opinions about the food available at the home; however the majority of these were negative. Visitors who we spoke with told us they were aware that the food was not liked by some people. We sampled the food on one day of our visit, it was fish and chips and the food was fresh, tasty and hot. Two people whose rooms we visited had tinned food in their room, one of these people told us, "The food is not that good here".

People told us that if they didn't like the food on the menu for that day they could have a sandwich. The registered manager told us that sandwiches were also available if people missed their mealtimes. We found

the dining room to be locked shut with the light off after lunch, not inviting people who may want to ask for a sandwich. Some people told us that the response from kitchen staff could be abrupt. One person told us that if they said their food was cold, "They get a cob on and put it in the microwave for you". Another person said they had asked for eggs to be flipped and were told, 'This is not a restaurant'. We mentioned to the registered manager that we found signs giving instructions in the dining area to be negative. For example one sign stated, '9 – 10am, a cooked breakfast will be served between the above times. Please do not ask for a cooked breakfast after 10am'. There was no mention made of what was available after 10am. The signs had been taken away by the second day of our visit.

The kitchen staff showed us a weekly meal planner and a record of people's food likes. Arrangements had been made to cater for people's cultural and religious preferences with their food. For example there were two separate fryers, one of which was for the preparation of halal food.

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 be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the registered manager had arranged for applications for a DoLS to be submitted to the local authority for people who would benefit from them. These had been completed with a clear rationale with regard to why they had been applied for and how the person would benefit. These DoLS had been applied for after a capacity assessment had been completed.

Access in and out of the building was by fingerprint recognition equipment. This ensured that people who had an authorised DoLS in place and required support to access the community had this support with them and other people without this need were free to come and go as they pleased, with no restrictions. This also gave staff up to date information on who was inside the building and who was out in case of any form of emergency.

Staff we spoke with understood the principles of the MCA and how to support people to make decisions. One staff member gave us the example of a person who wasn't eating and said they supported them by, "Letting people know food choices, showing people the food and taking food to people's rooms. This all helps people to make an informed choice". We saw that during people's care, staff asked people for their choices and promoted decision making where possible.

As part of care planning, people were asked for their consent to various aspects of their care and treatment. Very few of the consent forms we looked at were signed by a person or indicated that the person had given their consent. Some had been signed by staff members with no explanation. Others had written on them that the person had refused to sign, with no further information with regard to if the person gave their consent or not. There was no reference to if the person gave their consent verbally or details of anything they may object to. Other consent forms had written on them by staff that the person was 'unable to sign'; however there were other documents in the care file that people had signed. When we asked the registered manager about one person she told us, "They can sign, if I went to see her now she could sign". More recent documents were clearer and gave details of verbal consent, when given and who to.

Visitors told us that there had been improvements made to the home environment and further improvements were planned. There was an ongoing building improvement plan in place. More than half of the bedrooms had been redecorated and had flooring renewed. Many people told us they were happy with their rooms. Comments included; "I like my room it has a great view"; "I have a decent room"; "Nice big room" and "My room is very nice".

Areas of the home had new flooring, the toilets and bathrooms had been updated and the downstairs dining room was bright with well laid out tables. The exterior of the building had been recently painted and all windows checked and repaired as needed. Other areas of the home needed updating and works were on-going.

A health professional told us, "They will be the first to ring us, they won't just wait for a visit". We saw that the home worked closely with district nurses, GP practices and other agencies in supporting people with their health care.

Good

Is the service caring?

Our findings

One person when speaking about the care they received told us, "It's beautiful. It's the only place where I've settled. None of the hostels would take me, I was on the street. Now I've started to do things that I used to. It's been positive for me. I'm a lot happier here that I would be in a flat by myself". Another person said, "Of course we would all like our own home. But overall the home is quite good". A third told us, "It's great here, it's good. It's superb, I've been here for ten years".

A visiting professional told us, "The guy we saw today spoke fondly of the staff". Another told us, "I've witnessed very good care here". A third said, "The staff are lovely". Another said, "The staff are always patient with people, never seen anyone be short".

We saw that people were relaxed at the home as they went about their business or spent time relaxing. We saw some occasions when people who had become upset received emotional support. In one example the staff member tried to work out quickly what was upsetting the person and sat down to be on the same level as the person. The staff member knew a song the person liked to sing and sat and sang it with them. Once the person was calm and laughing the staff member started to work out the problem. The person was supported with a caring approach and the staff treated the person with dignity and kindness.

We asked a visiting professional if they would be happy with one of their relatives receiving care in the home. They told us, "Definitely, not necessarily for the building. But for the service I would, I often see staff having a laugh with people".

Requires Improvement

Is the service responsive?

Our findings

People told us that they knew the staff and found them very helpful. One person told us they had recently had their support plan reviewed, they told us, "I gave my comments on it". A visiting professional told us they though the staff had been really responsive to a person's care needs. Another told us they thought, "The staff try their best".

Each person had an individualised care plan. Important information was kept at the front of the plan for staff to access. For example we saw that one person had a diabetes support plan, another person a dysphagia support plan for eating and drinking and a third person had instructions and guidelines for staff relating to their religious convictions. Some people who we spoke with told us that they had been involved with putting together their care plan and had been asked for their feedback about their care plan. We saw that people had a pre assessment of their needs before moving into the home, this identified people's support needs and helped to ensure that the home could safely meet them.

People who wished to give personal information had a personal life history booklet, which enabled staff to know more about them and their background. We also saw that, as part of people's assessment, their personal preferences were documented. Examples of these were people's faith and what it meant to them, preferences for male or female carers, people's interests, music preferences, favourite shops, preferred waking times and what contact they had with family members.

People had a dependency assessment which prompted staff to look at different aspects of a person's care and to make sure these aspects of a person's care were planned. This assessment looked at; pain and discomfort management, mobility, personal care needs, skin integrity, support with nutrition and the person's social behaviours.

We saw examples of effective care planning that was respectful, non-judgemental, person centred and gave staff guidance on mitigating risks. For example one person had an alcohol support plan which provided daily guidance for staff and ways to mitigate risks and support the person if they became intoxicated. Other people had effective care plans in place for support needs such as; sensitivity to light, oral care, social anxiety, a deterioration in their mental health. Some people made allegations when they experienced a deterioration in their mental health. We saw that there were plans in place for staff to support people with allegations they had made and that allegations were taken seriously and responded to effectively and proportionately. The registered manager told us that some people depending on their needs as identified in their care plan, had hourly or two hourly checks on their wellbeing and safety. People were also had their wellbeing checked at meal times and we saw that this was recorded in people's daily notes.

At times there were omissions in people's care plans that meant they did not give staff important information. For example, one person used a hoist to move and there were no instructions for staff recording the size of sling the person used and what loops were used on their sling. Another person had been identified as being at risk of pressure ulcers; however there was no care plan to address this need. One person had their fluid intake recorded; however we could not find any guidelines for staff regarding what

was a safe fluid intake for this person. Two of the eight people whose care plans we looked at had been identified as a high risk of falls, however no in depth falls risk assessment had been completed. For other people these were in place as required.

We saw that people's care plans were reviewed regularly and that these reviews were recorded. We spoke with the registered manager about this and they told us that they were in the process of developing and implementing a new approach to care planning, as they recognised some problems with the way they had been care planning. We saw that care plans had become more informative for staff as they had been reviewed and updated.

On one of the days we visited, volunteers from a local organisation visited to read poetry with people at the home. We spoke with the volunteers who told us that they came once a week and often a familiar group of five to eight people came to the readings. People who wanted to had started reading a poem or a verse themselves. The feedback about the group was positive from people we spoke with. Recently two people had attended an event outside the home prompted by the poetry group.

On one of the days we visited there was an Elvis tribute act on in the main lounge. The home provided soft drinks and a buffet for people who came to the show. The registered manager told us that over 30 people from the home attended, which was the best ever turnout to an event at the home. People we spoke with afterwards told us that the show was 'great' and people really enjoyed themselves. On another day we saw people were playing a game in the lounge.

Some people were not positive about the activities at the home. One person told us there were no activities, just TV. Another person said, "Not that I know of, there is TV like. I like cricket and rugby on TV but they don't have it here". Some people chose to spend a lot of time in their rooms. We saw notes that showed that activities at the home were discussed regularly at residents meetings.

Requires Improvement

Is the service well-led?

Our findings

It was clear during our observations that people knew the registered manager, felt comfortable around her and had a positive relationship with her. The manager often stopped people and asked how they were. She was very observant and respectful, asking people questions to ascertain how they were doing. For example we saw the manager stop and talk to one person and ask them what they thought of the book they were reading. The manager knew all about the person's favourite authors and had lent them a book to read. Another person who had stayed in bed asked for breakfast in bed. The manager knew the members of staff who the person preferred to assist them with eating and arranged for this. We saw that the manager was often approached and asked questions by people living at the home and staff. People felt at ease with her and she was knowledgeable about their care.

Staff were positive about the registered manager and her style of leadership. One staff member told us, "She's really approachable and very supportive. I feel I can always go to her. She discusses things with you and gives you time. Having really good support makes our job easier". Another staff member said, "She's lovely, really approachable". A third said, "She's lovely and easy to talk to, doesn't make you feel nervous and makes it clear we are all part of the same team".

The registered manager told us that she thought the care at the home was excellent. She said "People who come here may have had very chaotic lives. We offer support that is non-judgemental in a family atmosphere".

The manager arranged for regular audits and checks of the home and reviews of people's care and care records. Some of these had been effective and had provided information that the registered manager had used to make improvements. For example in the response to incidents that happened at the home and improvements made to the building.

However we found that some audits and checks had not highlighted areas requiring improvement.

For example, a communal areas check was completed on 28 November 2016, 10 days before our visit. This looked at the safety of windows, lighting, doors, floors and trips and other areas. These checks had not addressed the concerns we had regarding the environment that were highlighted to the registered manager on our first day.

Monthly room safety checks were completed for each person's personal room. We looked at these from August to November 2016 and they showed that some people had burns in their flooring and carpet from cigarette butts. There was evidence that this was increasing as it was noted in four people's rooms in August, increasing each month to nine people's rooms in November. In some of these rooms there was no equipment present that would detect cigarette smoke and alert staff members. This information had not contributed to the risk assessment process at the home.

Reviews of people's care files had not highlighted omissions in some people's assessments and missing

information from some documents.

We looked at the organisations safeguarding file. For each safeguarding event there was a copy of the incident report and of any notifications made to the CQC. These had been audited by the registered manager.

When we looked at the records of incidents we saw that information from nine incidents that would be notifiable to the CQC had not been sent. Some of the incidents has been typed onto the CQC forms but had not been sent. The registered manager told us that some of these were from a time when she was away from the service and others were errors. We asked the manager to ensure a system was in place that made sure statutory notifications were sent to the CQC as required.

These are breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because audits and checks at the home had not led to necessary improvements to the safety of the service being provided.

The registered manager and provider told us that they had recognised a need to change the structure of the organisation. They employed two assistant care managers; the most recent of these had started five weeks ago. They worked over a seven day rota so each day an assistant care manager was present. They also appointed a business manager who took oversight of health and safety, staff training, and was currently reviewing the organisation's policies. They prepared information from incidents and accidents for the monthly managers' meetings. The registered manager told us that they are well supported by the provider and that they communicated every day.

The registered manager told us that the home had improved but said that in some areas they are not yet where they want to be. They were working on a new system of care planning and when we looked through people's care plans we found that more recent documents were clear, aspirational about people and person centred. The registered manager told us, "We should never give up. We should expect the same standards for others as we would for ourselves".

Accidents and incidents were reviewed monthly as part of the managers' meeting. One senior staff member told us they wanted to make sure that they were responding appropriately and learning from any incidents that occurred. The provider told us that looking for trends had been useful in helping to improve people's support. Some staff we spoke with told us that there were fewer incidents at the home than previously.

The home had appropriate policies in safeguarding which provided staff with relevant information and contact details for the local authority. There was a whistle blowing policy that gave staff contact details of the public concern at work organisation, where staff could raise concerns outside of the organisation if necessary.

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 17 HSCA RA Regulations 2014 Good governance Because audits and checks at the home had not led to necessary improvements to the safety of the service being provided.