Rodwell House Limited

Rodwell House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rodwell House is a care home providing, accommodation, personal and nursing care to up to 79 people in one purpose-built building. People were living with a range of complex health care needs. This included people living with dementia, diabetes or Parkinson's disease as well as people with a learning disability. At the time of our inspection, 74 people were living at the service.

People's experience of using this service and what we found
Despite highlighting shortfalls to the registered provider in a number of our previous inspections, they had failed to take action and as such people living at Rodwell House continued to receive a poor level of care.

The registered provider was unable to demonstrate robust governance arrangements and learning had not taken place to improve the service. The service was without a registered manager and there had been a lack of consistent service-based management presence over a number of years. There was a lack of commitment or urgency to ensure people's quality of care improved and that where shortfalls were identified by management, these were addressed in a timely manner. Infection control practices were not sufficiently rigorous to help ensure people were kept safe from the spread of infection.

People said they were not provided with enough attention from staff as staff were too busy and they told us they were, "Bored", particularly those people who were confined to their rooms. People said the quality of the food provided to them had deteriorated and that staff did not always demonstrate a kind, caring approach and one that enabled them to make their own decisions. People reported staff continued to speak in their own language which was a concern we had identified at previous inspections.

There was an insufficient number of staff available to meet people's care needs and ensure people were not at risk of social isolation. We heard how staffing levels had changed and this had impacted on people's daily lives. Despite the service having a safeguarding procedure, staff did not learn from incidents that had occurred as we received a number of safeguarding concerns over a period of several months. People therefore continued to be at risk of harm whilst living at Rodwell House.

Individual staff were kind, caring and attentive towards people and we heard from some people and their relatives that they were happy living at Rodwell House. However, we were also told by people how they felt staff did not always demonstrate a respectful and compassionate approach. Although people were invited to give their views on the service, their feedback was not always listened to.

People's care plans were not contemporaneous, and staff were not always able to tell us about people's individual care needs. Where people were at risk of harm, information was not always in place for staff to give them guidance on how to respond to this.

We expect health and social care providers to guarantee autistic people and people with a learning disability

the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• There were insufficient activities staff within the service to provide people with individual, meaningful activities and external trips no longer took place. This meant people did not have the opportunity to access the community.
Right care:
• There was a wide mix of people living at the service and as such people's individual characteristics and needs were not always recognised by staff. Staff did not always take time to read people's care plans and were unable to tell us about people.
Right culture:
• The changes within the service meant that there was a constant turnover of staff. This resulted in people receiving care from staff who may not know them well and staff who did not always speak English in front of people. People were admitted to the service without the registered provider considering it was an appropriate setting for them.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We have issued the registered provider with a recommendation in this respect.

Although staff said they received sufficient training and felt supported by the new manager, we heard examples of poor care being provided by staff and where shortfalls or concerns had previously been identified at this service, training had not taken place with staff to help ensure they did not reoccur.

People received the medicines their required and when needed, the input from healthcare professionals. People said they felt safe living at Rodwell House and staff were able to demonstrate their understanding of reporting any safeguarding concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
We carried out a focused inspection to this service in December 2020 when we inspected on the key questions of Safe and Well-Led. Prior to that we completed a fully comprehensive inspection in October 2019 covering all key questions. The overall rating for the service at both inspections was Requires Improvement and we found breaches of Regulation. The registered provider completed an action plan after that inspection to show what they would do and by when to improve.

At this inspection we found that not all breaches of Regulation had been met and we also identified new breaches of Regulation relating to staffing, infection control, risk management, safeguarding, training, the premises, respectful and person-centred care and governance. You can see more detailed information about these in all of the key questions in this report.

Why we inspected
This inspection was carried out in response to numerous concerns we had received. These related to staffing levels, poor care, poor quality of food and lack of empathetic management. It was also partially prompted by our data insight which assesses potential risks at services, concerns in relation to aspects of care provision and the rating at the last inspection. The overall rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection.

Special measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Rodwell House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Rodwell 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.

A new manager was at the service, however they had yet to register with the Care Quality Commission. As the service is without a registered manager the registered provider is legally responsible for the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return in advance of this inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with eight people who used the service, two relatives and someone visiting two people about their

experience of the care provided. We spoke with 16 members of staff including the manager, the deputy manager, clinical lead and the provider's compliance manager.

We reviewed a range of records. This included 10 people's care records, three recruitment files and medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, governance information and recruitment paperwork. We spoke with another relative.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our focused inspection in December 2020 we issued a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment processes had not been effective to ensure staff were suitable for their role and to make sure deployment of staff across the service was appropriate. At this inspection, we found the provider had not fully met the breach of Regulation 19 as people reported a continued shortage of staff.

- Some people told us staff were always on hand to assist them. One person said, "Never had a problem with staff, always around." A second told us, "Staff are always around. You have the carers and the helpers."
- However, other people gave a differing view. One person told us, "When you want something, they take ages. I call out and they don't hear me." A second person said, "I'm not sure they have enough [staff]. They [staff] say they will be back, but they never come." A relative told us, "At times they are a bit short of staff which means she may have to wait." A second relative said, "There is a general lack of staff. Sometimes there is nobody on the floor. On one occasion I had to ring [my family member's] bell and no one came and I couldn't find anyone." A professional said, "Not always enough staff."
- We found staff were rushed and there were occasions during our inspection when we could not find staff. Staff told us, "We spend our time getting people up, doing the medicines, carrying out personal care and then it's another medicines round. We are rushed and people have to wait." We also heard, "Staff are tense and rushing. People feel it affects their personal care. We don't have time to spend with people." A relative reported to the local authority, "We waited at least an hour for someone to come and change her." A second relative told them, "At 11.30am she was still in bed."
- The lack of staff meant people may be unsafe. We found one person sitting on the bed in another person's room. This person was recorded as having the potential of being, 'aggressive'. Staff were unaware of this person not being in their own room and it took us several minutes to find a staff member to let them know.
- Insufficient staffing levels or suitable deployment of staff also meant people may not receive the attention they required. During the day on the second floor, we were aware of a member of housekeeping staff trying to find a carer to assist one person who was becoming distressed. The housekeeping staff eventually found a carer telling them, "[Person's name] is getting agitated, I can't find anyone. Can you go and see her."
- The manager told us they had introduced a 'care companion' system, where staff were allocated a certain number of people each shift. They said, "If you have someone on shift for four days, they stay with the same people to provide a holistic approach."
- Although some staff said they felt the new way of working was good, one staff member told us, "The new system is working, but needs more time," Other staff said there were not enough of them to carry out

people's care unhurried. One staff member said, "It can be good if we have enough staff, but some staff are allocated too many people."
● Staffing levels were decided based on people's dependency. We were told five staff were on duty on the ground floor for 20 people, eight staff on the first floor for 37 people and four staff on the second floor for 21 people. Two nurses were on shift each day, with one on the ground floor and one on the first floor.
● Many people required continual input from staff. A large number of people were non-weight bearing and used a wheelchair. They required staff to move them for personal care or for transferring which meant two staff were tied up during these periods. However, we heard this may not always happen, with a relative reporting to the local authority, " Only one carer changed mum, her pjs, bedding everything. When I mentioned it should be two, I was told that sometimes [person's name] can help by moving herself."
● The manager told us of three people who required a great deal of staff time. They described these people's routines and requirements and told us, "Between the three of them, they take up a lot of staff time."
● There was a wide range of complex needs within the service and people were largely unable to care for themselves and fully reliant on staff. Seven people had multiple sclerosis, 31 people were living with dementia, six people were elderly and frail, people who were diagnosed with a learning disability and five people were on palliative care. Three people were cared for full time in bed.
● In addition to a shortage of care staff we also heard there were an insufficient number of nurses. We were told, "One nurse isn't enough, there are 37 people on this floor. If we had another nurse, we could do more checks, we could check on wound care. We cannot predict what is going to happen and if there is an incident we get called away."

The failure to provide a sufficient number of suitably qualified, competent and skilled staff in order to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited through a robust process. Prospective staff completed an application form, gave evidence of right to work in the UK and provided identification. Staff also underwent a Disclosure & Barring Service check (DBS) which helped establish if staff were suitable to work in this type of setting.

Assessing risk, safety monitoring and management

At our focused inspection in December 2020, we found that people may not always safe because staff did not take enough action to respond to potential risks and information for staff was inconsistent. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified similar concerns.

● In some areas of the service, we found hazardous cleaning products stored in an unlocked cupboard. Although a staff member said the cupboard had a lock, we found it was broken. We also noted a jar of thickening powder on a shelf in the kitchen area. Although people did not appear to be at risk of picking it up and inadvertently ingesting it, the thickening powder was not being stored in line with an NHS England safety alert in 2015. This alert recommended that thickening powders should be stored securely, out of reach of people.
● One person was unable to use a call bell, however their care plan stated they could. We spoke with this person and they were unable to tell us where their call bell was, despite it being beside them. This demonstrated to us they would not know how to alert staff when needed.
● A second person was at ligature risk; however, they had a flexed call bell in their room. Their care plan stated, 'Staff have removed the call bell and landline from his room. Staff should ensure hourly checks are done and keep the door open at all times to ensure his safety'. Yet, we saw their door was often closed or

pulled to and the person had their call bell in the room.
● At the last fire risk assessment in April 2021, there were a number of areas identified are requiring improvement and the service had been given a medium risk rating. One required action was to rag rate people's individual personal evacuation plans (PEEPs), however this had still not been done.

The on-going potential risk to people was a continued breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did note some people's risk assessments were comprehensive and covered all key areas, such as risk of falls, pressure damage or malnutrition. One person was at high risk of falls as they could become dizzy when standing up. Staff were reminded to encourage them to get up slowly, accompany them when walking and encourage them to sit down if they became dizzy.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. Sluice rooms on two floors were not being used correctly by staff and two smelled strongly of urine. The bins were filled with soiled pads and unused pads were being stored, out of their packaging, in the same area. There was also faecal staining on some of the equipment. All sinks were dry to touch and had clearly not been used by staff. In two bathrooms we found trolleys of dirty laundry which remained there for most of the day.
● A relative told us, "I have some concerns about the cleanliness at times. I find (my family member's) table encrusted in food and I end up cleaning it."

The lack of robust infection control processes was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People said they felt safe living at Rodwell House. One person told us, "I feel safe as there are always people around."
● The service had been the subject of a number of recent safeguarding concerns and they were working with the local authority safeguarding team to investigate these. These were raised between June and October 2021. We reviewed the information relating to these concerns and found a general theme of reports of poor care, lack of staff, neglect and concerns about people's safety.
● A relative told us, "I am always worried about her." Other relatives had reported to the local authority, "Care line frequently left out of mums reach on the wall," and "His call bell cord was not in easy reach for him to use."

● This showed that although management had a process in place for preventing safeguarding concerns and learning, people had not been protected from abuse. In addition, lessons had not been learnt as changes had not been made to the service to help ensure people were free from potential abuse.

The lack of robust processes in place to help ensure people are safeguarded from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with on the day were aware of the different types of abuse - a staff member told us, "I would inform the nurse [of any concerns]." However, following the recent spate of safeguarding concerns management found not all staff knew how to identify potential abuse or how to report it. This had led to additional training for staff. The compliance manager told us, "We are now producing a video and written information in staff's own language to help them understand the processes."

Using medicines safely
● People received the medicines as prescribed and staff followed good medicine administration practices.
● People's medicines were kept in locked cabinets in their rooms and other medicines were stored in temperature-controlled conditions, with the room and fridge temperatures checked daily.
● Topical medicines (medicines in cream format) were labelled with the date they were opened, so staff knew if they were still safe to use.
● People's medicine administration charts were held electronically and when administering medicines care staff scanned the bar chart on the person's cabinet as each medicine was administered.
● The electronic system had an alert process built in to prevent the wrong medicine being given to the wrong person or at the wrong time. Any missed or late medicines were alerted to management.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last fully comprehensive inspection in October 2019, we issued a recommendation in relation to staff training and supervision as although improvement had been made since the previous inspection, systems needed to be embedded into regular practice. We found any changes made had not been sustained.

● Staff completed an induction period, which included training, when they first commenced at the service. We saw records relating to two new staff members and saw they had completed an induction as well as all statutory training. New staff members shadowed experienced staff to ensure they were confident in their role. A staff member told us, "I did my induction on the ground floor and only started working on my own two or three days ago."
● Where staff were administering medicines, they underwent a competency assessment to help ensure they were able to complete this task safely.
● Staff training covered all aspects of care, including, fire, first aid, moving and handling and the Mental Capacity Act. A staff member told us, "Training is okay." A second told us, "Plenty of training."
● The manager told us, "We have allocated the training and care companion role to a senior staff member." This staff member said, "We have raised our expectations of what we want. All staff do the Care Certificate (a nationally recognised set of expectations for people working in care) before going on the floor. They are put on the rota for a two-day induction with an experienced member of staff, then go on the rota as a helper for a week. They have to get 100% on their workplace assessment and their written work."
● Staff had the opportunity to meet with their line manager to discuss their role, any concerns or personal development. A staff member said, "Supervisions are good. We have meetings every day with the manager as well."
● However, despite the induction, training and supervision systems in place, there was an overall failure to ensure staff were appropriately trained to ensure they were fully competent in their roles. Relative's had reported concerns to the local authority. One told them, "Staff displayed very poor manual handling techniques. I had to intervene as the bed head was in an upright position whilst they were trying to move [person's name]. They proceeded to hoist whilst she still had a cushion underneath her which places her at a great risk of skin tears." A relative told us, "There is a general lack of training. Staff don't know people."
● In addition, people reported staff continued to speak in their own language, rather than English. This was identified at previous inspections. The manager told us , "There are courses online" and that they would have an expectation that , "They can read and write English." However, they added, "Still a problem with [non] English-speaking staff." This showed us that although this had previously been highlighted to the

registered provider, they had introduced changes to the staff training so help ensure staff had a good command of the English language.
● We also found the registered provider had failed to ensure staff were trained to automatically read people's care plans to ensure they got to know people, what care they required and to understand information relating to people's risks.

The failure to ensure staff are sufficiently competent to provide care in a safe way was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our fully comprehensive inspection in October 2019 we found a lack of compliance with the principles of the Mental Capacity Act 2005 and issued a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a continued failure at this inspection to comply with the Act.

● The manager explained each person's care plan was being reviewed. They told us, "We are looking at those. We have reviewed the mental capacity assessments."
● Although there were references to people's capacity to make decisions in their care records and capacity assessments were completed, it was not always clear that best interests' discussions took place. One person was determined as lacking capacity to make complex decisions, but there was no best interests paperwork to support any decision made on their behalf. A second person was also determined as lacking capacity, but there was no information on what the capacity assessment related to and no best interests paperwork. The capacity assessment was left blank, with a note stating a DoLS application had been submitted.
● Staff were able to explain the Mental Capacity Act to us. One staff member said, "It's when people are not able to make decisions for themselves. It's about making decisions for them for their safety." We also heard staff asking for people's consent before carrying out any care.
● Where people received their medicines covertly (without their knowledge) we saw capacity assessments and best interests' decisions as well as involvement from the GP and pharmacist.
● DoLS applications had been submitted where people's liberty was being restricted, although some had yet to be authorised by the local authority's DoLS team.

We recommend the registered provider continues to review people's capacity in line with the principles of the Mental Capacity Act 2005 and evidence of capacity assessments and best interest discussions are recorded.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs; Supporting people to eat and drink enough to maintain a balanced diet

● There were a variety of nationally recognised standards and guidance used to help assess people's needs. Checks carried out by staff included a person's risk of malnutrition, skin breakdown or pain threshold. However, we were not assured staff could meet people's individual needs.

● The service was not providing support to people with a learning disability. The provider had not considered the guidance around Right support, Right care, Right culture (RSRCRC) which advises social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. People should be able to get out as much as possible, including shops, groups, clubs and cinemas when they want to.

● One person told us, "I shouldn't be here. This is an old people's home and I shouldn't be in an old people's home. It's not right."

● There was a lack of meaningful activities for people with a learning disability including no access to sensory rooms and limited access to the community. The service was situated near a busy road, outside of town. A relative said, "The outings don't happen anymore. There used to be a lot. But they got rid of the bus and driver and there is only one activity person now."

● We spoke with the compliance manager about these concerns who told us, "There are only two of the 78 we support at Rodwell with a learning disability diagnosis. I am obviously aware we need to meet their support needs in all areas and staff have been given access to the guidance. We do not routinely admit residents with a learning disability and the two people we do support are at Rodwell due to their nursing needs becoming their primary need." However, whatever the primary need, if a person has a diagnosis of a learning disability, the provider should be able to demonstrate how they are meeting RSRCRC.

● People's rooms were personalised and where people required adaptations or equipment, this was provided. We saw some people had a ceiling hoist to assist with their moving and handling and others had specially adapted chairs.

● However, although the service had one large lounge on the ground floor which doubled up as a dining room at mealtimes, we did not see any smaller communal areas or quiet areas where people may like to relax in peace. The manager told us, "It's a big issue. It's (the lounge) too big and long."

● The manager showed us a new kitchen installation at one end of the lounge, explaining a second kitchen was to be installed at the opposite end. They told us, "It will mean people can come up and help themselves to food. They'll be able to see what choices there are. We will involve the chef so they can get direct feedback." They added, "The second kitchen area will have an oven which means staff can help people with life skills and people can bake." However, this would only really benefit people who were mobile and not permanently in their room.

● The environment was not suitable for people living with dementia and staff struggled to explain to us what they could do to make it so. Although there was signage for bathrooms and toilets, there was nothing stimulating or sensory for people to look at when they walked along the corridors, and there was nowhere for people to sit outside of their bedroom unless they went to the lounge area on the ground floor. A staff member said, "I think there should be more. They [people living with dementia] need more things and activities."

● People gave mixed views on the food. We were told, "Today's meal is not as good as some others" by one person. A second person said, "The food is not too good. The main meals could improve. There are always two choices, but both are pretty tasteless." A third person said, "The food is horrible. I just leave it." However, one person said their lunch was, "Excellent" and another told us they enjoyed the food. A relative told us, "The food seems very good."

● We observed a mealtime and overheard one person saying, "It's rubbish." There were a lot of people in the dining area and some people had carers who were chatting with them. Other people however, had no

engagement from staff as they assisted them.
● We spoke with the manager and compliance manager about the quality of the food. They told us, "We have an excellent relationship with the kitchen and the chef is open to going to another of our services to learn to make the food more person-centred [in line with people's preferences]." They told us there was a three-month plan to introduce more varied and better-quality food.

Care and treatment not being delivered in line with people's wishes, current legislation, standards and guidance was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people required a modified diet, we saw they were provided with this and people's care plans clearly indicated people's likes and dislikes. We saw one person's lunch was in line with their care plan and another person had a food allergy which was recorded on the information from the kitchen.
● People at risk of malnutrition or dehydration had food and fluid charts kept, so staff could record people's intake.
● People were seen with drinks throughout the day and in the afternoon, there was a birthday celebration for one person in which party food was offered to people.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People told us staff contacted healthcare professionals on their behalf when needed. One person said, "They [staff] do call the doctor if needed." A relative told us, "An optometrist came in the other day and she's suggested some new glasses. The nurse came and spoke with me about it."
● There was evidence in people's care plans of referrals to healthcare professionals such as the Speech and Language Therapy (SALT) team, GP, physiotherapist and the community mental health team.
● Staff had involved dieticians for some people who had visited and agreed weight reducing diets. Where people were at risk of malnutrition, weights were monitored monthly and care plans amended as appropriate.
● Staff used handovers as a way of on-going monitoring of people. Weekly targets were set to ensure people were weighed as required, their food and fluids recorded, or areas identified which required regular monitoring.
● The manager told us, "We are working with a neuro unit in Holland to help develop and maintain people's skills where possible. We've got a few people back to their own home who have come in here from hospital."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. Some individual staff were caring. However, people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- We heard some positive feedback about staff. One person told us, "The carers are excellent." Another said, "Everyone is pleasant enough." A third told us, "Some of them are lovely."
- Despite these comments, we observed some less than caring actions by staff. At lunch time one person who was sitting at the table with three others, was crying out. Although a staff member came over to clear the lunch plates away, they offered the person no reassurance nor did they engage with them.
- A staff member told us two people, who were independently mobile, were only taken down to the ground floor to have their meals. They told us, "The reason why we don't let them downstairs is they try and get out of the home. We will take them down for meals, but bring them straight back up again."
- People told us they could not always make their own decisions. One person said, "I have a shower once or twice a week. I would like more." They also told us in the morning, "[Staff] come in and flip the light on [to encourage people to wake up]."
- One person, who was mainly nursed in bed did not have their call bell within their reach. They told us, "Staff leave it (over) there, so I can't press it."
- The manager told us, "We are in a period of trying to settle the home and new ways of working. The culture is something that needs to be addressed."

The lack of respectful and compassionate care shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, we did also see positive interactions as well on the day. One staff member was continuously checking on people's welfare. Another sat with one person gently rubbing their hands and when staff went into people's rooms, we could hear they were kind and courteous.
- We saw staff reassure people when they became anxious and staff crouch down to talk to people at their level and acknowledged people as they walked past them.
- Some people were supported by staff with their independence. One person told us, "They ask me what I want and try and encourage me to do things." A second person said, "One of the nurses has offered to take me to church. I would love to go outside."
- A relative told us, "All the staff are very kind and caring." A second relative told us, "I am really impressed with the care and how the staff are to him. They are attentive to him when he doesn't sleep at night. He seems more settled in here." A person visiting two people said, "My first impressions are staff are very caring

and helpful. [Person] looks a lot better than he did when he first came in."

● We heard of a positive impact staff had with people, with a healthcare professional telling us, "I have seen some very good care in Rodwell house. One gentleman moved in and he was in a very neglected state, never left his room and spent all his time in his bed. Within five days he was sitting up in the lounge, all clean shaven, looking very smart and able to give himself a drink which is something he had not done in a while."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last comprehensive inspection in October 2019, we found there was a lack of person-centred care planning. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found at this inspection further work was needed to ensure people consistently received person-centred care.

- People's care plans varied in terms of the detail they contained, in addition to this staff's knowledge of people was mixed. We asked staff about some people's backgrounds as well as their needs and they were not always able to provide us with information. One staff member said, "I don't know anything about his background," whilst another told us, "I see she walks all the time. I offer her tea and coffee. I haven't read her care plan."
- However, other staff were more knowledgeable, with one telling us, "[Person] is from [country name] and her daughter is a [daughter's profession]. She can be resistant to care."
- Some people's care plans talked about the person's childhood, family, likes and dislikes, as well as where they used to work. This helped staff get to know people. However, not all care plans contained this level of detail.
- One person displayed an aggressive nature at times and could throw small objects. Their care plan was clear in how staff should respond to this and what topics of conversation staff should use to distract the person and calm them.
- Where appropriate, care plans were clear about offering healthier food choices for people. For example, people requiring high protein or low carbohydrate diets had plans in place for these to be delivered.
- The manager told us, "The care plans are not unsafe, but they are just lacking. They are not as comprehensive as I would have liked. Although the detail is there, it is embedded in the care plan and difficult to find." They said all care plans were being reviewed and updated and this piece of work would be completed by the end of the year.
- Despite our findings in relation to the records, some people felt staff knew them. A relative said, "Staff have really taken the time to get to know him." They added, "We were all fully involved in the care plan and we can access his care notes on the relative's page which means I don't have to worry as I can see what has gone on. We are really impressed with the care."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We found activities varied across the service and we received mixed views from people, especially from

people who stayed in their rooms. Some people told us, "What's best is the entertainment. There is always something to keep you amused" and, "We have a singer this afternoon and pets coming in. The entertainment is great."

● However, other people told us, "I do get bored, you are left with you own thoughts. It would be nice to have someone to natter to" and, "I get bored and half the time I just want to sleep." A relative had fed back to us, "Activities not going ahead now and only one lady in the activity team" and another relative told us, "The carers don't have time to do the activities." A healthcare professional said, "It was always one of the positive points of Rodwell House, but I think she [activities lead] has now left, which is sad for the residents."

● Staff also told us, "We could do with more activities for people with dementia. People in their rooms can get bored."

● We heard that since our last inspection, the number of activities staff had been reduced from four to just one and the care companions were expected to carry out activities with people. However, in reality these staff did not have time and they told us, "It's only if you help in the lounge you have time to speak to people; when you're helping them with their meals."

● The outcome of the reduction in activity staff meant one activities person was expected to organise events in the main lounge, spend one to one time with people when needed, visit people in their rooms as well as organise lateral flow tests for visitors.

● The notes from the most recent residents meeting recorded people saying, 'there is not enough activity staff to engage with and help us do things'.

The lack of robust person centred care planning for people as well as a lack of socialisation was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● Most people had end of life care plans in place, which detailed wishes and choices that had been discussed with people and their relatives.

● Where there was no end of life plan, reasons for this was documented. For example, the person did not wish to discuss this at the time.

● Clinical staff liaised with the GP when people required end of life medicines and local hospices were involved.

Improving care quality in response to complaints or concerns

● People told us they would know how to raise a concern or complaint. One person said, "If I was unhappy about anything, I would tell my daughter and she would speak to the manager." A relative told us, "I can just knock on the nurse's door and speak to them." A second relative told us they had raised a complaint which had been responded to by the service.

● Complaints information was displayed around the service for people to refer to. A relative told us, "I've met the new manager and I would have no concerns raising any issues."

● Although the service recorded complaints, these were not stored as a separate log and as such it was difficult to see what action had been taken, whether the complaint was resolved and whether the complainant was satisfied with the outcome. We spoke with the compliance manager about this who explained, "We record our complaints on the PCS [electronic] system. We review these as part of the KPIs and also in monthly manager meetings." This showed us that complaints were being monitored by the organisation.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People with specific communication needs had documentation in their care plans relating to this. Such as where people required staff to speak more loudly, or asked closed questions.
● One person's care plan stated that communication could be aided with picture boards, which were in place. People who needed glasses or hearing aids appeared to be using these appropriately.
● There was clear signage on bathrooms and toilets which helped those people who were mobile and walking around the service to navigate their way around the building.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate due to a number of continued breaches and lack of significant improvement in the service. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The registered provider and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our focused inspection in December 2020 and comprehensive inspections in March 2018, August 2018 and October 2019, we found a lack of good governance and robust management oversight within the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found little improvement at this inspection and a number of continued shortfalls.

● At the last three of our inspections, people had commented on the lack of English-speaking staff within the service and this continued to be a problem. During a residents meeting in October 2021, people commented, 'staff still speaking in their native language. This is happening in the resident's rooms, corridors and communal areas'. A health professional told us, "The difficulty for me was the language barrier of some staff which limited actual conversation with the residents." The manager told us, "Still a problem with English speaking staff. I would be lying if I said it wasn't a problem." This meant there was a continued risk that staff would not understand people's care needs or instructions given out when they were on duty and although the registered provider was aware of this shortfall, they had continued to allow this to happen without addressing it robustly.
● People did not receive good quality care which achieved good outcomes for them. In the residents meeting in October 2021, people reported they did not know who their daily companion was, the quality of care was not good, their medicines were often late, and the food was going from bad to worse. Staff told us they felt the introduction of the care companion model introduced by the manager had affected staff morale.
● The manager and compliance manager were aware of the shortfalls within the service. However, despite this there appeared a lack of commitment or urgency to improve people's care. For example, the compliance manager raised the question of the quality of the food with the manager in September 2021. This was also commented on by people at their residents meeting in October 2021 and yet, the manager told us it would take three months to make changes. The manager was also aware that care plans were not person-centred, and they lacked detail. But again, they did not aim to complete their review of each person's care plan until the end of 2021.
● We found continued breaches of regulations at this inspection and repeated concerns about the safety of

people, the deployment of staff and staff's understanding of people's needs. We also found the registered provider had not considered current guidance in relation to people with a learning disability and had continued to move people into the service despite not being able to accommodate their needs.

● The provider was not registered to provide care and accommodation to people with a learning disability. However, despite this they have moved people into the service who had a learning disability.

● The service was without a registered manager which is a requirement of registration. In the last six years, this service has had 13 managers. All of whom had left after a short period of time and only two of those had registered with CQC. A relative told us, "There is constant management change which is really quite worrying. We never receive any correspondence and there aren't any meetings. Changes happen and no one is informed."

● Residents meetings took place in which people had the opportunity to give their views. We read people were open with their views on how they felt their care could improve. However, the registered provider had not listened to people's views as changes had not been made to improve the care people received.

● Although we read 12 people attended the most recent residents meeting, there were 74 people living at the service. There was no evidence of other people being asked for their views or feedback being sought from different groups of people, such as people with a learning disability.

● Our observations at this inspection showed little overall improvement had been made since we last visited Rodwell House and the feedback received from people and relatives supported this. The registered provider had not demonstrated sufficient overall management oversight of the service throughout the change of managers. As such there continued to be multiple failings at the service which had not been addressed robustly by the registered provider. We have demonstrated these failings throughout our report and shown how these impacted on people.

The on-going lack of good governance and management oversight or commitment to improve people's care was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our concerns about the service, the manager told us they felt they had started to make change. They said, "I listen to staff. I've allocated care plans to nurses to start reviewing them and I've introduced a new management system with myself and two deputies".

● We asked people, their relatives and staff about the new manager and were told, "I've not had much to do with the new manager, but I know who she is" and, "I've not met the new manager, but my daughter has." Staff told us, "The new manager listens to us and we can speak to her, but she's only been here a short time so not sure yet is she's positive for the service or not" and, "The new manager is fine. She offers support."

● The compliance manager told us, "There are manager's meetings now which never happened before. Information is cascaded through handovers and there is on-going monitoring. We roll positive and negative learning across all services and we are creating a shift in attitude. For example, we are rolling out the care companion role. [The manager] and deputy carry out care when needed which is helping to create a shift in (staff) attitude."

● Services providing health and social care to people are required to inform the Care Quality Commission (CQC) of important events that have happened in the service. The provider had informed the CQC of events including significant incidents and safeguarding concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● Relatives told us they were kept updated on their family members care and when changes took place and where necessary, the provider applied duty of candour.

● We reviewed care records which showed staff had appropriately involved healthcare professionals in

people's care.

- Staff worked with the local authority safeguarding team to investigate any safeguarding concerns.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider was not providing person-centred, responsive care to people in order to meet people's individual characteristics and to avoid social isolation.

The enforcement action we took:

We have imposed a condition to the providers registration in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure people were treated with respect and dignity.

The enforcement action we took:

We have imposed a condition to the providers registration in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure good infection control practices were being carried out and risks to people were identified and guidance in place for staff.

The enforcement action we took:

We have imposed a condition to the providers registration in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to put robust processes in place to help ensure people were safeguarded from abuse and improper treatment.

The enforcement action we took:

We have imposed a condition to the providers registration in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure good governance or robust management oversight within the service to improve people's quality of care.

The enforcement action we took:

We have imposed a condition to the providers registration in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient suitably skilled staff available to meet people's needs.

The enforcement action we took:

We have imposed a condition to the providers registration in relation to this breach.