EBS Services Limited

Rodney House Care Home

Inspection report

4-6 Canning Street
Liverpool
Merseyside
L8 7NP
Tel: 0151 709 3883
Website: www.rodneyhouseliverpool.co.uk

Date of inspection visit: 30 April 2015 and 5 May 2015
Date of publication: 24/06/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

At our last inspection in June 2014, breaches of legal requirements were identified. We asked the provider to take appropriate action to ensure improvements were made. We undertook this comprehensive inspection on the 30 April and 5 May 2015. During this visit we followed up the breaches identified during the July inspection and found the provider had taken appropriate action in relation to the majority of the breaches previously identified.

Sufficient improvements had been made to way in which staff ensured peoples' dignity and respect, the safety and suitability of the premises and its cleanliness. Appropriate action still need to be taken with regards to people's care and welfare and how the provider assessed, monitored and managed the quality of the service provision.

Rodney House Care Home offers single occupancy accommodation over five floors. The home provides support for people with their personal care needs. There are 57 beds reserved for this purpose. The home offers

Summary of findings

short stay accommodation and long term care. At the time of our visit, there were 54 people who lived at the home, one of whom was accessing short stay accommodation.

There was no registered manager at the home. 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.' A new manager had commenced employment at the home in November 2014 and had applied to the Care Quality Commission (CQC) to become the registered manager. This application was still in progress at the time of our visit.

During this inspection, we found breaches of Regulations 9, and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People's care plans did not cover all of people's needs and risks. They lacked person centred information to enable staff to understand and relate to the people they were supporting and people's emotional needs were not fully considered in the planning and delivery of care. For example where people had episodes of challenging behaviours or upset, care plans lacked information about how to communicate with people to alleviate any distress. Some of the information provided to staff on people needs and support was also conflicting and difficult to follow. This placed people at risk of receiving inappropriate or unsafe care.

Personal emergency evacuation plans contained limited information about people's evacuation needs and there was no record kept of which people who lived at the home were in the building at any one time. This meant staff may not know who was and wasn't in the building in an emergency situation.

Where people had mental health conditions which had or may have had an impact on their ability to consent to decisions about their care, their capacity had not been assessed in accordance with the Mental Capacity Act 2005. There was no evidence people had had support from a family member or advocate in making decisions about their care. Consent forms in people's files had often been signed by staff or simply noted the person had refused to sign. This meant it was unclear if the person consent to the decision or not.

People had a choice at mealtimes and were given a suitable range of nutritious food and drink. The home catered for special diets such as religious or diabetic needs and alternatives to any of the mealtime options were always provided. People identified at risk of malnutrition, had their dietary intake monitored and received dietary supplements to promote their nutritional intake. Some of the nutritional guidance for staff to follow in relation to people's care was however poor and some people's dietary needs were not consistently monitored.

Health and social care professionals and a GP we spoke with during our visit said they thought staff at the home cared for people well. They said staff sought advice when needed and acted on it appropriately. We observed staff supporting people at the home and saw that they were warm, patient and caring in all interactions with people. Staff supported people sensitively with gentle prompting and encouragement and dealt with potentially challenging situations in a non- confrontational way. People were seen to be relaxed and comfortable in the company of staff. From our observations it was clear that staff knew people well.

The home was clean and various parts of the home had been refurbished. Refurbishment plans were still in progress at the time of our visit. The provider's infection control standards had recently been inspected by the NHS Infection Control Team and the provider had done well, scoring 91.13%. The home also achieved a five star rating (excellent) from Environmental Health in relation to its catering facilities and standards. We observed a medication round and saw that the way in which medication was administered was safe.

Staff were recruited safely and had had their suitability to work with vulnerable people checked prior to employment. The number of staff on duty was sufficient to meet people's needs. We observed staff to be kind and respectful and staff offered a range of activities to occupy and interest people. The home had recently advertised for an activities co-ordinator to organise future activities and events.

Summary of findings

We looked at how staff were appraised, supervised and trained staff at the home. We saw that staff had been appropriately supported in their job role. We found some gaps in the training of some staff members but this was in the process of being addressed by the manager.

We saw that regular residents and staff meetings took place and that the manager had been open and honest with people and staff about their future plans for the home. We saw that people were able to express their views at the meeting and that a satisfaction surveys had been sent out to gain people's feedback on the quality of the service. The surveys returned so far indicated people who lived at the home were generally satisfied with their care. We checked a selection of complaint records and saw that the manager had investigated and responded appropriately to complaints made.

There were some audits in place to check the quality of the service. There were audits in place for medication, catering, bedroom cleanliness and routine repair and maintenance issues. The systems in place required further development to ensure the risks to people's health, welfare and safety were identified and addressed. For instance, there were no care plan or health and safety audits in place, only one accident and incident audit had been conducted and the last medication audit had been completed in July 2014. We noted that the manager had made positive progress in improving the management of the home since they commenced in employment in November 2014. We spoke to the manager about the quality of the audits. They said they were in the process of reviewing the systems in place in order to make improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe and required improvement.

The provider safeguarding policy required updating but staff we spoke knew how to identify and respond to potential abuse.

People's individual risks in the planning and delivery of care had not always been fully assessed and appropriate risk management actions were not included in people's care plans.

Personal evacuation plans required improvement. Records relating to which people were in the building at any one time were not kept. This meant there was a risk staff would not accurately know who required evacuation in the event of an emergency.

Staff were recruited safely and there were sufficient staff on duty.

Medication was safely administered and managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people had mental health needs that could potentially impact on their capacity, the principles of the Mental Capacity Act 2005 had not been followed to ensure people's consent was legally obtained and their human rights respected.

Staff had received regular supervision and appraisal. There were some gaps in the training of staff which were being addressed by the manager.

People were given enough to eat and drink and a choice of suitable nutritious foods to meet their dietary needs. Some people who required support with their dietary intake had not had their needs properly assessed or planned for in the provision of care.

Is the service caring?

Good

The service was caring.

Staff were observed to be kind and respectful when people required support.

Interactions between people and staff were pleasant and people appeared relaxed and comfortable with staff. We observed staff dealing sensitively with potentially challenging situations in a non- confrontational manner

People's independence was promoted and people were able to make choices in how they lived their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive

Summary of findings

People's needs were individually assessed and care planned but the quality of the information was poor and sometimes conflicting.

Person centred information was limited and staff lacked guidance on how to support people's mental health and emotional needs.

A range of social activities was provided and people were able to come and go from the home as and when they wanted.

There was a complaints procedure in place displayed in communal areas. Complaint records showed complaints were handled in a timely and appropriate manner.

Is the service well-led?

Requires Improvement 

The management and leadership of the service had improved since our last visit but further progress was still required.

There were some quality assurance systems in place to monitor the quality of the service but they did not effectively identify all of the risks to people's health, safety and welfare

Staff told us they felt supported and that the management of the home had improved since the two new managers came into post.

The manager held regular staff meetings and people's satisfaction with the service was sought through regular resident meetings. A satisfaction questionnaire had recently been sent out to people who lived at the home.

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 30 April and 5 May 2015. The first day of inspection was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspection Manager and two ASC Inspectors.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also spoke with the Local Authority with regards to the home.

At this inspection we spoke with seven people who lived at the home, the provider, the manager, the deputy manager, three care staff, the maintenance person, a domestic member of staff, two healthcare professionals and a GP. We looked at a variety of records including seven care records, four staff records, a range of policies and procedures, medication administration records and a range of audits.

We looked at the communal areas that people shared in the home and with their permission visited people's bedrooms. We observed staff practice throughout both of our visits.

Requires Improvement

Is the service safe?

Our findings

We spoke with seven people who lived at the home. Some of the people who lived at the home had mental health conditions that affected their ability to communicate and some had issues related to alcohol misuse. A care worker we spoke with told us that approximately half of the people who lived at the home used alcohol on a regular basis.

When we asked people who lived at the home if they felt safe. One person told us; "It's safe enough here, safer than out there anyway." Another person told us that they did not feel safe and that some of their belongings had gone missing.

We spoke with a GP who worked closely with the home and they told us; "People are safe here. They do better here than other places and we are confident that people get their prescribed medication."

We reviewed seven people's care records. We saw some evidence that the risks in relation to people's health and welfare were assessed and regularly reviewed. For example, moving and handling, nutrition, pressure sores and people's risks of falls. We found however that not all of the risks in relation to people's care and safety were appropriately or accurately assessed and in some cases the risk management actions identified were not clear.

For example, two people's moving and handling risk assessments had not been fully completed or scored to indicate the level of risk; two people were noted to have poor dietary intake but had incomplete nutritional risks assessments and two people's weight recordings over a short period of time did not make sense. One person was noted as having existing skin integrity issues which made them more susceptible to pressure ulcers, but these risks had not been considered in the planning and delivery care. This meant there was a risk that people needs were not being met.

Three people whose care files we looked at had significant mental health concerns that meant they sometimes displayed challenging behaviours. These behaviours had not been adequately risk assessed and monitored in the delivery of care. This meant staff had insufficient guidance on how to prevent such behaviours or manage the risks when they occurred. This placed people at risk of inappropriate or unsafe care.

We found that some care files had personal evacuation plans in place to advise staff how to evacuate people in the event of an emergency, whereas others did not. We found that personal evacuation plans were limited. For example, there was no information provided to staff about people's mental health needs and the type of emotional support they may require in an emergency situation. There was no signing in and out sheet for people who lived at the home to use when they left and entered the building. This meant there were no records maintained of who was and wasn't in the building in the event of an emergency.

These examples demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulations) 2014. This was because people who lived at the home were not protected against the risks of receiving care that was inappropriate or unsafe as the planning and delivery of care did not meet all of the person's individual needs.

We saw that the provider had a policy in place for identifying and reporting potential safeguarding incidents. The policy did not provide guidance to staff on who to report allegations of abuse to in order to safeguard people in their care for example, the local safeguarding team and the Care Quality Commission. It also made reference to the manager conducting a monthly review of accidents/ incidents, injuries and daily records for possible signs of abuse. There was no evidence this was done.

We checked a sample of the provider's safeguarding records and saw safeguarding incidents had been appropriately reported to both the Local Authority and the Care Quality Commission. They had also been subject to an internal investigation by the manager of the home with any actions taken documented. There were financial systems in place to safeguard people's monies such as their personal allowance and a CCTV system monitored communal areas for any untoward incidents.

Staff spoken with had attended safeguarding training and demonstrated a positive commitment to protecting people from the risk of abuse. Staff were able to describe potential types of abuse and which external bodies to report their concerns to. This assured us that staff knew what to do in the event of any allegation of abuse being made.

Accidents and incidents were recorded with body maps in place for any injuries sustained. We reviewed a sample of these records and saw that appropriate action had been taken.

Requires Improvement

Is the service safe?

We did a tour of the building. There were five floors with 57 individual bedrooms. A small number of bedrooms had en-suite facilities. A passenger lift enabled access to each floor for people with mobility issues. There were communal toilets and bathrooms on each floor with bath and shower facilities. There was an onsite laundry and a smoking room for people who lived at the home to use, should they smoke. The ground floor had a choice of three communal lounges, a tea room where people could make their own drinks and a treatment room where health and social care professionals including GPs could visit people who lived at the home in private.

Various parts of the building had recently been refurbished. For example, bathrooms and toilets throughout the building were in the process of being upgraded and most were completed. The manager showed us the impervious antibacterial wall-coverings that had been fitted to toilet and bathrooms walls. Impervious surfaces mean they can be thoroughly mopped and disinfected. A non-slip flooring compound had also been applied to toilet floor to prevent slips and falls. We found all bathrooms and toilets to be clean. A number of bedrooms had been re-decorated to a good standard. Some parts of the building still required re-decoration and there were various items of equipment and debris scattered about the building which required removal. For example, there was an armchair in one shower room, a bed stored outside a person's bedroom and an old furniture box stored behind a chair in one of the communal hallways.

There was a plentiful supply of personal and protective equipment such as aprons, disposable gloves and antibacterial hand gels throughout the home to prevent the spread of infection. We saw that there was a domestic member of staff working on each floor of the home. They were contracted to work at the home via an external cleaning company. They told us they worked regularly at the home. We saw that the NHS Infection Control team had carried out a visit to the home in March 2015 and the provider was compliant with infection control standards, scoring 91.13%.

Records showed that systems and equipment in use at the home such as the home's electrical installation, fire alarm system, specialised hoists and fire extinguishers had all been externally serviced and maintained. We saw that the maintenance person undertook regular health and safety checks for example, hot and cold water temperature checks, call bell audits and PAT testing of the home's appliances. This meant that the systems and equipment in use had been verified as safe and suitable.

We asked about staffing levels. We were told that five care staff were on duty throughout the day and four at night and there was always a senior member of staff on duty. We looked at the last eight weeks rotas and saw that staffing levels were consistent. The manager told us that they had recently changed the deployment of staff throughout the day as they felt that this met people's needs more consistently. The rotas demonstrated the changes that had been made. We saw from the rotas that the manager and the deputy manager were supernumerary to the staff levels but we saw that both regularly supported people at the home with their day to day needs. The manager told us that between them, they tried to provide management cover at the home from 7am – 8pm whenever possible. They told us this enabled them to regularly met up with, and support the night staff.

There was no tool in place to measure dependency levels in the home to assess whether these staffing levels were safe and we initially had concerns that the staffing levels were too low. No-one we spoke with however reported any concerns regarding the staffing levels deployed at the home and we observed that people's calls for assistance were responded to promptly.

We looked at the recruitment records for four members of staff who had recently been employed to work in the home. The files contained a job application, interview questions records, references, record of Disclosure and Baring Service (DBS) disclosure, and other relevant information. The manager told us that they were in the process of recruiting to replace staff that had recently left. The provider had policies in place relating to staff recruitment, conduct, and disciplinary and grievance procedures. We saw that all staff had been issued (in March 2015) with a document entitled "Minimum standards for staff". This detailed all the requirements and expectations for staff conduct and behaviour. The manager told us that they had felt that this was necessary to ensure that all staff were aware of the home's expectations of them, as employees.

We looked at how medicines were managed at the home and found it to be safe. Senior care staff were responsible

Requires Improvement

Is the service safe?

for the ordering and administration of medication to people who lived at the home. Three people liked to receive their medication early. This was given to them early in the morning by the night staff.

We saw that medication delivered to the home was recorded appropriately on people's medication administration records (MAR) and counter-signed by two members of staff. Medicines were supplied in a monitored dosage blister pack format and stored in two trolleys. One trolley contained morning medication and the other contained medication for lunchtime, teatime and night. We found that two tubs of prescribed creams had been left in one person's room.

We checked people's medication administration records and saw they were completed in full with no missed signatures. A record was made of any medicines that were refused and any medicines that were not administered for example, if the person was out at the time the medication round took place. We saw that one person had regularly refused their prescribed medicines and this had been reported to the person's doctor. We also saw records to show that if a person had been drinking alcohol, their medicines were withheld for their own safety.

A small number of controlled drugs were prescribed and these were stored safely and recorded appropriately. One person received anti-coagulant medication and we saw detailed records of blood tests. One person was diabetic and was able to administer their own insulin injections, supervised by staff and we saw that records of regular blood sugar tests were carried out. Medicines that were to be given 'as required', such as pain relief medications, were recorded appropriately and running totals of the quantity administered and remaining were maintained.

The senior care assistant we spoke with demonstrated good knowledge of the medicines people took and what they were for.

Requires Improvement

Is the service effective?

Our findings

We viewed the care records of six people with mental health conditions and/or complex needs. We found that the provider had not fully complied with the requirements of the Mental Capacity Act 2005 (MCA). This meant people's legal rights in relation to consent had not been appropriately respected or their human rights protected.

Some of the people who lived in the home were able to give their consent to the care and support they received and some of this was recorded. For example, there were various consent forms in use for staff to administer the person's medication, consent to share personal confidential information and consent to the use of the CCTV. However recording was inconsistent.

In two care plans, the forms recorded that the person 'refused' or 'refused to sign'. In these instances the forms had been signed by a member of staff. It was unclear whether people had simply refused to sign or had refused to sign as they did not consent. In a third care plan, it was recorded that the person was 'unable to sign' and the forms had been signed by a member of staff but there no other evidence in the file to indicate that the person had given their verbal consent or had the capacity to consent.

Information in people's care files indicated that some people may not have had the capacity to make some of the decisions they were required to make. People's capacity to consent however had not been assessed or considered in the planning or delivery of care. There was no evidence that people who may have struggled to make informed decisions about their care were supported to do so for example, by a family member or advocate.

We saw that staff had received training in the Mental Capacity Act (2005) but that it required updating to reflect new legislation and guidance.

These incidences were a breach of Regulation 11 of the Health and Social Care Act (Regulations) 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

We spoke to the manager and the provider about the issues we had identified. They acknowledged that the implementation of the Mental Capacity Act legislation in respect of people's care was an area for development.

We saw that people had two options to choose from for their lunchtime and evening meal. On the day of our visit, the choice at lunchtime was cheese or beef salad or a sandwich with a choice of filling. The evening meal consisted of lasagne and garlic bread or salad and a choice of dessert. We noted that religious diets were catered for and fresh fruit was available for people to help themselves to.

We talked to the cook about people's options at mealtimes. The cook told us that people were able to have a full cooked breakfast and many had this. One person who used the service said they didn't like what the options were for tea time and the cook offered to make something different

We spoke with three people about the food at the home. All three said they were happy with their meals and a choice was always available. They also told us they had toast at about 9pm. We saw that people were able to make drinks in the 'tea room' at any time. There were dispensers for hot and cold water, tea, coffee, milk and sugar and there was also a trolley service at 11am, 3pm, and 7pm. This ensured people had access to suitable hydration as and when required.

There was evidence of some good practice in respect of people's nutritional care. For example, during lunchtime, we observed a staff member encouraging a person to have something to eat who had been refusing food. They offered many different alternatives and gently coaxed the person in different ways to have something. The staff member engaged the person skilfully in conversation and talked about how important it was to keep up energy levels. The person eventually went happily went with the staff member to the kitchen.

Care plans included a tool for the assessment of nutritional needs and the risk of malnutrition and two people had been identified as being at risk of malnutrition. Detailed records of their food intake had been kept and dietary supplements prescribed for them to ensure they received adequate nutrition.

Some of the nutritional guidance for staff to follow in people's care files was poor and people's weight measurements had not been regularly or consistently taken For example, one person's nutritional assessment (MUST) noted them as having a poor dietary intake. Their care records indicated they regularly skipped meals and were prescribed a vitamin supplement to promote their

Requires Improvement

Is the service effective?

dietary intake. The person's monthly weight measurements had only been completed once and there was no care plan in place or guidance to staff on how to encourage the person to improve their dietary intake or information on the right types of food the person should eat to promote their health and well- being.

One person had recently been admitted to the home. The manager told us the person had been come to the home with weight loss issues and requiring support with personal care. This person's nutritional needs had not been assessed. The person's weight was taken every other week but there was no information regarding the person's height to enable staff to assess whether the person's weight was within an acceptable weight range. The person's weight records also indicated the person had lost four pounds in the two weeks since admission and then gained five pounds the following week. The records did not make sense.

These examples are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulations) 2014. This was because people's nutritional needs had not been made appropriately considered in the provision of care.

We spoke with a member of staff from an organisation called Liverpool Waves of Hope, who worked closely with staff at the home in support of people's needs. They told us that staff at the home had formed excellent relationships with the people they cared for and that staff supported people well. They said staff promoted people's health and well-being and people benefitted from living at the home. A healthcare professional we spoke with during our visit, who visited people at the home weekly, said that staff communicated with them well about people's health and well-being. They said "They call and give me an update".

We also spoke with a GP who had been regular visitor to the home for a number of years. They told us that the home supported people well with health issues. The GP reported that significant improvements had been made since the new management team had taken over the home. The GP gave us examples of how the home had supported people to manage their alcohol dependency and improve their physical and mental health. The GP acknowledged that Rodney House was a "Difficult place to work and manage" but that staff contacted them for help "Appropriately and when it was necessary".

We spoke with the manager and two staff about the people they cared for. Staff we spoke with had a good knowledge of people's needs. We observed staff supporting people throughout the day and from our observations it was clear staff had good relations with the people they cared for.

We looked at staff training records to make sure that staff had received the training they required in order to meet people's needs effectively. We saw there were some gaps in the training of staff members and some training required updating. We noted gaps in alcohol awareness, dealing with epilepsy and Mental Capacity Act/ Deprivation of Liberty Safeguard training. These were key areas as there were people in the home who needed regular support with these areas. The manager told us that they were taking action to ensure that this training was received as soon as possible. We saw that they had a monitoring system in place to monitor the training staff undertook and were working to ensure the gaps were met through monthly training.

We saw that induction procedures in the home for new staff were good. Staff were supported with shadow shifts and regular fortnightly supervision throughout their induction period. We looked at the supervision records for six members of staff and saw that since the manager and deputy manager had come into post, they had ensured that five of these staff member had received regular supervision on a bi-monthly basis. We saw that staff had received support and guidance, constructive feedback with areas for each member's personal development noted. We noted that one person had not received supervision. The manager told us that this person was a relief staff member and they had focussed on ensuring permanent staff members received appropriate support in the first instance.

We saw that the manager had made improvements to the way in which staff communicated with each other at the home. Regular staff meetings were held bi-monthly and minutes were readily available for staff to read. Staff meetings had been held at different times of the day to enable the maximum number of staff to attend with minimum inconvenience to them. A staff message book had been introduced to enable important information to be shared across the staff team and we saw that staff had initialled to indicate that the message had been read. A managerial message book was in use too. This enabled the manager and deputy manager to record any issues of concerns and ensure that they were followed up.

Requires Improvement

Is the service effective?

People's care records showed that they received support from a range of health and social care professionals and prompt access to medical assistance when their general health declined. Records gave information about the reasons why professional support had been sought and documented any professional advice given.

Good

Is the service caring?

Our findings

During the inspection we observed a number of interactions between staff and people who lived in the home. We saw that staff interactions were supportive and caring and that staff knew people well. Staff supported people sensitively with gentle prompting and encouragement.

For example, we observed a member of staff approach a person from the home who had entered the building carrying some alcohol. We saw that the staff member engaged the person in conversation in a non-confrontational way. The staff member talked with the person about their safety and how best to manage their drinking without any judgement or accusation. The person responded positively to the staff member and an amicable solution was achieved without any upset or anger. This demonstrated that the staff member knew how to support this person. They provided information and explanations in a careful way whilst respecting the person's life style choices.

We spoke with the manager regarding some concerns we had about the physical appearance of some of the people who lived in the home as they appeared dishevelled, unkempt and unclean. The manager explained that this was an on-going concern and one that they were working hard to improve on. Many of the people who lived in the home had mental health and alcohol problems and were reluctant to spend time or money on their personal appearance. The manager had introduced a 'self-neglect policy'. This outlined the expectations of staff to support people who lived in the home to care for their personal hygiene and appearance. During the inspection we observed a member of staff approach a person on a number of occasions and ask them to comb their hair. The staff member did this gently and respectfully but persevered until the person had achieved the task.

Staff we spoke with gave clear examples of how they protected people's privacy and dignity. For example, they spoke about showing people good manners, closing doors during the delivery of personal care, ensuring people were suitably dressed and maintaining people's right to confidentiality. We observed that staff treated people with dignity and respect and that people were comfortable in their company.

The manager told us that they had recognised that there were some people in the home who would be better supported in a different care setting that would be able to meet their needs more appropriately. The manager had engaged with social workers and support service to reassess these people's needs with a view to them moving to new accommodation.

Requires Improvement

Is the service responsive?

Our findings

We found that staff were knowledgeable people's individual needs and challenges but these were not well documented in their care plans. We looked at seven care plans and saw that recording of care plans and risk assessments were inconsistent and the quality differed in different care files. Care plans were not person centred and many contained records that were outdated and conflicting.

For example, there was very little personal information such as details of people's past lives to help staff to understand the person and how to motivate them. Some care files had lots of care plans in place, some were repetitive and some risk management plans looked exactly the same as the care plan. Plans were not clear for staff to follow and it was difficult to understand each person's needs and the person centred care they required.

People's emotional needs and support had not been adequately assessed and managed. For example, one person's mental health had significantly declined, some external support had been accessed but the person's plan of care had not been updated to reflect this decline. There was also no guidance to staff on how to support this person's emotional needs to prevent a further mental health decline. Another person experienced visual hallucinations and delusions but there was no guidance to staff on how best to support this person when these incidences occurred. We also found that staff had received little training in mental health.

In one person's file a social worker had reviewed the person's care and care plans and made a note on the person's file to say "I would recommend that Rodney consider reviewing their care files and ensuring all care plans and risk assessments are re-written on an annual basis." "I would recommend that Rodney House establish a more robust, descriptive and structured set of behavioural care plans."

These examples are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulations) 2014. This was because the planning and design of people's care did not fully or appropriately meet their needs.

We saw that people were able to choose how to live their lives at the home. For example, people were able to come and go from the home throughout the day, get up and go to bed when they wanted and could choose to have their own key to their room should they so wish.

We saw that people liked to sit in a small lounge at the front of the home, although there was a choice of a larger, more comfortable lounge. There were some activities provided by the home such as bingo, card games, poetry reading, movie nights and pamper sessions. A hairdresser visited weekly and a barber visited by request. Details of the activities available were displayed. A staff member we spoke with said staff had tried to organise activities at the home but they were currently poorly attended. They said they often accompanied people to the shops and said they personally were going to a concert with a person at the home in the next few weeks. We spoke to the manager about activities, they told us they in the process of recruiting an activities co-ordinator but were finding it difficult to get the right person for the job.

We looked at the complaints procedure displayed in the large communal lounge. We saw that it was easy to understand with clear timescales for the acknowledgement, investigation and response to any complaints made. Contact details for the manager and the provider were supplied but there were no contact details for the Local Authority, the Care Quality Commission or the Local Government Ombudsman. This meant people may not know who to escalate their complaint with, should they be dissatisfied with the manager's or provider's response to their complaint in the first instance. We looked at the provider's complaints records. We saw that the manager had fully investigated and appropriately responded to the complaints in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

The manager had commenced working for the home in November 2014 and the deputy manager in December 2014. The manager had made an application to be the Registered Manager which was being processed at the time of the inspection. Feedback from the provider, staff, visiting professionals and people who lived in the home was positive about the new management team.

At this visit, we looked at how the manager and provider ensured the quality and safety of the service provided. We that there were a range of monthly audits which included a medication audit, catering audit, periodic bedroom checks and a daily building checklist which recorded any maintenance issues. We saw that where actions were identified these had been resolved.

We found that there were no care plan audits in place to assess the quality of the care planning and risk assessment information. This meant that the issues we identified during our visit with respect to quality of risk assessment and care planning information had not been picked up and resolved. We spoke to the manager about this who said they recognised the existing care files required improvement and had started to set up new care plans for people at the home. We saw evidence of this during our visit.

Medication audits were completed externally by the pharmacy who supplied medication to the home. We reviewed two audits from June and July 2014 and saw that where actions had been identified these were acted upon but no further audit had taken place since July 2014. We asked the manager about, this, who said they would resolve this with the pharmacy without delay.

The new management team had introduced an accident and incident audit, but only one had been undertaken. This was in January 2015 and there was little evidence that this information had been used to improve the safety of the service so far.

We spoke the manager about the quality of the audits systems in place and expressed our concerns that they did not fully identify and address potential risks to people's health, safety and welfare. The manager said that they recognised the audits required review and that they had plans to do so over the next few months.

They told us they had spent the majority of their time in the first few months of employment getting to know the service and the staff. They told us they had concentrated on getting the staff 'on board' with the home's ethos towards people's care and ensuring that staff understood their job role responsibilities. They told us they hoped to ensure there was a culture shift at the home in the way in which people were supported. They said they wanted to set up new systems and facilities that supported people who lived at the home to re-discover or develop new life skills, for example, opportunity to do their own laundry or cooking in order to encourage their independence. We saw evidence that this culture change was in progress and saw that the manager had made a number of changes to support this process.

We asked one staff member if they thought the home was well run. They said it was and said that since the two new managers had come into post the management of the home had improved. During our visit we found the manager responsive with a proactive and inclusive approach to people's care.

We saw that a meeting for people who lived in the home had been held in January 2015 and that a number of issues had been discussed. The manager had been open and transparent about the changes that they were trying to make. We also saw that the people who lived in the home were reminded about the smoking policy and what their responsibilities were. We saw that the next meeting was planned for May 2015 and an agenda was displayed in the home for people to add to if they wished.

We were told that satisfaction questionnaires had been given to the people in the home but not all responses had been received. We looked at the responses that had been handed in so far and generally comments were positive. This assured us that people's opinions and suggestions to were sought by the manager the provider to enable them come to an informed view of the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who lived at the home were not protected against the risks of receiving inappropriate or unsafe care because the design and delivery of care did not meet all of the person's individual needs and risks. Regulation 9(1)(a)(b)(c) and 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There were no suitable arrangements in place to ensure that the service obtained the consent of , and acted in accordance with the consent of people who lived at the home.. Regulation 11(1)(2)(3) and(4).