Rodwell House Limited

Rodwell House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Rodwell House is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Rodwell House is a privately-owned service and provides accommodation for people who require nursing or personal care, and treatment of disease, disorder or injury. The service provides nursing care for up to 75 people.

At the time of inspection there was not a registered manager in post. 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.

On the first day of our inspection visit there was a manager in post who had commenced the registration process. However, during this inspection we were informed that the manager had left their post. This was the fifth change of manager in nine months which meant the service was not consistently well-led.

The service currently has a large number of safeguarding concerns related to people's care and treatment. These related to a lack of staff, poor staff practice and a number of falls and injuries. These are subject to ongoing investigations by the police. At this time the outcome of this is not known. During our inspection two further safeguarding concerns were identified that had not been reported in line with good practice. One included a person who had unexplained cuts and bruising from June 2018 and another was raised by a relative in June 2018.

Staff deployment at the service at the service was not effective to ensure that people's needs were met. Staff were allocated to people by the lounges they used and not by the floors they lived on. This meant that staff were allocated to people over the three floors and they would not attend to people's needs if they were not in their allocated lounges.

Staff were knowledgeable about the people who had been allocated to them but they had insufficient knowledge about other people's needs so would not attend to them when they had asked for support. This led to delays in care being provided to people. People were not always treated with kindness and respect and their dignity was not always promoted. Staff would only attend to people who had been allocated to them.

People were put at risk of infection as staff had failed to follow the provider's infection control policy. There was an infestation of flies in two of the three lounges and one member of staff had failed to ensure that personal protective equipment was used when cleaning faeces off a toilet floor. This people at risk of infections. Risk assessments were not always in place in relation to people's needs.

Some risk assessments required further detail to ensure people were protected from the risk of harm. Accidents and incidents were recorded and analysed but lessons learned had not been recorded.

Quality assurance systems were not robust and did not lead to continuous improvement at the service. Monthly audits had been undertaken and actions were put in place, but they had not identified the issues we found regarding infection control, reporting safeguarding concerns and care plans that lacked sufficient information. Neither had they identified the issues related to daily noted being copied and pasted and the poor standard of English used within them.

People were not always treated with kindness and respect and their dignity was not always promoted. People's wishes had not always been respected by staff.

Staff had not always received appropriate support, training and supervision as is necessary to enable them to carry out their duties. The environment a required further development to meet the needs of people living with dementia.

The provider had failed to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. Improvements were required around the recording of the wishes of people's end of life care. We have made a recommendation around this.

Medicines were stored, recorded and administered to people but other information regarding medicines as required were not in place.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed.

People were supported to ensure they had enough to eat and drink to keep them healthy and people were complimentary about the food. People had access to all healthcare professionals as and when they needed them. People who needed them had wound care plans that aided nursing staff to provide ongoing treatment to aid the healing process.

People's rights under the Mental Capacity Act (MCA) were respected. People's needs and choices were assessed before they were admitted to the service.

Staff promoted people's privacy because they knocked on doors before entering people's rooms and attended to personal care needs in private. We observed some good positive interactions between staff and people. Currently there was no person living at the service from the lesbian, gay, bisexual or transgender (LBGT) communities. Staff told us that they would treat all people equally.

People had a range of activities they could be involved in. Residents meetings took place at the service where people had the opportunity to have discussions about the service. Regular staff meetings took place and we saw the minutes of these meetings that had been held in May. Topics discussed included creating a positive working environment, responding to call bells, staff sickness and recruitment of staff.

The provider and staff worked with other relevant agencies that were involved in the care of people.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff had not followed the correct procedures for the reporting of suspected or alleged abuse.

The deployment of staff was not effective to ensure people's needs were met.

People were put at risk of infection as staff had failed to follow the provider's infection control policy.

Risks had not always been assessed to ensure that people received safe care.

Medicines were stored, recorded and administered to people but other information regarding medicines as required were not in place.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had updated their training as is necessary to enable them to carry out duties they are employed to perform. Supervisions were not always effective.

People were supported to ensure they had enough to eat and drink to keep them healthy and people were complimentary about the food provided.

People had access to health care professionals when they felt unwell or required annual checks on their healthcare.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's liberty may be being restricted, appropriate applications for

DoLS authorisations had been completed.

People's needs and choices were assessed before they were admitted to the service.

The environment and equipment used at the service suited the needs of people but requires further development to meet the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with kindness and respect and poor care practice did not promote people's dignity.

Staff promoted people's privacy through knocking on doors and attending to personal care needs in private.

People's independence was promoted by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints made to the service had not been addressed in line with the provider's complaints policy.

Improvements were required around the end of life for people.

People had care plans that had been produced from the pre-admissions assessments.

People had a range of activities they could be involved in.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance checks were not robust to ensure that the service was following best practice and they had failed to address some serious concerns.

Records relating to people's care were not always accurate.

The service was not well led by a competent, skilled and qualified manager. The service has been without a registered

manager in day to day charge of the service since November 2017.

Staff had worked with other healthcare professionals however, relations between some professionals required improving.

Notifications had not always been provided to the CQC as required.

Rodwell House

Detailed findings

Background to this inspection

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

This inspection took place on 29 June, 2 July, 20 July, 9 and 13 August 2018. All inspection visits except 13 August were unannounced. The inspection had been brought forward as a result of concerns raised by the local authority.

The first day included an inspection team of three inspectors and a nurse specialist. The second day included pharmacist inspector and one inspector. The third day included three inspectors, the fourth day three inspectors and the final day included one inspector.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) as we had brought the inspection forward. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with six people, seven relatives, four nurses,10 members of care staff and two domestic staff. We also spoke with the managers who were present during our inspection visits and three clinical lead staff. We observed how staff cared for people, and worked together. We also reviewed care plans and other records within the service. These included 13 care plans and associated records, medicine administration records, two staff recruitment files, and the records of quality assurance checks.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. One person told us, "I feel safe with staff, they never upset me. All staff (including night staff) look after me well." Another person told us, "Staff here are very welcoming, they are kind and very caring." One relative told us, "My [family member] is safe here with staff. We have never seen anything untoward. Staff always treat people right." Another relative told us, "People here are very safe because staff look after them well." A third relative told us, "My [family member] is really happy here."

Despite these positive comments we found people were not always kept safe. Safeguarding procedures relating to suspected abuse were not being followed by staff. There had been a large number of safeguarding concerns raised through the local adult social care team by visiting medical practitioners, relatives and the CQC since April 2018.

People had not been protected from the risk of abuse. Staff had not been reporting incidents to the local authority safeguarding team or the CQC in a timely manner. This meant they had not been investigated to explore if further action would be required to keep people safe. In addition, multiple safeguarding concerns had been raised with the local authority by healthcare professionals, the local authority and relatives of people. Other safeguarding concerns had been raised by staff with the management of the service but no action had been taken. For example, an unexplained bruise was found on one person in June 2018 and had been recorded as 'announced to nurse'. There was no other information around what actions had been taken as a result. On 2 June 2018 it was reported again and it was not until the 5 June 2018 that another nurse asked advice from the persons GP.

Staff were aware of the procedures to follow if they suspected or witnessed abuse but had failed to follow their training or the providers policy. For example, by not reporting to the relevant safeguarding authorities when concerns had been raised. A senior member of staff told us that a person had unexplained bruising and cuts that had not been reported as a safeguarding concern when it was first noted in June 2018. The temporary clinical lead on duty made the safeguarding referrals for this whilst we were inspecting the service in August 2018. Staff told us that they had received e- learning in regard to keeping people safe from abuse but as demonstrated not all staff were putting their learning into practice.

Failure to report suspected abuse in a timely manner was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control practices did not protect people from the risk of infection. For example, on two different days during the inspections we found that the doors to the sluice rooms were left unlocked and soiled pads were easily accessible in these rooms. This meant that people could access these rooms and were therefore put at risk of infection. We noted t there was a strong odour in one of the sluice rooms and sinks and urine bottles were stained. There was faeces on the floor in a communal toilet and a dirty pad on the floor. A member of staff attended to this but they did not wear personal protective equipment such as gloves or apron. We noted that this member of staff then went into one of the lounges without washing their hands.

We also observed another staff member carrying yellow clinical bags from a sluice room without wearing any personal protective equipment. This meant that there was a risk of infection to people living at the service.

There was an infestation of flies in two lounges that were seen landing on people and surfaces where people were eating and touching. Due to the lack of management of infection control there was a risk that these flies could spread infection to people. We were told that a pest controller had visited the service to try to eliminate the flies. The member of staff we spoke with told us they had been advised that the only way to stop the flies entering the service was to keep the windows closed. This had not been done and we found the windows were open on the inspection.

Risks to people's health and safety were not always managed consistently to ensure people were safe. Staff were not always aware of the risks associated with people's care. One person, who was a risk of dehydration and was not left with a drink. Their care pan stated, "Leave a full glass of drink in front of [the person] and top up when needed." A member of staff told us that they were aware that the person could drink independently and stated that they should have left a drink with the person. Their care plan had no risk assessment around their mobility despite them being at risk of falls. The fluid chart had no target amounts. In terms of his fluid intake the care plan stated, "[person's name] requires prompting to ensure they take enough fluid especially as they have kidney failure."

Staff's management and understanding of risk to people did not always follow guidance in individual risk assessments. One person was labelled as being aggressive and resistant to their care. One person's care plan recorded, "Do not try and support [person's name] too early in the morning as they prefer to get up and dressed about 11.00." However, staff had placed a behaviour risk assessment in place due to "None compliance." This had been caused by staff not following the guidance and trying to get the person up at the incorrect time. It went on to say the person was happy with strip washes. Their relative advised that in June they had a period in hospital with a serious infection and were now a "Changed man." There was no new risk assessment around this only notes of the hospital stay on the date they had been discharged.

A relative told us they had been involved with the care plans but stated that things were not always followed through. They told us that they had brought specific equipment to help with their family member's oral hygiene but could not be assured that staff had been using this as the persons oral care had got worse.

There were people living with varying forms of dementia and not all had risk assessments in place. For example, there was no guidance in a person's care plan to detail what dementia they had or any risks associated with this type of dementia. There was no guidance for staff on how to approach personal care and the behaviour care plan was blank. One person was diabetic and there was no risk assessment or care plan developed to ensure that staff knew how to provide safe care and support to the person.

Accidents and incidents were recorded and analysed but lessons learned had not been put in place. For example, one person had a fall and banged their head. There was an analysis of what had happened and the action taken but there was no information about how to avoid a repeat of this.

Failure to assess and manage risks to people and the lack of prevention, detection and control the risk of spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the size and layout of the service people were not always supported to have their needs met due to the ineffective deployment of staff. People told us that there were times when they had to wait for staff to

respond to their call bells. One person told us, "I sometimes have to wait a long time for my call bell to be answered." Another person told us they had to wait up to 10 minutes before staff responded to their call bell. Relatives and visiting healthcare professionals also told us that they felt there were times when there were insufficient members of staff on duty because they could not find any free staff when they needed them. One relative told us, "There are not enough staff because my [family member] has been left too long waiting to be changed." Another relative raised a concern because their family member had to wait one and a half hours before a member of staff would attend to them to change their wet pad.

The provider was monitoring the times taken to respond to call bells. Their aim was to achieve an 80% response rate and above for all bells to be answered within five minutes. Records for July 2018 showed that staff had only achieved this during two of the four weeks. The records did not specify by how long over 10 minutes these were responded to. In one week 66 calls went over the 10-minute time scale and 80 in another week. This left people not receiving care and treatment in timely manner when requested.

Staff told us that they sometimes felt they rushed people's care so they could attend to the next person. One member of staff told us, "We need at least one other care staff to work all day because people here have more complicated needs." Another member of staff told us, "We need more so we can spend more time with people, we always feel rushed."

The duty rota showed there were sufficient numbers of staff on duty to meet the needs of people however, the issue we found was that staff were allocated to lounges rather than by numbers of people on each of three floors at the service.

Failure to deploy sufficient numbers of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local authority Quality Assurance team continued to visit the service on a weekly basis. The report from the 4 September informed that staff had now been allocated by the floors rather than the service lounges. This must be monitored by the management of the service and embedded into practice. We will check this at the next inspection.

Some people had risk assessments that gave guidance to staff on keeping them safe whilst supporting them in regaining their confidence. Where assessments had been completed these covered areas such as falls, nutrition, skin integrity, medicines, Multi-Universal Screening Tool (MUST) and Waterlow (skin integrity). These risk assessments provided staff with direction about the risk and how to mitigate and manage the risk. For example, one individual had a highlight on the front page of their electronic record that they were at considerable risk of becoming malnourished and developing pressure ulcers. Their skin integrity plan recognised that they had an air mattress and informed of the prescribed creams that staff were to use.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed. Records contained the required documentation, including a full employment history, references and Disclosure and Barring Service (DBS) check had been obtained for new staff. The DBS helps providers ensure only suitable people are employed in health and social care services. However, we did note that one reference was missing. The manager told us that this would be actioned immediately.

Medicines were administered, recorded and stored safely. The provider had an electronic system for recording medicines administration. This system also prompted staff to reorder medicines when stocks were getting low. The sample of stock balances we checked matched those on the electronic system. We also checked if the prescribed instructions matched those on the electronic system and for the sample

checked the instructions were correct.

The electronic system produced a daily management report which identified any missing entries and if any medicines were not available. These reports showed that people were getting their medicines as prescribed and only one medicine was recorded as not available in the previous week. The registered manager told us when prescriptions were required urgently these were dispensed from local pharmacies.

When medicines were prescribed to be given 'only when needed', administration details were added to the electronic system; however, there were no individual protocols in place. This meant there was no information to enable staff to make decisions as to when to give these medicines. This meant people might not be given their medicines when they needed them in a way that was consistently safe. When people were prescribed topical preparations, their use was recorded on separate charts and body maps.

We recommend that PRN (medicine when required) protocols should be in place to keep people safe.

People told us that they received their medicines on time. One person told us, "Yes, I would say I get my medicines on time and it is always correct."

Medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Medicines were administered by staff who had received training.

Requires Improvement

Is the service effective?

Our findings

Staff were not always sufficiently qualified, skilled and experienced to meet people's needs. Staff had received all the required mandatory training. However, through observations during the inspection staff were not always effective when putting this training into practice. For example, in relation to poor infection control, the management of risk and lack of identifying and reporting safeguarding incidents. There was training that was overdue for staff which included basic oral care, fire safety, first aid, infection control, moving and handling and safeguarding adults which were all the areas we found concerns with during our inspection. The manager gave reassurance that training was to be provided and they had sent text messages to all staff informing them that if they did not update their training they would be removed from the duty rota.

Staff gave us mixed feedback on the quality of their training. They told us that this was all online training. One member of staff told us, "The training is all e-learning but I do not feel that this training is enough, we need more one-to-one and group training." Another member of staff told us, "Training is good, they send you letters and reminders if you need to complete training and they state that you would be taken off the floor if your training is not up to date." Care staff told us that they had received one-to-one supervisions and records provided to us evidenced this. However, supervisions were not effective in identifying the shortfalls in staff practice that we identified at the inspection.

Failure to ensure that staff received appropriate training and supervision as necessary to enable them to carry out duties is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nursing staff had attended training regarding medicines, wound care, syringe driver (a small battery-operated pump that gives medicine continuously under the skin over a period), venepuncture (a medical procedure for drawing blood), and leadership. Staff could inform us how they put this training into practice.

The environment did not suit the needs of people living with dementia. Not all people's bedrooms had their names on to help orientate them. The communal areas of the service did not have large signs to help people navigate around the service.

We recommend that the environment is further developed to meet the needs of people living with dementia.

People were supported to ensure they had enough to eat and drink to keep them healthy. People and their relatives were complimentary about the food provided. One person told us, "The food is very good, my plate would always be clear." Another person told us, "There is a menu that comes around every morning. They always ask for your opinion."

People and staff told us that drinks and snacks were available throughout the day and night. We observed one person ask for a cup of tea and this was made for them. Care plans gave information on their nutrition and the support people required when eating and drinking. One person required thickened drinks and

pureed foods. Fluids were to be given on a teaspoon whilst sitting upright and we observed this happen at lunchtime. The chef was aware of people's dietary needs and they had a list of these in the kitchen. This information included people who had allergies, required pureed food, and people's food preferences.

People had access to all healthcare professionals that supported them to live healthier lives. Daily records included information regarding people's healthcare. For example, when the GP had visited, dental and optician appointments and visits from dietitians. Records of feeding regimes was discussed with dietitians and were in place for people who were on a Percutaneous Endoscopic Gastrostomy (PEG) feed. PEG feeding regimes provided clear guidance relating to the time the feed should be administered, the recommended fluid intake, feeding position for the person and cleaning instructions for the PEG equipment.

Wound care plans were in place for people who required them. These included photographs of the wounds, dates when dressings were changed and the progress of wounds. Nursing staff could describe their understanding and the importance of wound care and the process they followed to ensure people received the appropriate care so their wounds could heal.

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. Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. Staff had an understanding of the Mental Capacity Act 2005 including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required.

One member of staff told us that they got people's consent before they undertook tasks with them. For example, one member of staff told us, "We get people's consent before we move them." This was confirmed during discussions with people and during our observations other than on one occasion that we have mentioned in the key question of Caring. Another member of staff told us, "The MCA is to help people who lack the capacity to make decisions for themselves."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty was restricted to keep them safe, appropriate applications had been made. People were supported in accordance with these DoLS authorisations.

Mental capacity assessments had been undertaken and where people lacked capacity, best interest meetings had taken place and a DoLS application had been submitted. For example, an assessment had been carried out to determine whether a person had capacity to consent to 24-hour supervision. Where people lacked the capacity to make a particular decision, staff had consulted all relevant people, such as relatives, social workers and healthcare professionals, to ensure the decision was made in the person's best interests. The provider had submitted applications for DoLS authorisations to the local authority appropriately.

People's needs and choices were assessed before they were admitted to Rodwell House. There had not been any new admissions to the service since June 2018. People and their relatives told us at the last inspection that they had been involved in the assessment process.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were generally caring people. Relatives were also complimentary about the caring attitudes of staff. One person told us, "Staff are caring and helpful." Another person told us, "I love all the staff here." A relative told us, "I find the staff to be very good, they are a nice team."

Although some people said staff were kind and caring, we found that people were not always treated with kindness and respect. For example, one person was asking for a drink. A member of staff told us in front of the person, "[Person's name] refused a drink and they are aggressive." We asked if they could be a bit more discreet and they then moved away from the bed to talk to us. The member of staff started to lower the bed without asking for the person's permission or informing them what they were doing. The person said, "Don't put it down, don't put it down." The member of staff ignored the person and continued to lower the bed not considering what the person wanted.

People were not always treated in a dignified way. We observed one person coming out of their bedroom with no clothing below their waist. We raised this concern with the manager who told us that they had an issue with staff considering people's dignity. They said that they were trying to instil in staff. A relative told us that their family member had been incontinent. The relative told us that staff present had no respect for the person's dignity as they took their clothes off without talking to the person or reassuring them. The same relative told us that an optician visited their family member and staff just woke them up, moved them to their wheelchair and with no communication between staff and the person. They also told us that their family member had heard two staff arguing in front of them about who was going to clean them. We were informed by a senior member of staff that one member of staff had stood by and watched a family member check the pads of their relative in a communal area where other people were sitting without discussing with the relatives that this was not an appropriate thing to do. The senior member of staff did address this with the member of staff.

As people were not always treated in respectful and dignified way is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff helped them to be independent but they would help them when they needed it. One person told us, "Staff do help me to do things for myself." We observed people freely moving around the communal parts of the service independent of staff support.

Aside from the examples above there were times where people's privacy was promoted by staff. Staff told us that they promoted people's privacy through knocking on doors and attending to personal care needs behind closed doors. One member of staff told us, "I always make sure that the curtains are pulled and the door is closed when I am attending to the personal care needs of people." People and relatives confirmed that this practice took place. We observed staff knocking on doors and attended to personal care needs with the doors closed.

We observed some positive and caring interactions between staff and people. One member of staff

approached a person and said, "Hello [person's name] how are you?" The person replied, "What are you here for." The member of staff told them that they were going to take them to lunch if they would like to go. After the person had been taken to their lunch the same member of staff returned and said to another person, "Hello [person's name] did you want to come to lunch." They then gave the person time to adjust their wheelchair and went off with them. The member of staff saw that another person had their hand clenched tightly. They asked if they were alright and talked to them about their hand and that they might hurt it if they kept it like that. The person then relaxed their hand.

Another person asked a member of staff about the volume of the television as it was getting louder then quieter. The member of staff took the time to look at the remote and explained to the person that the volume was fluctuating as the programme was switching between the studio and the outside broadcast. Another staff member knelt to talk to a person and asked about the bingo and if the person had won. The member of staff asked about the person's health to check they were okay and before leaving they told the person where they were going.

During lunch we observed staff interacting with people and providing support as and when required. A member of staff came up to a person and explained what the lunch choices were. The member of staff described what a poppadum was and asked the person if they wanted the curry. When the person said no the member of staff asked the person if they wanted cauliflower cheese instead. The person said they did and the member of staff brought this to them.

The manager told us that no person living at the service was from the lesbian, gay, bisexual or transgender (LBGT) communities. They told us that this was explored during the pre-admission assessment so people could inform them.

Requires Improvement

Is the service responsive?

Our findings

People's concerns and complaints were not always responded and listened to or used to improve the quality of care. Complaints and concerns information was available to people and their relatives, however, not all complaints received had been recorded or acted upon. For example, one relative told us that they had made two complaints to the service in June 2018 and to date had not received a response from the provider. We looked at the records of complaints and this complaint had not been recorded. Part of this complaint included a safeguarding concern we notified the local authority safeguarding team. One relative told us they had made a complaint to the previous manager but nothing was resolved. They told us, "We put a letter of complaint in about the previous manager, she wasn't very pleasant, she would turn things around on you like it was your fault." We could not find a record of a complaint from this person.

The provider had appointed a member of staff to oversee and respond to complaints and these were being addressed during our inspection. This now must be embedded in practice.

As complaints were not always recorded and responded to this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people told us that they knew how to make a complaint and they would raise any concerns if they had any. One person told us, "I feel comfortable with raising complaints and concerns." Another person told us, "If I had a difficulty with the staff I would speak to them." A relative told us that they would be happy to complain.

End of life care was provided sensitively and in line with people's needs and preferences. People had end of life care plans in place that staff would follow at the appropriate time. Some plans were detailed, however there were some that had information missing from them such as people's preferences for their funeral arrangements. There was information about people's preferences such as if they would prefer stay at Rodwell House or go to hospital. However, referrals to palliative care teams and information from the local hospices about people's end of life care was recorded in another file, therefore this information could easily be missed by agency staff who were not familiar with the system.

We recommend that all information relating to people's end of life should be recorded in one place that would be readily accessible to all staff, agency staff, relatives and healthcare professionals.

Staff told us that they would ensure people who were on end of life care received a peaceful, pain-free and dignified death. They told us they would attend to their personal care needs as normal and ensure that they were kept clean at all times. Staff also told us that they would offer emotional support to relatives.

People and their relatives told us they had care plans in place and that they had been involved in developing them. One person told us, "My care plan is person centred and I have been included in the review of it."

Care plans had been produced from the information gathered during the pre-admission assessments and

included information regarding skin integrity, mobility, elimination, mental well-being, communication, sleeping and nutrition. Care plans were held on an electronic system and were accessible to people and their relatives. Care plans were personalised and detailed daily routines specific to each person. For example, one person's mobility care plan informed that they could walk around their suite using a frame, however, they had an unsteady gait and could be at risk of falls. The person's support choice was that they could walk with assistance but that staff should be mindful that they liked to be independent and had the capacity not to accept help. Another person's care plan detailed they liked to come downstairs but they also liked to watch the television in their bedroom. This person was dressed and watching their television in their room.

Care plans we looked at provided detail about people's needs and daily notes confirmed if they had been attended to. For example, one person's care plan stated that they suffered from having seizures/ticks. The care plan gave information on what to do if the person had a seizure. We noted in daily notes staff had written when they had seen signs of ticks. The notes stated that staff had reported this to the nurse and the person's family. Care plans recorded if people preferred showers or baths. We noted that one person preferred a shower and we saw from notes that they often had showers.

People had a range of activities they could be involved in. There were three activities coordinators employed at the service. People told us that there were plenty of activities to do every day. One person told us, "I try to do the exercises" A relative told us, "Yes, [family member] loves getting involved with artwork and singing."

Staff in both lounges worked together with joined activities. There was a list of activities that took place and these included drawings, bingo, boxercise, chair exercises, hand massages, pedicures and manicures. The activity coordinator told us, "There are external entertainers who visit, on Friday's a singer comes in, and there is tap dancing, balloon tennis, they love it, some of them hit each other and have a laugh." During our inspections we observed people taking part in the daily activities and they were enjoying taking part in them.

Requires Improvement

Is the service well-led?

Our findings

The providers governance systems had not been effective in driving improvement in the quality and safety of the service people received. The lack of permanent management had meant that the service had not been well-led, and resulted in concerns being identified across all five of the areas we look at during an inspection.

The service had been without a registered manager in day-to-day charge of the service since November 2017 and there had been five managers since November 2017. The clinical lead also left in April 2018. In addition, there been a high turnover of care and nursing staff reported to us by families. This was also identified in the results of a survey of the service published in June 2018. This led to a breakdown in communication between staff teams service and relative's concerns not being addressed.

The providers governance processes had not identified and addressed the issues with the lack of good management in a timely manner. This impacted the care people received and caused the service to have multiple failings, as we have demonstrated throughout this report. Issues such as staff training not being completed, clinical supervision not taking place, complaints not being responded to, and the rapid turnover of staff demonstrated the lack of leadership. The poor management had also impacted on the morale and efficiency of staff. All of this had not been identified or addressed by the provider until multiple concerns had been raised about the service.

The results from the service survey published in June 2018 emphasised how the lack of good management had affected people and their families. It recorded that, "It is apparent that a number of the relatives are unsettled by the recent management upheaval and the lack of communication about this and other matters." The survey report went on to say, "There is continual turnover of nursing staff resulting in a shortage of qualified personnel which can impact communication and routine medical/nursing assistance. The rapid turnover of staff and resultant management changes has left residents/relatives uncertain who to contact about administrative matters." These issues were still ongoing at the time of our inspection in August 2018, with families telling us that they felt their concerns had not been listened to. The failure in communication had also been raised by staff. Staff and consultants at the service told us that the communication between the management and staff at the service had been very poor prior to the latest manager being put into post.

Staff responsibilities had been confused and not clearly defined by the provider, meaning that issues around the service and complaints had not been addressed. This led to a culture of blame with no one taking ownership of issues. For example, failures in systems were blamed on the previous manager or staff that had left. The consultant that had been employed to improve the service explained how the previous manager had not listened to their ideas and they had not been given the appropriate authority to make changes by the provider. It was only after the manager had left and the consultant was placed in the manager role they could begin to make changes. This had happened the week of our final inspection visit in August 2018. The consultant had been in the service for a number of months prior to this.

The failure to adequately define staff roles and responsibilities had continued with the introduction of the new clinical lead at our inspection on 13 August 2018. The manager had assured us that this staff members role had been clearly defined with the staff team and the clinical lead would be in charge in the week that the manager was on annual leave. When the time came this was not the case. On the first day of their employment the clinical lead had taken time to speak to families and people about their concerns. However, they found out that another member of staff had held a meeting with complainants on the same day and had not invited or informed the clinical lead. This staff member could not make changes or address any issues that may have been raised, nor had they fed back to the clinical need what had been discussed and agreed with the families. This led to a continuation of complaints being raised and not addressed.

Records were not always accurate and care plans and did not always have the most up to date care for people. For example, we saw that one person was being cared for in bed. There was nothing in the care plan to indicate that they were to be cared for in bed. One of the nurses told us "[The person] is cared for in bed, they do not get up." Their care plan had not been updated to reflect this. For another person there were sections for the recording of their lifestyle, their likes and dislikes and a personal profile that were left blank. Daily notes were not always written in plain English and some entries had been copied and pasted. One person's daily notes had the wrong person's name recorded.

Quality assurance systems were not robust. Although audits were being undertaken they were not always identifying the concerns that we found. For example infection control issues had not been identified. Improvements were still required to drive the service forward to ensure people were receiving safe, effective, caring, responsive and well led care.

Failure to operate an effective quality assurance system to ensure the quality and safety of the services provided and to maintain accurate, complete and contemporaneous records in respect of each service user was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action plans had been produced as a result of the audits and a monthly practice development report was published and discussed with the management team. The audits included care plan reviews, call bells, night time monitoring, open safeguarding referrals, pressure ulcers and staffing. These contained information that internal checks were picking up on issues and a response to address them was recorded. For example, an audit of call bell response times in June had identified that the time that staff took their breaks was having an impact on how quickly people were seen. As a result, this was discussed with the staff teams. The August audits had identified issues that included care plans that had not received a review that month. The action plan showed these had been completed.

People and those important to them had opportunities to feedback their views about the service. A satisfaction survey was completed this year and the results had been compiled. Out of 93 surveys sent out in April 2018, 32 responses were received. It compared the results to service the providers other services so they could do a 'benchmarking' activity. This is a tool used for continuous improvement at the service. Comments within the response included, 'My mum is happy and in turn that makes me happy,' 'The care at Rodwell House is very good,' 'I am so happy my mum is staying at Rodwell. I always talk highly of the service and would recommend it to anyone' and 'The music choice in the north lounge is more appropriate now for people with dementia'

Residents meetings took place at the service where people had the opportunity to have discussions about the service. We saw that regular meetings had taken place. Topics discussed had included food, laundry and housekeeping, maintenance, care and medication and activities. Also discussed were concerns raised about

staff speaking in their own language. The management of the service told us that people whose first language was not English were receiving English lessons and were working alongside other more experienced staff whose first language was English.

Regular staff meetings were now taking place. Topics discussed included creating a positive working environment, responding to call bells, staff sickness (none) and recruitment of staff. It also recorded that the review of care plans were being completed and most staff had received one to one supervisions. Head of department meetings also took place. The April meeting had included discussions about English lessons being arranged for those who wanted to attend. However, staff told us that these had not been acted on.

There were occasions were staff were able to influence positive changes at the service. Staff meetings for the North and South lounges took place in February 2018. Staff had asked for dementia-friendly crockery, and this was recorded as being part of Montessori and would be sourced. However, this was not in evidence at the time of our August 2018 inspection visit.

The provider was not aware of their duty to notify the CQC about significant event that took place at the service. Retrospective notifications had been received regarding some allegations of abuse. However, the provider has been sending notification to the CQC since June 2018.

The provider and staff worked with other relevant agencies that were involved in the care of people. Records showed that staff worked with healthcare professionals and the local authority adult social care team. The current manager had attended a meeting with the local GP practice so that a positive working relationship could be built.

This section is primarily information for the provider

Action we have told the provider to take

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

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people were provided treatment in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that staff reported abuse in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure that complaints

Nursing care Personal care Treatment of disease, disorder or injury	were recorded, investigated and responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that appropriate systems were in place to monitor the quality of care being provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff were deployed in an effective way and that staff received appropriate training and supervision.