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Bonhomie 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 18, 19 and 22 January 2016 and was unannounced

Bonhomie House is a nursing home which provides care and support to people living with a wide range of complex healthcare needs. These include acquired brain injuries, neurological conditions, physical disabilities and mental health issues. At the time of our inspection there were 67 people living at the service. Bonhomie House provides a range of accommodation. The main house is spread over three floors. The people living in the main house receive shared care provided by a team of nursing and care staff. Also on site are a number of both shared and single dwelling bungalows where people receive either shared care or one to one support. The service has an activity hall with a swimming pool and Jacuzzi which is used for therapeutic and leisure activities.

Bonhomie House had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently resigned from his post and left his position during our inspection. The provider had already recruited a new manager who was due to start the week following our inspection. Throughout this report the registered manager is referred to as the 'manager'.

Improvements were needed to ensure that all of the risks to people's health and wellbeing were adequately assessed and planned for. Incidents involving people and aspects of their care were not always being investigated robustly or escalated to the local safeguarding authority. Safeguarding investigations help to establish the facts about incident, understand the risk of further harm and make plans about how to ensure that people are safe in the future.

Some aspects of how people's medicines were managed needed to improve and parts of the environment or equipment used by people were not always clean or for purpose.

Whilst some staff told us they had received some supervision, many had not. There was no effective process in place to record and monitor the frequency with which supervision was taking place. The manager could not therefore be reassured that staff were being adequately supported to perform their role effectively.

We were concerned that 'blanket rules' were being used to manage people's smoking and that this was not always in line with people's choices or wishes. We have made a recommendation about this.

Whilst staff demonstrated a good understanding of the Mental Capacity Act 2005 it was not always clear that the principles of the MCA 2005 were being consistently and effectively applied. The provider had taken action to ensure that people were not were not unlawfully deprived of their Liberty.

People using the service told us they felt safe. Improvements were underway to help ensure that people received care from a stable staff team who were familiar with their needs.

Staff worked effectively with a range of healthcare professionals to ensure that people's healthcare needs were met.

People were provided with adequate food and fluids and were able to choose from a range of suitable meals.

People told us that staff were kind and caring. We observed a number of positive and warm interactions between people and staff and staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

Staff had a good knowledge of people's individual needs and wishes and their likes and dislikes. This enabled staff to respond effectively to any concerns or issues they might have about people's care. People were supported to take part in a range of activities both within and outside of the home.

Quality Audits needed to be more effective at driving improvements. We have made a recommendation about this.

The registered manager had cultivated positive relationships with people and the staff team and the organisation was committed to actively seeking the engagement and involvement of people and staff in developing the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements were needed to ensure that all risks to people's health and wellbeing were effectively assessed and planned for.

Environmental risks at service level were not always managed safely. Harmful cleaning substances were not kept securely locked away.

The provider had not ensured that incidents were fully investigated, preventative actions taken and where necessary were escalated to the relevant authorities.

Improvements were needed to ensure the proper and safe management of medicines. Medicines had not always been disposed of safely.

Some essential recruitment checks were not taking place. Further improvements were needed to ensure that there were suitable numbers of staff deployed at all times.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not receiving regular supervision which helped to ensure that they received feedback on their performance, were offered support, assurances and identify learning opportunities to help them develop.

Improvements were needed to ensure that agency staff had relevant training and were adequately informed about the needs of people they were supporting.

Improvements were needed to ensure that all areas of the home and equipment were kept clean and in a good state of repair.

Whilst staff demonstrated a good understanding of the Mental Capacity Act 2005 it was
not always clear that the principles of the MCA 2005 were being consistently and effectively applied.

Staff worked effectively with a range of healthcare professionals to ensure that people's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring. We observed a number of positive and warm interactions between people and staff.

People were supported to express their views and be involved in making decisions about their care.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We were concerned that 'blanket rules' were being used to manage people's smoking and that this was not always in line with people's choices or wishes. We have made a recommendation about this.

Staff missed opportunities to enhance the social interaction available to people when providing one to one care. Some people's daily care records were incomplete.

Staff had a good knowledge of people's individual needs and wishes and their likes and dislikes. This enabled staff to respond effectively to any concerns or issues they might have about people's care.

People were supported to take part in a range of activities both within and outside of the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

Incidents were not being robustly reviewed to identify learning from these and prevent similar situations from happening again.

Quality Audits needed to be more effective at driving improvements. We have made a recommendation about this.

The manager had cultivated positive relationships with people and the staff team and the organisation was committed to actively seeking the engagement and involvement of people and staff in developing the service.	

Bonhomie 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.

The inspection took place on the 18, 19 and 22 January 2016 and was unannounced. On the first day, the inspection team consisted of two inspectors and a specialist nurse advisor. On the second day there were three inspectors and on the last day an inspector and a specialist nurse advisor.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the manager tells us about important issues and events which have happened at the service. We asked the provider to complete a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 18 people who used the service. Their ability to communicate with us varied and some information was obtained with the help of staff or through the use of assistive devices. We also spent time observing aspects of the care and support being delivered. For example, we used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with the manager, the director of operations, the deputy and assistant managers, the chef, the maintenance person, the occupational therapist and 27 nursing and care staff, some of whom were permanent staff and some agency workers. We also spoke with three health and social care professionals and asked their views about the care provided at Bonhomie House.

We reviewed the care records of six people in detail. We also reviewed the recruitment records of four staff and the training and supervision records of a further 15 staff. We also looked at other records relating to the management of the service such as audits, incidents, policies and staff rotas.

The service was last inspected in April 2014 when no concerns were found in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

Many of the people living at Bonhomie House were doing so because they had experienced a catastrophic brain injury or an event which had led them to develop complex healthcare needs. Others were living with chronic mental health problems. At times, this affected how positive they felt about their care and about living at the service. However, all but one of the people we spoke with told us that they did feel safe living at Bonhomie. One person said, "It's an institution I have no desire to be in, but I don't feel unsafe, if I wasn't here I would have problems". Another person told us they felt "Safe and secure", they said Bonhomie gave them "A place to be" and "A roof over my head". One person told us that "more full time staff" would help them to feel safer. However we did find that some improvements were needed to ensure that all aspects of people's care were managed safely.

Some of the people living at Bonhomie could at times display behaviours that challenged or acted in a manner that placed them or others at risk of harm. Potential risks included the risk of self-harm or self-neglect, verbal and physical aggression and refusal of medicines or personal care. To manage these risks, many people received one to one or two to one care and support at all times. Risk assessments were in place which provided guidance on the measures staff could take to help ensure that particular risks were managed or reduced. For example, one person had risk assessments in relation to absconding and making accusations. Another person had a falls risk assessment which gave clear guidance about how staff should reduce the risk of the person falling. The permanent staff had a good understanding of people's risks. They were able to explain the actions they took to manage risks and described how they used particular interventions to prevent or reduce possible behaviours escalating. Their responses were consistent with the person's care plan and risk assessments. In most cases the risk assessments we reviewed were adequately detailed and supported people to stay as safe as possible without there being undue restrictions on their freedom and choices. One support worker said, "We don't do restraint here because we know people so well, we remove others from harm, we have had breakaway training but we can usually calm people down". Another said, "We talk with [the person] about it, if we can't calm them, we make sure they are safe and comfortable, it's important to let them have their space".

It was evident from speaking with the manager and staff and from reviewing people's care plans that the service was committed to protecting people's right to make informed decisions to take or accept certain risks if this helped them to lead a more full and rewarding life. For example, one person had a compromised swallowing ability but declined to follow the modified diet recommended by the Speech and Language Therapist (SALT). This created a degree of risk for the person. However, the person had the capacity to choose and this was their choice. Staff were aware of the increased risk and of the measures they should take to reduce the risk such as encouraging the person to eat in communal areas.

It was not always clear that all of the risks to people's health were adequately assessed and planned for. One person's suicide management care plan was not sufficiently detailed and did not provide staff with adequate information about what staff should do to support the person when they were anxious or agitated. This was of concern due to the number of agency or inexperienced staff working within the service. There was no evidence that the person was accessing any therapeutic programme or having regular mental health

reviews. A registered nurse told us, "They have not had an assessment for at least nine months". Another said, "I think it is longer than it should have been and should be arranged, it is too long as they are so much at risk". We have asked the general manager to ensure that this person's care and support is fully reviewed.

A number of people living at Bonhomie had difficulty swallowing which is also known as dysphagia. This condition can be life threatening and the risks associated with this need to be very carefully assessed and managed so people's records should contain individual risk assessments and an individualised emergency response plan. In one of the records we reviewed, whilst there was a choking response plan, this was not fully personalised and did not take into account the fact that the person was cared for in a customised wheelchair making the proposed interventions difficult to achieve. On the first day of our inspection we spoke with staff about our concerns that an agency worker on their first day was left alone in the dining room supporting a person known to be at high risk of choking. Staff told us that the worker had been briefed about the person's needs but when we asked the agency worker, they were not able to tell us who was known to be at risk of choking. On the third day of our inspection, we observed that another two agency workers, working only their second shift at the home were again left alone with two people in the lounge. One of these people was known to be at high risk of choking as they chose not to follow their prescribed diet. This person was coughing a great deal; they were red in the face. We spoke with one of the agency workers and asked them what they felt they should do as they did not appear to have noticed the person's potential need. They said, "He can have some brandy" and went to find a member of staff. Another member of staff arrived and supported the person to sit forward and rubbed their shoulders. The agency worker told us, "We have had a handover and that told us about people and what their conditions were, we were not told what we had to do if someone coughed like that". Improvements were needed therefore to ensure that information about risks to people's health and wellbeing were effectively shared and planned for.

We visited one person on two separate days. This person was cared for in bed but was able to use their call bell to summon help. On both days their call bell was not in reach. We were concerned that they would not have been able to summon help should they need this.

Environmental risks were not always managed safely. Harmful cleaning substances were not kept securely locked away. For example, a cupboard used for storing pool chemicals was not locked. We observed that a cleaning trolley containing harmful cleaning substances was left unattended for five minutes. Staff were seen to walk by the trolley but not take action to ensure this was stored away securely. None of the doors to the sluice rooms were locked although signs said they should be. This placed the health and safety of people who used the service at risk of harm from hazardous substances.

Risks to people's health and wellbeing were not always adequately assessed and planned for. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Although there were systems and processes in place to report incidents and accidents these were not being used effectively. We could not be assured that incidents were being reviewed robustly to ensure that any themes were identified and all necessary action had been taken to prevent similar incidents reoccurring. When reviewing the incidents for December 2015, a number of these raised potential safeguarding concerns, but they had not been escalated to the local authority safeguarding teams. We were told that staff had undertaken an internal investigation into many of the incidents which were in part related to the number of new staff supporting people that month, however, the subsequent investigations had not been sufficiently robust. For example, staff had completed incident forms in relation to unexplained bruising, the incident log said that the bruise was due to a fall, but there was no evidence to say how this conclusion had been reached. Staff had reported concerns about people not receiving proper care and attention. One incident

related to a person being found with their clothes smouldering due to a discarded cigarette butt. This person's risk assessment said they should be monitored at all times when smoking. There was no evidence that the incident had been looked into further to establish how, with constant monitoring, an incident of this nature was still able to happen. The person's risk assessment had not been updated in light of the incident. One incident related to a medicines error. A doctor had suggested that this should be raised as a safeguarding matter. There was no evidence that this was done. This meant that an opportunity for reduce future risk and achieve organisational learning had not taken place.

The provider had not ensured that systems and processes were established and operated effectively to ensure that incidents were fully investigated, preventative actions taken and where necessary were escalated to the relevant authorities. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Improvements were needed to how some aspects of people's medicines were managed. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. The MARs had mostly been completed accurately but we did identify some concerns. For example, one person's MAR included a double prescription for one medicine. This meant that they had been given twice the intended amount for a period of three days before this was identified and rectified by staff. This prescribing error had not been identified when the medicines were checked upon arrival at the service. People who were prescribed 'PRN' or as required medicines did not have sufficiently personalised PRN care plans and protocols in place. The provider's policy stated that PRN plans should be kept with the person's MAR's but they were currently stored in the person's care plan which meant they were not readily accessible when staff were completing the medicines rounds. Most medicines awaiting disposal were secured in tamper proof containers, however, we found a strip of one medicine which still contained a tablet in the general waste bin of the medicines room. The disposal of this medicine had not been recorded in the disposals book. This meant that medicines were not being disposed of safely or in line with the provider's policy. We noted that there was an oxygen cylinder in the medicines room. The registered nurse told us that the cylinder had been there for over 19 months and attempts to dispose of it had not been successful. We spoke with the management team about this during feedback. They agreed to ensure this was disposed of safely.

Many people were prescribed topical medicines such as creams and lotions. However the provider did not use a specific chart or a topical medicines administration record (TMAR) which detailed how frequently the medicine should be applied or to which parts of the body. Staff intermittently recorded the application of creams in people's daily records, but only in terms of 'creams applied'. This meant that the provider could not be assured that people were getting their medicines as prescribed. We spoke with the manager about this. They told us that TMARs would be introduced immediately. Improvements were needed to ensure the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Records showed the provider had not followed all of the checks that help to ensure that safe recruitment decisions are made. We noted that in two of the records we reviewed, a full employment history had not been obtained. This information is important as it allows relevant background checks to be undertaken. The provider's recruitment policy stated that this information would be requested as of 1 January 2016 due to changes in 'CQC requirements'. The need for a full employment history has always been a requirement in line with Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and now Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Just over five weeks ago a significant number of agency staff, some of them very long term team members

and familiar with people's needs, had suddenly no longer been available to work at the service following changes at the agency supplying them. This sudden loss of key staff had a significant impact on the service which the leadership team had been working hard to address. The leadership team consisted of the manager, a deputy manager and assistant manager. Clinical care was led by a full time clinical lead who supported a team of registered nurses one of whom was a registered mental nurse and one a learning disabilities nurse. At any one time there were three registered nurses on duty. Once a week the clinical lead was supernumerary which allowed them to update care plans and oversee the weekly doctors round.

Day shifts were currently staffed by 36 support workers who were either allocated to provide one to one care to people or work as part of the team providing shared care. At night this reduced to 19 care workers. The number of care staff required was based upon the assessed needs of people using the service which in many cases was determined by the organisation funding or commissioning the person's care. The service had a high number of staff vacancies with there being currently 19 vacancies for support workers. There were two vacancies for registered nurses.

In addition to the nursing and care staff, the service also employed a team of housekeeping staff, laundry staff, a chef and kitchen assistants, an administrator and maintenance staff. An occupational therapist and physiotherapist were based at the home as was a counsellor one day a week. There were no designated activities staff and supporting people to be engaged in social and leisure activities was part of every support workers responsibility.

Ensuring that there were enough agency staff and they were suitably trained was a major undertaking for the service in a short space of time. We were able to see that the provider, manager and staff team had and were continuing to work hard to manage the situation and a range of measures had been put in place. Resources had been made available to offer agency staff training bespoke to the needs of people using the service. Permanent staff were working extra supernumerary shifts to observe practice, offer advice and model best practice to new staff. We were told that some shifts had been overstaffed to ensure that new staff were able to work alongside more experienced staff. A range of new care documents had been put in place so that new staff and agency staff could acquaint themselves with people's needs and the conditions they were living with. The occupational therapist told us that they were checking staff knew what they were doing by joining handovers and assessing staff competence of new staff with moving and handling tasks.

Further improvements were needed, however, to how staff were deployed. For example, in the two weeks prior to our inspection there had been 25 shifts when target staffing levels had not been met. One person who required one to one care had been supported by 22 different care workers between 12 January and 18 January. Their care plan stated that they should have a small group of staff to work with person. People told us that there was too many agency or new staff supporting them. They also told us that there were at times, delays in their needs being met. One person said, "You press your button and no-one comes" and another said that delays in call bells being answered meant they were not always supported to the toilet on time or could not get a hot drink when they wanted.

Generally the staff we spoke with felt that the difficulties with staffing levels were beginning to settle and stabilise. One care worker said, "They were struggling in the bungalows, in the last five weeks there have been lots of new faces, but it is starting to even itself out". The manager told us that people and staff were working to rebuild therapeutic relationships and trust and that this would take time. The director of operations and general manager told us that efforts were continuing to reconstruct a stable and skilled staff team to ensure that people's needs were met in a safe and consistent manner. These will need to be will need to be embedded in practice and sustained to ensure that improvements are made which ensure that there are sufficient numbers of suitably skilled staff deployed to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care. One person said, "I have a shower every Friday, they [the staff] are usually very good". Another told us that staff knew how to help them transfer using specific equipment. Staff were positive about their training and the support from the management team. A health care professional told us that the clinical care was "Above satisfactory". Other health and social care professionals had recently provided positive feedback to the home about the effectiveness of the care provided. They had described staff has "Friendly and professional" and were reassured that the person they were involved with was "Well cared for and happy" and "In the right place".

Whilst people told us they received effective care, some aspects of the support provided required improvement. The provider's appraisal and supervision policy stated that staff should have an annual performance appraisal and four formal supervision sessions each year. Of the 17 staff records seen none of these staff members had received supervision in line with the frequency determined by the provider. In three cases, the staff member had not received any formal supervision in 2015; one of these was a registered nurse. Five staff had only received one session in 2015, six had received two. We were not able to see any records of staff having received an annual appraisal. The management team had no system in place to monitor when staff were receiving supervision. We were aware that the registered manager did operate an open door policy and we saw that staff frequently sought advice and support from more experienced members of staff. The manager said that informal 'in touch meetings' took place during which managers observed practice and then engaged with the person and staff to discuss the interaction, promote learning and ensure positive outcomes. Staff confirmed these meetings were taking place and were helpful and supportive. One support worker said, "We don't get as much supervision as we used to, but the team leaders go around observing staff and advising". However, improvements are needed to ensure that staff receive regular supervision as this provides an important opportunity for managers to meet with staff, provide feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

When new staff started at the service, they undertook a 'First Day at Work Induction'. This involved an explanation of their role and responsibilities, a tour of the building and other practice information and advice. We were told that staff then had an opportunity to shadow more experienced staff for a week or so. The provider showed us that there were four dates planned in 2016 which would enable relevant staff to undertake a 3 day course which upon successful completion would lead to them being awarded the care certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. The Care Certificate is normally completed within the first 12 weeks of employment.

Staff training was mostly delivered face to face and included 'five essentials' which were safeguarding and the MCA 2005, health and safety, infection control, basic first aid, food hygiene and fire training. Staff also undertook annual training in moving and handling and fire safety. Additional training relevant to the needs of people using the service was also provided and a range of dates were arranged for this to take place

throughout 2016. This included managing behaviour which challenges others and caring for people who might present a risk of suicide and for those living with an acquired brain injury. A smaller number of staff had undertaken training in tissue viability, mouth care, continence care and diabetes and foot care. 22 staff had completed training in Managing Actual and Potential Aggression (MAPA). Alongside the formal training, the manager had developed a number of tools to help ensure that staff had the necessary skills and knowledge to perform their role effectively. For example, a 'Night time care information folder' had been developed. Inexperienced or new night staff were able to refer to this and find hints and tips on specific practice matters relevant to people's needs such as effective communication, diabetes and safe use of bed rails. The folders also contained information about the staff member's role and responsibilities and 'grab sheets' which gave a summary of each person's needs. The service had a training room which contained a range of learning and development resources such as person centred planning and dignity and respect. Posters were readily available around the service which helped staff to understand about good hydration and nutrition. Our observations indicated that the permanent staff were well trained and knowledgeable. They were able to tell us about how they might recognise someone was dehydrated and about how they responded when people displayed physical or verbal aggression. Their replies were consistent and in line with the information contained within people's care plans.

The permanent staff we spoke with were positive about the training available and told us that this helped them to perform their role effectively. One care worker said, "[the manager] is brilliant at training, you can ask him anything". Another said, "The training is good". The registered nurses told us that they got the training they needed to maintain their clinical skills and revalidation. Revalidation is the way in which nurses demonstrate to their professional body that they continue to practice safely and effectively and can therefore remain on the nursing register.

Some agency staff did not have the information they needed to meet people's needs. Agency staff had recently undertaken a range of training which was in line with the essential training delivered by the provider. One agency worker, however, did not have all of the relevant training. We spoke with the general manager and operations director who explained that they were meeting with agencies to discuss with them their requirements in relation to the training of agency workers. We also found examples where the agency staff on duty had not been fully informed about the needs of the people they were supporting. The service needs therefore to ensure that there are proper arrangements in place to check that only suitable trained agency workers are engaged to work within the service and that they are provided with a robust induction.

Most aspects of the home were generally kept clean and were in a good state of repair, however, some improvements were needed. Some areas of the home were affected by a malodour and some of the carpets were badly stained, although we did see that the provider had plans to replace these in 2016. We observed that a hoist was rusty and would have been difficult to clean effectively. We pointed this out to the manager who took action to ensure this was addressed. A number of people's wheelchairs were soiled with food debris. We were told that the night staff were meant to clean the wheelchairs, but there were no checks in place to ensure this was happening. We found a commode strapped together with tape and others with badly stained pans. We were told that these would be replaced. A number of people told us that there were no cleaners at weekends which meant that they did not get their bins emptied or toilet cleaned. We spoke with the operations director about this. They advised that they were recruiting to these posts and hoped that this was an area that would improve shortly. They said that in the meantime, staff completed essential cleaning at the weekends, although we were not able to confirm this as the cleaning schedules had not been completed at weekends for the last five weeks.
When visiting the kitchen we noted that there was a hole in the floor covering making cleaning the area difficult. The chef advised that the damage had been reported on a number of occasions. Staff told us that on the first floor there was no sink in the kitchenette area. They said that they had been promised that this

would be addressed for many years. Staff told us this affected them being able to effectively wipe down tables and generally keep the area clean. Following our feedback, the provider took some immediate action to address some of our concerns, however, further improvements are needed to ensure that all of the premises and equipment within it continue to be well maintained.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The manager was informed about the MCA 2005 and its Code of Practice and staff had received training which helped them to understand that people had the right to make decisions for themselves if they had the capacity to do so.

Staff involved people in decisions about their care, such as which meal choice they would like, or which movie they wanted to watch. We observed that a member of staff visited one person to tell them that an activity was taking place. After the staff member left, the person said the staff member was "Nice". They also told us that they were always asked if they wanted help". There was evidence that consent was considered as part of the care planning process. For example, one person had a mental capacity care plan which stated that the person had capacity to make decisions for themselves. This person had signed a consent form which stated that staff had talked to them about their care and support needs and involved them in writing their care plan. A staff member told us, "Mental capacity is a client's mental ability to make decisions which affect their lives, everyone has capacity until proven otherwise and we all respect this, some people do not always make decisions that are in their best interests but when they have capacity, they have the right to choose".

We did find that it was not always clear that the principles of the MCA 2005 were being consistently and effectively applied. For example, one person's care plan said they had capacity to make decisions about whether they drank alcohol. The plan stated that the person demonstrated a full understanding of how this might affect them. The outcome of this care plan was, however, recorded as, 'Staff to act in his best interests'. This would not be required if the person had capacity make their own decision regarding this matter.

Where people with capacity had taken a decision that others might think was unwise, staff listened and respected these decisions, but checked along with other professionals that the people fully understood the risks involved. For example, two people had chosen not to follow professional advice in relation to their dietary intake. Their records contained evidence of how staff had ensured that the person understood the risks involved in this decision. Where people did lack capacity to make specific decisions, there was evidence that a mental capacity assessment had been completed and that staff had been involved in a best interest's consultation along with other people and professionals who knew the person well. For example, one person had a mental capacity assessment and best interest's decision around the use of covert medicines. This helped to ensure that people's rights were protected because staff acted in accordance with the MCA 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home. Some had been approved whilst others were awaiting assessment by the local authority.

We received mixed feedback about the food provided at Bonhomie. One person said the food was "Dreadful", they told us they often had to "Fall back on egg on toast". Another person said, "The food used to be really good… it's now often overcooked or undercooked". Others described the food as "Ok" or "Alright". Another told us the food was "Good, they know what you like".

Each day there was a planned menu which included meals such as fish and chips, pasta, curries and pies. If people did not want the planned meal then they could choose from the daily alternative menu which included omelettes, salads, sandwiches or jacket potatoes. During the inspection, on one day the chef had prepared 11 different alternatives to the main planned meal. We were told that people could come down to the kitchen at any time and ask for sandwiches or snacks. We saw that this happened. A member of staff told us, "This is people's home, if they want hot chocolate and toast at midnight that we what we are happy to provide". This indicated that people were able to make a choice about when and what they ate.

People views were sought about the menu and food choices and information was available about their likes and dislikes. Feedback forms were used to record their views about the dining experience and the support they received from staff. Staff told us that the menu was seasonal and that they were currently asking people for their views about meals they would like for a spring menu. They told us that changes were made to the menu based upon the feedback from people. People are supported if they wished to follow a reducing diet; we were told that one person had been supported to loose four stone in weight following a healthy eating diet.

Plans were in place which provided guidance to staff about the risks to people in relation to their eating and drinking. Information about people's dietary requirements was available in the night staff folder, at the nurse's station and in the kitchen and the chef demonstrated a good understanding of these requirements. People had a 'mealtime information' document in their rooms, this described how the person should be positioned for eating and drinking, the level of assistance they required, the type of diet they needed and potential risks associated with eating and drinking. Training had been provided to staff on food textures and information about the importance of good hydration was available around the home. One care worker told us, "Pushing fluids is really important". People were weighed regularly and assessed using nationally recognised risk assessment tools to determine whether they were at risk of malnutrition. Where people were experiencing difficulties with eating or swallowing their food, they were referred to specialists such as speech and language therapists and their guidance was followed.

People living at this service had complex health and social care needs and so a range of healthcare specialists were involved in their care. A local GP visited the service once a week to conduct a clinical review of people's healthcare needs. People were also visited regularly by community mental health professionals and consultant psychiatrists. Speech and language therapists (SALT) had been consulted when people developed swallowing problems. Some people had been referred to the pain clinic to assist in managing their chronic pain. People were supported to have eye tests, diabetic eye screening, foot care and asthma reviews. We observed that one person's wound care plan included photographs at each stage of the dressing with clear step by step instructions. This was excellent practice. Staff had involved the tissue viability nurse on a regular basis and we saw that staff were following their guidance. A visiting healthcare professional told us they had good communication with the staff at the home and that the home readily took on information and advice. They told us the home communicated well with them kept them informed regarding changes to care plans and people's medicines. This helped to ensure that key information about people's health and wellbeing was effectively shared.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us the staff were "All very nice people, there are no unpleasant ones". The person's wife said the staff showed "nothing but kindness, they always make an effort, they get a breakfast for me if I visit early". Another person said staff were, "Nice", "OK" and "Friendly". A staff member told us, "Yes all staff are kind, if I had any concerns, they would know about it, I can't fault how people are looked after". An agency worker said, "Staff are so lovely and caring here, this place is one of the best, others nag and shout, but not here".

There were examples, of positive and warm interactions between people and staff. We saw staff smiling and joking with people. Our observations were that the general atmosphere in the home was calm and relaxed and people seemed settled. At lunch staff supported people in a person centred manner. They explained to people what the meal was, asked them if they wanted to wear an apron to protect their clothes. Staff readily spoke with people whilst supporting them to eat and drink, asking how the food was, would they like a drink, or another pudding. A staff member gently asked a person if they could wipe their mouth.

Staff spoke fondly of the people they cared for. They spoke about the importance of developing a good relationship with the people they supported. Staff spoke about people respectfully and described the importance of valuing people, respecting their rights to make decisions about the care they received and respecting people's diverse needs. The manager said, "We really do care about these guys, we can change someone's mood by just being there".

People were supported to express their views and be involved in making decisions about their care. Some people were able to verbally communicate their wishes, whereas others required the use of equipment such as a white board or other assistive technology to indicate their choices. Staff seemed to have a good understanding of how people communicated and used this effectively to talk with people about their care and support needs, supporting them to remain in control where ever possible. A person told us, "Yes I have had my care plan read to me – I agreed to it". Another person told us they had a care plan and day to day records and had talked "A little bit about the care they needed".

The manager told us that a number of people were currently working with a local advocacy service to ensure that they were supported to express their views and to ensure their rights were protected when important decisions or choices needed to be made. People were also actively encouraged to be part of the residents committee and take a key role in developing their service. People's families were also encouraged to be involved their care. They were welcome to visit at any time and were seen as a key part of helping the person to be supported to achieve personal goals. A senior member of staff acted as a family liaison officer. Their role was to support family members to understand and adjust to their loved ones disabilities and to work in partnership with them to help ensure that the person got the best support possible. Health and social care professionals also worked alongside people planning their care and support. One professional had fed back to the home how impressed they had been at the attempts made to support a person to attend their review. This demonstrated that people and those important to them were supported to express their views to be involved in planning the care provided.

Staff we spoke with during the inspection demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person. Staff told us they were careful to ensure people's doors were closed when providing personal care and knocked on people's doors before entering their rooms. Where people chose to act in a manner that could compromise their dignity, staff acted to limit the impact of this where able. The manager demonstrated a commitment to ensure that dignity and respect was central to the care provided at the service. They had led training sessions on the subject and also undertook 'dignity and respect' in action reflections with staff.

Requires Improvement

Is the service responsive?

Our findings

The manager and the permanent staff team spoke with real knowledge of people's individual needs and wishes and their likes and dislikes. For example, one staff member told us how one person would indicate their wishes by moving their head. They showed an awareness of this person's enjoyment of music and explained in detail how the person's needs were met including the care of their PEG. Another member of staff was able to demonstrate knowledge of different persons care needs, their interests, family contact, likes and dislikes, their communication methods and the signs that might show whether or not they were contented. We noted that the person appeared to be relaxed and responded well to the staff member appeared to have a good rapport with the person.

We visited another person who was unsettled. Staff responded to them in a friendly way. They were aware that presenting as unsettled was linked to the person's mental illness and so spoke with them in a reassuring manner. They knew what the person liked doing and encouraged this. They were aware of the person's cultural needs and read to them from their preferred book. We also saw that they encouraged the person to socialise as they were aware that the person could get upset when alone. There was a member of staff available who was not allocated to work one to one with this person but was available to help assist the other staff and thereby ensure consistency of support.

We spoke with three other staff members about two people's needs. They all knew the care plans and the two people well and knew the interactions they had to follow to manage risks and possible behavioural issues each person might present with. For example, all three staff told us they how they responded should the people refuse their medicines. All three described a consistent approach which was in line with the care plans and risk assessments. A health care professional told us that staff knew the people they cared for well and effectively communicated any concerns or issues with their care.

An assessment of the care and support people needed had been undertaken. Each of the people records we reviewed contained a care plan which included some information about the person, their likes and dislikes, needs and wishes. For example, people had care plans in relation to areas such as foot and nail care, moving and handling, pressure area care, prevention of falls and their wishes in relation to resuscitation. Where able people had signed their care plans to confirm that they had been involved in drafting it.

Staff had developed documents which helped to clearly describe people's preferred routines. For example most people had a 'Lifestyle and Preferences' document in their bedrooms. Whilst this was a largely a tick box document, it helped to give new or less experience staff an understanding of what was important to the person, the signs that might mean they were happy or sad. It described whether the person might display behaviour which other might find challenging and the practical help they needed with personal care or eating and drinking. It recorded whether the person had a preference for male or female carers and the activities they enjoyed. Most rooms also contained a moving and handling profile and a 'Grab sheet' or 'My daily Care preferences' which described their preferred daily routines. A member of staff told us, "The grab sheets are really useful; we use them to run through people's needs with agency staff who don't know the service users".

Staff had spent time with people completing a large poster sized personal profile of their life before they came to live at the home and the things that were important to them. These were in the process of being scanned so that they could be added to people's files to enhance the person centred information available for staff and agency staff working alongside the person. The manager said staff had really engaged with this process which had been really beneficial and was only possible because staff and person had developed a trusting and positive relationship.

We did observe some areas for improvement. We observed that one to one care was not always delivered imaginatively or in a person centred manner. There were missed opportunities for staff to engage with people. Instead they were often just stood nearby, observing people and then intervening as necessary. For example, we visited a group of people living in one of the bungalows. Five people were sat in one room along with five members of staff. The staff told us they were waiting for tea to be sent over. There was a lack of personal interaction taking place.

Two people expressed a concern to us that their choices around smoking were not always respected. One person said they were not happy with the current arrangement which was that they were supported to have a cigarette every hour. They told us they had not agreed to this. We spoke with staff about this, they told us that three of the people in the bungalow smoked and had a cigarette every hour. They said, "They have a cigarette every hour or they would be smoking every five minutes. They added that "This had been decided for them". We were concerned that this indicated that 'blanket rules' were being used to manage people's smoking. The manager told us that the smoking area was a wooden shelter situated between the main house and the satellite bungalows. However we saw lots of people smoking outside the entrance to the main house. There were a large number of cigarette butts on the floor in this area indicating that this was where people chose to smoke. We were told that this was unofficial smoking area that should only be used in 'exceptional' circumstances. However, due to the number of cigarette butts we observed in this area on both days of our inspection, it was clear that this area was being used on a regular basis for smoking.

We recommend that the provider review the smoking arrangements within the service to assure that people's wishes are being respected and so that the service can assess whether action is needed to reinforce appropriate smoking areas.

Staff maintained daily records which noted how the person had been repositioned, what they had eaten and what activities they had been involved in. These daily notes helped to ensure that staff were able to monitor aspects of the care and support people received. However we found a number of examples where these had not been completed or were out of date. For example, we found care records in one person's room dating back to 2008. Two people's daily records had not been completed at all on two days in January 2016. Most people had the helpful 'grab sheets' but we found some examples where these were not in place. We noted that in some cases, people had two sets of daily logs that contained similar but not identical information. A member of staff told us they didn't know why both logs were in use. Having key information in two places would have made it difficult to effectively assess how much fluids a person was having for example.

The service had a large activities hall. This was not a separately staffed building with a timetable of events but rather a place where people could go with their support workers to take part in group or individual activities based upon the person's wishes, abilities and preferences. The hall contained a swimming and hydrotherapy pool and a Jacuzzi which were available for leisure activities if appropriately qualified staff were on duty. Also available were pool and table tennis tables, a drum kit, a piano and music system. Gym equipment including parallel walking bars was available. A relative told us, "[the person] goes to the activity hall to do bar work and there are plans underway to develop a kitchen area upstairs so that they and

practice cooking and making hot drinks". The manager told us that there were also plans to develop part of the activities hall into a pub at the request of people using the service. Chickens were kept on site cared for by people using the service. A range of activities also took place in the main house. On the first day of our inspection, people were taking part in a 'Relaxation to Music' activity provided by an external entertainer. The second day, the occupational therapist was playing their guitar in one of the communal lounges. People seemed to enjoy this and there was a lively atmosphere with people joining in the songs, laughing and making requests for their favourite songs. The OT told us that they also undertook individual sensory activities with some people used game stations with others. Trips out were held to zoo's local farms and garden centres, cafes, restaurants, cinema and concerts. One staff member said, "If someone wants to go out, we take them". They explained that they were taking one person to see a punk band. People also had the opportunity to take part in religious worship every other Sunday.

People's views about the activities provided were mixed. One person told us that they used their one to one support to go shopping either by taxi or sometimes on the bus which they enjoyed. Others felt this was an area which could improve still further. One person said there was "Not enough to do, there are no activities apart from watching TV or listening to radio in my room". Another person said, "I used to knit now I can't, I watch TV, chat, there is music entertainment every so often, there is not a lot going on". We did see, however that in general , feedback at the last residents committee meeting was positive about the activities with people looking forward to decorating the home, having a Christmas party and Christmas movies. Also the last 'Residents Satisfaction Questionnaire' rated activities as either 'OK' or 'Very Good'.

We were told that activities were arranged every day and staff seemed to have a good knowledge of what people enjoyed. One staff member said, "Some people require a low stimulus environment, or do not want to take part in activities, we know what people like". They explained that they tried to arrange activities in response to people's interests and choices, but it was difficult to motivate some people due to their anxieties, however, people who preferred to spend time in their rooms were still visited and offered the opportunity to get involved in games, but if they did not wish to then their wishes were respected.

Complaints policies and procedures were in place. When concerns or complaints were raised, these were logged so that actions taken to address them could be monitored and reviewed by the manager. We reviewed four complaints or concerns that had been raised between November and December 2015 and saw that these had been fully investigated in an open and transparent way. The management team had been proactive and put in place a range of remedial actions to address the concerns and prevent any reoccurrence. Where it was acknowledged that procedures or systems had gone wrong, we saw that an apology had been made in line with the provider's duty of candour. This helped to ensure that appropriate actions had been implemented to address concerns raised, in accordance with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

Although asked, most people were not able to tell us their views about the leadership of the service in any detail, although one person did say, "The manager takes an interest". A relative told us the manager was "Super". We were also able to observe was that a number of people visited the manager in their office to express their regret that he was leaving the service. The staff we spoke with were all very positive about the manager. Comments included, "[the manager] is a good leader, he is really good, if the emergency alarm goes, he is straight there". Another staff member said, It's a great management team, I think we are lucky….he is by far the best manager we have had, he has turned the place around, he comes out and about and talks with the service users". A registered nurse said, "He has made lots of improvements". Without exception, all of the staff we spoke with were saddened at the news that the manager was leaving his post and expressed regret about this.

The manager told us that it was important to him to cultivate a positive relationship with people and the staff team and it was clear that the manager operated an open door policy both for people and staff. When people visited him in the office, he freely chatted with them and gave then his full attention, stopping whatever he was doing. We observed that he had a good understanding of people's needs, their concerns and anxieties and was able to reassure them about this in a person centred manner. He expressed a commitment to developing the staff team, their skills and knowledge and we were able to see evidence of this in the extent of the additional informal training aids and mentoring he provided both to the permanent staff team and agency staff. When necessary the manager had undertaken mediation with members of the staff team to resolve practice issues and sustain a positive culture. Staff told us that despite recent challenges within the team, staff morale was good. One staff member said, "We do have a good team", Another told us, "I love it here". This was echoed by all the permanent staff we spoke with some of whom had been at the service for over 20 years. A registered nurse told us, "People come here and they do better, many of us started here as agency and chose to come here permanently, every day is different".

Some areas of how the service was managed, however, required improvement. For example, The Regulations require that the provider inform the Care Quality Commission(CQC) about any incidents that are reported to the police. An incident of missing monies had been reported to the police in December 2015, but CQC had not been notified. It was not evident that incidents were being robustly reviewed to identify learning from these and prevent similar situations from happening again.

The manager told us that the organisation was committed to actively seeking the engagement and involvement of people and staff in developing the service and driving improvements. Resident committee meetings took place on a regular basis. From the minutes of these we were able to see that these were an opportunity for people to express their views about the care they received and improvements they would like to see. The planned development of a pub and the return of a poetry club were at the direct request of people using the service. A 'Bonhomie Newsletter' was published regularly to keep people in touch with events and developments happening within the home we were saw included expansions the allotment and brining in quails to live alongside the chickens. The annual satisfaction survey was last undertaken with people in February 2015 and the responses to this were all either good or very good. Questions asked

included, 'How do you rate staffs attitude' and 'How do you feel your views and concerns are treated'.

Staff meetings were held on a regular basis. These were used both as a learning and development tool and an opportunity for staff to express their views about issues such as staffing matters. For example, the July 2015 meeting was used to discuss methods of communication and the importance of caring for people in line with the 6 C's of care which are Care, Compassion, Competence, Communication, Courage and Commitment. Staff were positive about the team meetings and felt that changes were usually made as a result of these although one staff member said, "We have team meetings, staff are open, we give our input, sometimes things change, not always though, we have been waiting for a sink on the first floor for years".

Staff completed some health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. For example, the maintenance man carried out checks of the safety of electrical items, water checks, lighting and the safety of paths around the site. However, there was no specific schedule relating to how often some of these checks should take place and in other cases the records were incomplete or not up to date. For example, weekly checks of the water system to ensure effective control of legionella were last completed on the 14 December 2015. It was not clear that some of the fire checks were happening, for example, the last recorded weekly fire alarm test was 24 December 2015. On both days of our inspection, we found bedroom doors that were fire doors wedged open. We were only able to find one fire safety audit. This had been completed in January 2016 and had also identified concerns about fire doors being wedged open. We brought this to the attention of the manager who reassured us that these issues would be addressed as a priority. The most recent fire risk assessment was also not available to view as this had recently been completed. We have the provider to share this with us and will check that any actions or recommendations have been carried out.

People had personal emergency evacuation plans which detailed the assistance they would require for safe evacuation of their home. Information held with the PEEPS suggested these had last been reviewed in October 2014. The provider also had a business continuity plan which set out how the needs of people would be met in the event of an emergency such as a fire or flood. There were a number of risk assessments in place to address and manage other environmental risks. These included risk associated with portable heaters, call bell failures and a range of infection control risks such as those presented by the safe use of sharps and caring for people with conditions such as hepatitis C. Checks were being undertaken of equipment such as hoists was being undertaken by external professionals.

A range of audits were undertaken by either the registered manager, the quality assurance manager or the operations director. These were used to monitor the effectiveness of aspects of the care provided and other issues such as dignity, mealtimes, infection control and medicines management. Some audits or checks had been undertaken in response to specific issues or concerns that had been identified and the manager had undertaken an unannounced check at night to help ensure that the support being provided to people was safe and effective. However, we could not be assured that this system of audits and checks was being fully effective. This is because our inspection highlighted a number of areas where improvements are required. We were also not able to see that the provider used the outcome of audits to inform a service improvement plan. This is a plan that highlights what the service was doing well and the areas it could improve on and the timescales for achieving these.

We recommend that the service review its systems and processes to ensure that they have fully effective governance including assurance and auditing systems.

It was evident that the registered manager and leadership team had nurtured effective working relations with relatives and other professionals and worked collaboratively with them to try and ensure people

received person centred care and effective healthcare support. The manager told us they were proud of the staff team, of their caring and positive attitude and of their hard work and flexibility in light of the recent staffing issues within the service but they were also aware of the continued challenges facing the service and of the need to continue to build and retain a stable and skilled staff team. They expressed a confidence that the provider would continue to support the new management team to achieve this. Following feedback about the outcome of the inspection, the provider's leadership team showed a commitment to acting promptly to make improvements and told us they would begin working on an improvement plan with immediate effect.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensure that each of the risks to a person's health and safety had been fully assessed and planned for . Regulation 12 (1) (2) (a) (b) (c) The provider had not ensured that people's medicines were managed and disposed of safely. Regulation 12 (1) (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected against the risk of improper treatment by means of carrying out an robust investigation to incidents and not where appropriate escalating these to the safeguarding authority. Regulation 13 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff received appropriate supervision and appraisal as is necessary to carry out their duties effectively. Regulation 18 (2)(a)