Rodwell House Limited

Rodwell House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
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 home and provides accommodation for people who require nursing or personal care, diagnostic and screening procedures and treatment of disease, disorder or injury. It also provides personal care to people who are on a tenancy agreement. The service provides nursing care for up to 75 residents.

At the time of our first inspection visit there was a manager in post who told us that they had commenced the registration process. However, since our last inspection visit of the 20 April 2018 we were informed that the manager had left their post. This was the third change of manager in five months at the home and this meant that the home was not consistently well led. The clinical lead for the home had also left the service since our inspection.

People and their relatives told us they felt the service was safe. They stated that all staff were very kind and they had no concerns about their safety.
Staff had received training in relation to safeguarding and they knew the processes to be followed when reporting suspected or actual abuse. Records of safeguarding were maintained at the home and were discussed with staff. The management at the service had gathered information and contributed to the safeguarding processes as expected by the local authority safeguarding teams.

However, since our inspection visits 11 safeguarding concerns have been raised which include three which the police are at an early stage of investigating. All of the incidents are being considered by the local authority and no outcomes are available at the time of this report. The local authority held a Provider Failure meeting whereby they placed an embargo on future admissions to the home until these concerns have been investigated. We are working with the local safeguarding team and the police and are closely monitoring the service. We wrote to the provider to request an action plan about how and when the provider will address these concerns. The provider had responded and told us that they had employed two clinical leads providing cover seven days of the week whilst they were actively recruiting a full time person for this role. They have employed a Safeguarding Specialist to investigate all the concerns. The provider also informed that they would voluntarily cease new admissions to the service pending the outcome of the Safeguarding Specialist's report.

The provider had followed the correct recruitment procedures for all but one staff employed at the home. Action was taken to address this immediately.

People and their relatives told us they felt the service was safe. They stated that all staff were very kind and they had no concerns about their safety. Staff had received training in relation to safeguarding and they

knew the processes to be followed when reporting suspected or actual abuse. There were sufficient numbers of staff at the home and the manager was monitoring the deployment of staff to ensure that people's needs were being met at all times. Medicines were being administered and stored safely. People were not prevented from doing things they enjoyed as staff had identified and assessed individual risks for people. Accidents and incidents that occurred had been recorded and analysed .Records showed that staff were taking action in response to falls and incidents and lessons were being learned from these. The environment was clean, tidy and free from malodours. Infection control processes were followed by staff to minimise the risk of cross infection.

Staff had received training, regular supervisions and annual appraisals that helped them to perform their duties. New staff commencing their duties received induction training to help prepare them for their role. People and their relatives were complimentary about the choice of food provided. Staff supported people to eat a variety of foods. Those with a specific dietary requirement were provided with appropriate food and nutritional risk assessments were in place for those who had identified issues in relation to this. People had access to external health services and professional involvement was sought by staff when appropriate to help maintain good health.

People were encouraged and supported by staff to be as independent as they were able. People told us that staff respected their privacy and promoted their dignity through attending to their personal care needs in private. People's religious and cultural needs were respected.

Documentation that enabled staff to support people and to record the care they had received was up to date and regularly reviewed. People's preferences, life stories, personal care needs, likes and dislikes were recorded. People took part in a variety of activities that interested them. People's end of life care was attended to in a sensitive and caring way that encompassed their preferences and needs.

Complaints were taken seriously and information about how to make a complaint was available for people and their relatives.

The registered provider had a quality assurance process in place to monitor the service provided to people. People and their relatives had opportunities to give their views about the service through meetings and surveys. The culture of at the service had improved since the arrival of the new manager; staff were more communicative with people and their relatives. There was a relaxed atmosphere at the home.

The provider was aware of their responsibilities with regard to reporting significant events to the Care Quality Commission.

We have made one recommendations to the registered provider. 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?

Good

The service was safe.

Medicines were being administered and stored safely.

People were protected from unsuitable staff because safe recruitment practices had been followed in regard to one member of staff.

Staff were knowledgeable about the process to be followed if they suspected or witnessed abuse.

There were sufficient staff deployed at the home to meet people's needs.

Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed.

Accidents and incidents were recorded and monitored by staff at the home to help minimise the risk of repeated events.

The provider had carried out full recruitment checks to ensure staff were safe to work at the service. New staff were being employed which would reduce the need for the use of agency staff.

Infection control processes were robust.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and had opportunities to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People's nutritional needs were assessed and individual dietary needs were met. People could choose what they ate.

People had involvement from external healthcare professionals and staff supported them to remain healthy.

People's needs and choices were assessed and care, treatment and support was delivered in line with the pre-admission assessment.

Is the service caring?

Good

The service not consistently caring.

Staff who assisted people during lunch did not engage in meaningful conversations with people.

People told us they were looked after by caring staff.

People's care and support was delivered in line with their care plans.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in their care plans, and when people's needs changed, staff responded to ensure they received the appropriate level of support

People had opportunities to take part in activities that interested them.

Complaints were taken seriously and information about how to make a complaint was available for people and their relatives.

People's end of life care was provided sensitively and in line with people's needs and preferences.

People lived in an environment that that was adapted to meet their needs.

Is the service well-led?

Requires Improvement

The home is not consistently Well Led.

There had been three changes of manager since November 2017. This could have an impact on people's care and the staff team as

well as the leadership of the home For example, some issues identified in audits and surveys had not been followed up on in a timely way.

Actions identified in the provider's system to monitor the quality of care had been met.

People and their relatives had opportunities to give their views about the service.

Staff felt well supported by the manager.

Staff met regularly to discuss people's needs, which ensured they provided care in a consistent way.

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 20 March and 20 April 2018. The first date was unannounced, the second was announced.

The inspection team consisted of two inspectors, one nurse specialist who was experienced in care and support for elderly people and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed to see if we would need to focus on any particular areas at the home.

During our inspection we spoke with five people, six relatives, the lead nurse and eight members of staff. We also spoke with the manager who was present throughout the day. We observed how staff cared for people, and worked together. We also reviewed care plans and other records within the service. These included eight care plans and associated records, medicine administration records, six staff recruitment files, and the records of quality assurance checks carried out by the staff.

Good

Is the service safe?

Our findings

People told us that they received their medicines on time and when they needed them. One person told us, "They have written down the pain killers I need in my folder and if I am in pain I just tell them and they offer me a painkiller. My medicines are always on time." Another person told us, "When I was taking loads of medicines they [staff] reminded me and always told me what each one was for. Now I don't take many but they bring them and stay in the room while I take them. They know I know what they are for and I know I can ask anything if I forget. I always do get them on time and they come and find me wherever I am if I'm not in my room." Relatives also told us that their family members received their medicines on time. One relative told us, "That [medicines] is all very well organised and they wear a red apron and do not let anyone interrupt them. If [family member] is under the weather they ways tell me when I come in or call me or the other members of the family." However, one person told us, "They bring it at meal times and I know what they are for. I don't have them on time every time but they are nice when they give them to me and apologise for being late. I tell them it's not good enough as I worry about it."

There had been historical concerns in relation to medicines management and the staff had support from the pharmacist from the NHS Clinical Commissioning Group (CCG). During our inspection it appeared that these problems had been addressed.

We observed the lunch time medicines administration and found this process was very sensitively managed by one of the registered nurse's (RN) on duty. All systems were followed correctly. The medicines, record books, ordering systems and audits were in place and completed. The home used the 'Wellpad' system which is an electronic system for the administering and ordering medicines. This system informs staff which medicines were and were not due for administration. For example, if paracetamol had had the correct period of four hours between doses. This system had identified that one item had not been signed for; this enabled the management team to follow up with the responsible nurse.

People were protected from unsuitable staff because safe recruitment practices had been followed. Recruitment 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.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. Concerns had been raised in regard to the numbers of staff on duty and the use of agency staff at the home. However, during this inspection people and their relatives told us that there was enough staff deployed at the home. One person told us, "They [staff] are always available and always checking in on you so I think there are enough. They have been really nice to me and tell me to just ask if I need anything." Another person told us, "There are usually enough of them to go around, you do not have to wait long and the young lady who cares for me is very nice, kind hearted." One relative told us, "I come in at different times throughout the week and they [staff] are always on hand. I know them all." Another relative said, "[Family member] has two carers and I assume that when one is not on duty then the other one is. Both staff are very

nice and [family member] is very fond of them. They would tell me if they were not receiving good care, they trust the staff as I do."

The manager told us that the staffing at the home had been determined through the use of a dependency tool that assessed the number of staff required to meet people's assessed needs on each shift. The manager told us that there were sufficient staff on duty to meet the needs of people that included a skill mix of RNs and care staff. The manager and deputy manager were supernumerary to the duty rota and assisted with care duties as and when required. This was confirmed during the viewing of the staff duty rota and discussions with staff who told us that there were enough staff on duty each shift. A member of staff told us, "If someone calls in sick it can be a stretch but we call agency, but people's needs were always met and they were safe." However, another member of staff had informed us that they could do with extra staff in the morning on the dementia unit. The manager told us that there were six members of staff and one RN on duty each morning in the dementia unit and, according to the staffing tool, this was one extra member of staff to meet needs of people. The manager told us that they were currently monitoring this unit to ensure that staff were being appropriately deployed. The manager also told us that there had been a recruitment drive and six new staff had recently been recruited, this would help to eliminate the use of agency staff. The aim of the home was to become fully staffed and not to rely on the use of agency staff. The manager stated that agency staff were now rarely used at the home. On the day of our inspection there was only one agency staff member on duty.

People told us that they felt safe at the home. One person told us, "I do feel safe here. They look after you well and give you lots of time." Another person told us, "I do feel safe and well." Relatives told us that that they had no concerns about the safety of their family members. One relative told us, "I have no concerns about safety at all. [Family member] are well looked after and they [staff] look after their belongings." Another relative told us, "I don't have any worries in that department at all."

Staff members we spoke with told us they had undertaken adult safeguarding training within the last year and training records provided to us confirmed this. Staff were aware of the procedures to follow if they suspected or witnessed abuse. One member of staff told us, "I'd speak to the nurse in charge and then management. If I felt it was not going anywhere I would ring the safeguarding line."

Records of safeguarding were maintained at the home and were discussed with staff. The management at the service had gathered information and contributed to the safeguarding processes as expected by the local authority safeguarding teams. However, since our inspection we have been made aware of 11 new concerns raised in regard to people not receiving the care they need. These are currently being investigated.

People were kept as safe as possible because potential risks had been identified and assessed. Each person had risk assessments in place to help them maintain their independence. The provider told us in their PIR that risk assessments were recorded within the care plans and highlighted low and high risks, we found this to be the case. Assessments had included risks in regard to falls, nutrition, skin integrity, medicines, Multi-Universal Screening Tool (MUST) and Waterlow (skin integrity). Risk assessments provided staff with guidance about the risk, how to manage the risk and the action to take when the person became exposed to the risk. For example, one person had a prompt on the front page of their electronic record highlighting that they were at significant risk of becoming malnourished and developing pressure ulcers. The person's skin integrity plan documented that they had an air mattress and informed of the prescribed creams that staff were to use. Records showed that staff checked the person's skin daily and encouraged the person not to spend too long sitting in their wheelchair.

Accident and incident records were maintained by staff. Records showed that staff were taking action in response to falls and incidents and lessons were being learned from these and the manager had introduced a more detailed analysis to identify any patterns or trends in regard to falls. For example, one person had an assisted fall in March 2018 whilst being supported with toileting. The person was not injured and their care plan and risk assessment had been updated in regard to this incident. Another incident identified that one person was found on the floor. Again, their care plan was updated. The lesson learnt from this was that supervision for the person required to be increased to help prevent a repeat fall. These incidents had been discussed with staff.

People were protected against the spread of infection within the service. People lived in an environment that was clean and hygienic. All areas of the home were very clean and tidy. Personal protective equipment (PPE), such as aprons and gloves, were readily available to staff. All hand basins contained hot running water, liquid soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff told us they had undertaken training in infection control and records confirmed this. One member of staff was able to inform us about the procedures they followed when cleaning. This included the use of PPE and changing them when going to another bedroom. We asked if they followed a schedule for cleaning and they showed us a cleaning schedule folder, with work ticked off and signed as completed. The provider undertook regular infection control audits to ensure that people lived in a clean and infection free service. We noted that one audit had identified that a lead person for infection control was required and this had been actioned at the time of our inspection.

Good

Is the service effective?

Our findings

People and their relatives told us that they thought the staff had been trained to carry out their roles. One person told us, "They [staff] do make me feel safe and they are confident, there is no dithering." Another person told us, "Yes I feel they do. They seem to know what they are talking about with me and know all about what help I need which I'm pleased about." A relative told us, "They [staff] are unbelievably well trained and well prepared." Another relative told us, "They seem to be trained.

Staff had received training appropriate to their roles. The provider told us in their PIR that an external body monitored the training undertaken by staff and flagged up when training was due. We found this to be the case. Staff told us that they had regular training and they had an induction when they commenced working at the home. One staff member told us, "We do a lot of ELearning and have to keep up to date with our training." Records provided to us showed that staff received all the mandatory training as required. Other training provided included dementia, end of life care and equality and diversity. Staff were able to explain what they had learned from their training and how they implemented this in practice. For example, one member of staff told us what they had learned from the dementia training. They stated, "You have to understand people and their background and family. If they refuse help, try another way at a later time."

Clinical staff had their competency tested by the management of the home. The RNs and care assistants who administer medicines had completed the training that included how to use the electronic medicines management system. The manager told us that no person had any involvement with medicines until they had completed this. Other training had been booked for the nursing staff that included venepuncture (this is a medical procedure for drawing blood), suprapubic and urethral catheterisation and syringe driver (this is a medical procedure for the control of pain, sickness, agitation and fits). This training would be completed by June 2018.

Staff told us, and records confirmed that they had received induction when they commenced their roles at the home. One member of staff told us, "[On induction] I had to learn a lot of different things and I worked with two staff who really helped me. I did all mandatory training courses before working independently." All new staff also undertook the Care Certificate training. The Care Certificate is an agreed set of training standards in adult social care.

People were supported by staff that had supervisions (one to one meetings) with their line manager. Staff told us that they had regular supervisions and they could talk to the management team at any time. Records provided showed that staff were receiving regular supervisions. Staff told us that the topics discussed during supervisions included people staff attended to, training, discussions about the delivery of care and any improvements that could be made.

People's needs and choices were assessed and care, treatment and support was delivered in line with the pre-admission assessment. People's needs had been assessed before they moved into the home to ensure staff could provide the care they needed. The provider told us in their PIR that they had a robust pre-admission protocol that allowed them to ensure people's needs could be met. We found this to be the case.

People and their relatives told us that they were involved in the assessment process. One person told us, "I had a visit from a team member and they gave me lots of time to ask and answer questions. I knew everything I needed to when I came and they had everything arranged like my hospital visits and doctors information. I didn't need to worry about anything."

People's care was provided in an holistic way to help ensure care was effective. The provider had appointed a Practice Development Manager whose role was to develop and implement 'Montessori' training for staff. This is training in regard to supporting people with dementia and included developing and introducing activities based on models of learning and rehabilitation. It focussed on the 'doing,' providing meaningful activities to the individual person to give them the opportunity to enjoy an enriched life.

People were supported to have enough to eat and drink to keep them healthy. A choice was offered for every meal and alternatives were also available. People's dietary needs and preferences were documented and known by the chef and staff. People and their relatives were very complimentary about the food provided. One person told us, "The food here is very good and you have plenty of choice." Another person told us, "There is a lot to choose from. It is very good quality and well cooked. I like that you can choose from several different things and eat when you are hungry and not just when they tell you." A third person told us, "Yes I like it [the food]. They help me to choose what I would like and tell me what it is. If you don't fancy something they will make you something else. I fancied kippers and they went out and got me some." The cook told us that they discussed the menus with people after each meal and also in the residents meetings. We noted in one meeting that people had requested a hot option for breakfast and this had been implemented. The menus seen offered a variety of meals that included fresh vegetables, fish, meat and pasta. There was a choice of breakfast meals that included bacon, fried eggs, hash browns, porridge, cereals and a choice of juice, coffee and tea.

People had access to all healthcare professionals that supported them to live healthier lives. People told us that they saw all the healthcare professionals they needed. One person told us, "I tell them [staff] and they organise the nurse to come and see me and they listen and call the GP or whoever I need to see. You see them regularly and immediately, sometime that day." Another person told us, "I have seen everyone while I've been here, doctor, dentist, optician, foot lady, hairdresser regularly. You only need to ask and they arrange it and tell you straight away when they will come. I am happy with this." Relatives told us that staff always kept them informed whenever their family member had a healthcare appointment.

Records confirmed that people were able to access a wide variety of core and specialist external services. For example, referrals had been made on behalf of people to agencies such as the GP, Speech and Language Therapists (SALT), dietitians, wheelchair service, optician and dentists. This showed that people's healthcare needs were attended to by the appropriate professionals. For example, one person had had been seen by SALT and they had recommended pureed food and thickened fluids. They also had a fluid chart and staff recorded how many teaspoons of thickened fluids the person had consumed each day. Records of weights were maintained to help identify any loss in weight. Where this had been identified appointments had been made with the GP and food charts had been implemented.

People lived in an environment that that was adapted to meet their needs. All equipment used at the home was serviced in line with the manufactures' guidance to ensure it remained in a good state of repair and was safe for people to use.

The Mental Capacity Act 2005 (MCA) provides legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had been undertaken and where people lacked capacity best interests meetings had taken place and a DoLS application had been submitted. For example, one person required to have their medicines covertly (medicines without the person knowing). A mental capacity assessment for this was undertaken and it documented that the person was unable to consent to this. A best interests meeting had taken place and authorisation from GP and pharmacist was evident on the form. The manager had notified the local authority so they could apply to the Court of Protection for those who were receiving supported living.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives told us that staff were caring and they helped them every day. One person told us, "They really are reassuring and good at what they do. They have sat with me when I've been upset and helped me to do personal things and not made me feel like a baby." Another person told us, "They are a good lot who know what they are doing." A third person told us, "They are lovely and kind and look after me so well. They are just a bit busy sometimes and you get the ones that don't speak much English at night but they do care." Comments from relatives included, "They have lots of time to give when they see it is needed for example if you're upset or my [family member] is frustrated. They are very calm." Another relative told us, "They are unbelievably kind and know how to adapt to every situation. There have been a lot of us visiting and they are so welcoming and patient with us all and explain everything."

During the day we observed staff interacting with people in a caring manner, engaging in conversations with people and providing support to people as and when required. Staff interactions with people were attentive and tactile. During lunch we observed staff supporting people as and when required and offering drinks.

People were supported to maintain relationships with their friends and families. Visitors were made welcome at the home. We observed family members visiting throughout the day and there were no restrictions on visiting time. One relative told us, "I can come in every day to visit my [family member], there are no restrictions. Staff always greet me and ask if I want a cup of tea."

People's dignity was respected by staff and their independence was promoted. Staff told us that they ensured all personal care was undertaken in the privacy of people's bedrooms with the doors and curtains closed. They told us that they made sure any exposed parts of the body were covered to maintain the person's dignity. One member of staff told us, "I keep the doors closed and explain to them what I'm doing. I close the curtains and make sure people are covered with a towel." We observed staff closing bedroom doors when they attended to personal care. People told us that staff were very respectful especially when helping them with their care needs. One person told us, "I feel they treat me with respect and it's all very dignified. They help me to cover up if I'm getting out of the bath and they turn their back. I asked them not to wake me at night for changes and they respect my wishes." Another person told us, "They always knock on my door and ask if they can come in. I can lock my door and do at night which is fine. They are very respectful." A third person said, "I have complete privacy. They offer to help me with tidying my room, if I say no they don't touch anything. They sometimes say I can't leave things all over the floor because it's a trip hazard and that's fine. They joke with me about it and make me smile."

Staff told us that they encouraged people to do as much as possible for themselves. For example, washing and dressing themselves. A member of staff told us, "If people are able, I put soap on the flannel and will ask them to wash themselves. I always give them support to choose their clothes but we don't push them."

People received care and support from staff who had got to know them well. For example, a member of staff was able to explain that one person had been a keen gardener. The person had requested to do some

gardening and gave a list of plants that they would like. The gardener had sourced these and they were waiting for the person to plant them. Staff told us that they got to know people through reading their care plans and having discussions with people and their relatives. One member of staff was able to give a description of a person's life history. This was exactly how it was described in the person's care plan. People told us that staff took time to get to know them. One person told us, "They have given me time to chat about my needs and they read your notes and find out about you. We have regular chats." Another person told us, "They know my particular needs, I feel they deal with everyone here as individuals. They know how I like things." A relative told us, "They [staff] are fantastic at this. Everything is recorded for the next person and I feel they work just as well with us and we are part of their team. It is one big team here."

People's religious and cultural needs were met by staff. People told us that they could practice their religious beliefs and church leaders visited the home to provide religious services. There was a daily record in place that provided information about individual people's cultural, religious and spiritual support as required. One person told us, I go to church with my friend. They arrange this and prepare me for her arrival. They always ask me all about it when I get back. I still choose how I live and make my own decisions and they write things for others in my care plan so we all know how I want things." Another person told us, "I have Communion here and they [staff] chat with me about organising this." We noted that one person was from a different country and English was not their first language. The provider had employed a person who was from that country and was able to converse with the person using their preferred method of communication.

The manager told us that no person living at the home was from the lesbian, gay, bisexual or transgender (LGBT) communities. They told us that this was explored during the pre-admission assessment so people could inform them. The manager and staff told us that they treated all people as individuals and respected their individuality.

Good

Is the service responsive?

Our findings

People received care that was personalised to their needs. People and their relatives confirmed that they had been involved with their care plans and were involved in reviewing their care. One person told us, "They did come around (to visit me), it was the manager I think and she asked me about what I needed. We talked about what my wishes are and after I moved here and we wrote it down and my sister and I chatted about it." A relative told us that they were involved with their family member's care plan and that they attended reviews.

Care plans and care was person centred. The provider told us in their PIR that they produced the care plans with people and their relatives to ensure that it was person centred and met all of their needs. We found this to be the case. Care plans were electronic and could be accessed by people and their relatives using a unique code to them. Care plans had been produced from the pre-admission assessments and had been reviewed on a monthly basis. They contained detailed information about people's care needs and actions required in order to provide safe and effective care and people's wants and wishes. For example, care plans contained sections for social interaction, skin integrity, elimination, mental wellbeing, communication, hygiene, mobility, End of Life, medicines, sleeping and nutrition. Each recorded the person's needs as well as 'Residents Support Choices'. One person had an identified need in regard to their mental wellbeing. The care plan informed that the person could be distressed by the hoist and may scream if staff did not transfer them carefully. A member of staff was able to describe how they did this so as not to cause distress to the person.

The nursing care planning system followed good practice and a day to day recording system was in place for people and was completed by care staff. For example, fluid charts, food charts and a staff actions monitoring form. There were clear clinical day to day objectives set in the care plans that assisted with meeting people's needs.

People had a range of activities they could be involved in. There were three activity coordinators employed at the home. People told us that there were plenty of activities to do every day. One person told us, "There is a lot to do. I like the entertainers and flower arranging. I like art time too. I go on the trips to the garden centre or cafes sometimes." Another person told us, "You can go out with them [staff] or with visitors. I go out for lunch with my friend. I like listening to music. They have pets visiting today and staff came to remind me. There is always a board with what's on." A third person told us, "They do trips too here but I like to go out with my family. They are going to the garden centre this week. Sometimes they will come and sit in my room with me and we do a puzzle together, and have a cuppa."

Relatives were complimentary about the activities provided by the activity coordinators. One relative told us, "They are kept entertained. [Family member] likes to sit and watch the world go by and they like the garden, they spend a lot of time out there in the summer. [Family member] gets their hair done and likes to watch a movie"

Activities available included shopping, visits to garden centres flower arranging, chair exercises, hairdresser

and external entertainers. During our visit there was a visit of a group of animals. People were observed holding chickens, cats, kittens, a rabbit and guinea pigs. There was also a Shetland pony making its way around the home to meet people in their rooms. People expressed their enjoyment through smiling whilst cuddling and petting the animals.

Complaints and concerns were taken seriously. The provider had a complaints procedure that provided the contact details of who to make a complaint to. It also provided the details of the local ombudsman and the local safeguarding team. The policy clearly stated that all complaints would be responded to within 28 days. The provider told us in their PIR that they had received 11 complaints during the last twelve months. It also informed that the management team at Rodwell House welcomed complaints and addressed them in a timely manner and we found this to be the case. Records of complaints received and actions taken were recorded. The manager told us that complaints were discussed with staff so they could help to prevent a repeat of the same complaints.

People and their relatives told us that they knew how to make a complaint and they were assured that complaints would be addressed by the manager. One person told us, "I feel any member of staff would take a complaint very seriously and act on it and get back to you quickly. I've never had to complain." Another person told us, "They listen to me whatever it is and make time to sit with you to talk. They give me feedback on any queries and if they can't help they find a way to. The manager is always available and so are the rest of the management." A third person told us, "The management team deal with concerns very quickly and they are very reassuring. The manager is such a lovely and kind lady and responds to you very quickly. She is very efficient. I needed to sort out some finance things and she assisted discreetly and gave very good advice."

End of life care was provided sensitively and in line with people's needs and preferences. Care plans included people's requests about their end of life wishes that included if they wanted to remain at the home or be admitted to hospital. One person's end of life plan documented that the person was a Catholic and would like to be read the last rites. There were two telephone numbers of priests to be called. It also recorded that the person would like a certain type music to play when they reached that stage of their life. A palliative approach to end of care was apparent and clear advice given by this team to ensure that appropriate guidance was followed. This was linked with the training and development of staff with the palliative care teams. Records showed that all staff had received end of life care training.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives were complimentary about the manager who had only been in post one month prior to our first visit. Comments from people included, "She is very nice and is always saying hello and asking me how I am. She comes around us all and you see her doing all the same jobs as everyone else," "She is such a nice person and has lots of time for you. She pops into my room to say hello every day. She is new and I feel I know her very well. There is no hierarchy here" and "You can speak with her at any time." Comments from relatives included, "Yes she is very kind and very efficient and personable. I would say the management are strong" and "Yes she is good. She has an open door approach and has helped me arrange everything with solicitors. For someone so new here she is very proactive."

Staff were also complimentary about the manager and the changes they had made. One member of staff told us, "They [manager] are very approachable." Another member of staff told us, "The home has been well led since the arrival of the new manager; they are approachable and very supportive. This has been the best manager there has been and they go on the floor a lot."

At the time of our 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 the manager who was in post told us that they had commenced the registration process. However, since the last day of our inspection we have been informed that this manager had left the service. This was the third change of manager in five months at the service. The home had been through a difficult time with changes to the management team, and another change of manager leaves the home without strong leadership to ensure people received safe care at all times. For example, we noted that some repeated actions from audits had only been addressed by the current manager. The issues raised in the survey of 2017 had not been addressed by the previous management of the home, these were only addressed by the current manager. This meant that without a manager in post there was a risk that robust quality assurance processes may not be in place and as such actions not addressed.

We had also been informed in May that the clinical lead for the service had left. We wrote to the provider requesting an action plan on how the service was to be managed, especially in regard to the current concerns that had been raised. The provider wrote and told us that they had temporarily employed two clinical leads providing cover seven days a week for the service whilst they actively recruited a manager and clinical lead. They also informed that they would voluntarily cease new admissions to the service pending the outcome of the Safeguarding Specialist's report.

We recommend that the registered provider ensures the quality of the service is maintained whilst there is a lack of a registered manager for the home.

The manager had told us that there had been a large turnover of staff since the last registered manager left. They told us that the culture of the service had become more inclusive and communication between staff, people and their relatives had improved. This was confirmed during discussion with people, relatives and staff.

Quality assurance systems were in place to monitor the quality and running of service being delivered. The provider told us in their PIR that audits were carried out every month to monitor the running of the home. We found this to be the case. Monthly quality audits were undertaken by the quality audit lead person for the provider. These included audits on care plans, call bell response times, night time visits. Weights and daily chart reports, infection control, analysis of falls, e- learning and staff supervisions. An action plan had been produced for issues that had been identified during the audits. For example, it was identified that not all care plans had their monthly review in January 2018. In the March 2018 audit this was identified as having been completed. The audits also identified that the medicines were still subject to a safeguarding investigation and the manager was closely monitoring this.

A survey was carried out in October 2017 of people who lived at the home and relatives. There were some very good comments in the responses returned. For example, "I would recommend the home to other people," and "Rodwell House is an excellent home. We have seen a lot of nursing homes in the area and Rodwell House is by far the best", and "We are happy with the care our relative receives." However, there were a number of negative comments. For example, comments had included, "I am concerned that on several occasions the call bell had not been answered in a timely manner," "The communication between staff is not good and there seems to be a shortage of staff," "The food is not good, especially the evening meals." We found that the manager had addressed these issues and improvements had been made.

People and their relatives told us that the manager listened to what they had to say and always provided answers to them. One person told us, "[The manager] always comes back and gives us news on what is going on. They sit in the lounge and have their lunch or a cuppa with you." Another person told us, "I feel I can ask her any questions; the manager asks you to tell them what you think or write them a note. The manager is relaxed but very professional and informative."

Regular meetings took place with people and topics covered included food, activities and staff. During the meeting of March 2018 people had raised concerns about the difficulty of being able to understand staff who did not have English as their first language. The manager had acted on this and English lessons from a qualified teacher are provided to staff who require this. They also worked alongside staff who spoke English. The manager told us that two people who lived at the service and were ex teachers were also helping to teach English. People had also raised concerns that bread was not being served with the soup, the manager had taken action to resolve this.

Regular staff meetings took place which provided the opportunity for staff to discuss people they cared for and any topics related to the home. Actions had been taken to address topics raised. For example, discussions about call bell times. Staff were told that any staff could answer call bells, even if it was not their unit, as long as they were free. Actions were also listed to source dementia friendly crockery, revised cleaning schedules (which we saw); introduce wound folders and updates to staff training. Head of department meetings also took place that included discussions about medicines, food and fluid charts and training.

The provider and staff worked with some other related agencies that ensured people received joined up care, treatment and support. Records maintained at the home evidenced that staff had worked with the local safeguarding team, adult social care teams and all healthcare professionals. For example, GPs,

community nurses, psychiatric and palliative care specialists.

The provider was aware of their responsibilities with regard to reporting significant events to the Care Quality Commission and other outside agencies. Notifications had been received in a timely manner which meant that the CQC could check that appropriate action had been taken.