Mr Michael Baldry

Ennis House

Inspection report

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Date of inspection visit:
09 April 2019
10 April 2019

Date of publication:
28 May 2019

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?	Inadequate

Summary of findings

Overall summary

About the service: Ennis House accommodates up to 40 people in one adapted building. This is three houses that have been joined together over the years. One of the houses was not in use at this time, people lived in the main house or 'Oakleigh'. At the time of the inspection there were 35 people living there.

People at the home were living with a range of complex mental health care needs and dementia. Most people were independent and needed minimal assistance while others required some assistance related to their personal care and day to day support.

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

People's experience of using this service:

The provider lacked effective quality assurance systems to identify concerns in the service and drive necessary improvement. Where the need for improvement was identified these were not always addressed in a timely way. Improvements were needed to the recruitment of new staff.

There was a reliance on the care manager for oversight of the service. In their absence staff did not have access to all the information they may need.

The home was in need of general maintenance throughout. Infection control procedures were not always being followed to prevent spread of infection. A fire risk assessment had been completed however, we found an area of the home that had not been included in this risk assessment.

People were not consistently protected against the risk of abuse. There was a lack of oversight of incidents. This had resulted in reoccurring incidents not being recognised and therefore had not been reported as a safeguarding concern. There was no overview or monitoring of incidents, accidents and safeguarding to identify any trends or themes for individuals or the home in general.

Mental capacity assessments had not been completed in relation to key decisions which had been made regarding people's care. There was no information about whether people had capacity or whether decisions had been made in their best interests. Staff were unable to tell us whether people had Deprivation of Liberties Safeguards (DoLS) authorisations in place or if applications had been made.

Some people were able to independently engage in activities of their choice. However, improvements were needed to ensure people, who were less able, were able to access a variety of meaningful activities. There was no guidance for staff about how people could be supported to maintain their interests.

The provider had identified staff had not all received the training updates they needed and not all staff had received supervision. This was being addressed at the time of the inspection and a plan was in place to

ensure this was completed. Staff told us they felt well supported.

Staff had a good understanding of the risks associated with the people they supported. Risk assessments provided further information for staff about individual and environmental risks.

People were supported by staff who treated them with kindness, respect and compassion. Staff understood people's needs, choices and histories and knew what was important to each person. People were enabled to maintain their independence and make their own decisions and choices about what they did each day.

People were supported to receive their medicines safely and when they needed them.

People's health and well-being needs were met. They were supported to have access to healthcare services when they needed them. People's dietary needs were assessed, and people were provided with a choice of freshly cooked meals each day.

Rating at last inspection:
Requires Improvement. (Report published 18 April 2018.)
The provider sent us an action plan and told us how they would address these issues.

Why we inspected:

This was a planned inspection based on the rating at the last inspection. At this inspection we found that whilst some improvements had been made to the environment further improvements were needed. We also found further areas of concern that required improvement.

Enforcement:

Please see the 'action we have told the provider to take' section towards the end of the report

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:

We will ask the provider to submit an action plan detailing the steps they intend to take to ensure the required improvements are implemented. We will also continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Ennis House

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was undertaken by two inspectors.

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

Ennis House accommodates up to 40 people in one adapted building. This is three houses that have been joined together over the years. One of the houses was not in use at this time, people lived in the main house or 'Oakleigh'. At the time of the inspection there were 35 people living at the home. People were living with a range of complex mental health illnesses and dementia. Most people were independent and needed minimal assistance and others required some assistance related to their personal care and day to day support at the home.

The service was not required to have a registered manager therefore the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The first day of the inspection was unannounced.

What we did:

Before the inspection we reviewed the information, we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). Providers are required to send us this key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we looked at the care records of the home. This included three staff recruitment files, training, medicine and complaint records. Accidents and incidents, quality audits and policies and procedures along with information about the upkeep of the premises.

We looked at seven care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' two people living at the home. This is when we check that the care detailed in individual plans matches the experience of the person receiving care. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving care.

We spoke with eight people who lived at the home, thirteen staff members, this included the provider, and one visiting healthcare professional.

We spent time observing people in areas throughout the home and could see the interaction between people and staff. We watched how people were being cared for by staff in communal areas. This included the lunchtime meals.

After the inspection we contacted five health and social care professionals to ask for feedback about the service and we spoke with the care manager by telephone.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations have not been met.

At the last inspection in February 2018 we asked the provider to take action to make improvements as risks had not always been safely managed. At this inspection we found concerns in relation to safeguarding, infection control and managing risks. We also asked the provider to make improvement to their recruitment processes.

At the last inspection in February 2018 we also found concerns about the maintenance of the home. This has been reviewed in the key question 'effective.'

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not always safeguarded from the risk of abuse or harm. During the inspection incidents were bought to our attention that indicated some issues had not been reported to safeguarding.
- Although we asked for the information, the provider was unable to show us any safeguarding records to demonstrate what concerns had been previously reported or that a clear safeguarding process had been followed. There was no information found in care plans to identify when a safeguarding concern had been reported. There was no analysis of safeguarding's across individuals, or the home.
- A number of staff from a sister home, owned by the provider had recently come to work at Ennis House. This lack of oversight meant these staff were not always aware of previous incidents. Therefore, when further incidents happened, while staff addressed them appropriately at the time, they did not realise the significance of the incident and report it appropriately.
- A further incident was bought to our attention, this had not been recorded as an incident. The provider had not been made aware of what had happened. Once the provider was made aware he told us about the significance of the incident and how he would address it.
- The lack of oversight and the addition of a number of new care staff meant incidents had not been recognised as reoccurring and therefore had not been reported as a safeguarding concern. There was no overview or monitoring of incidents, accidents and safeguarding to identify any trends or themes for individuals or the home in general.
- Staff told us they knew what steps to take if they believed someone was at risk of harm or discrimination. They were aware safeguarding concerns were reported to the local authority safeguarding team. One staff member told us how they had raised concerns with the local authority in the past. However, other staff told us they would inform senior care staff about concerns who would then make decisions about when a safeguarding referral was needed.

These issues are a breach Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● People told us they felt safe living at Ennis House. We saw people approaching staff to discuss concerns. Staff were aware of situations when people may feel unsettled and sought to reassure them, for example when new people were visiting the home. This was seen during the inspection, when staff identified us and reassured people why we were visiting.

Preventing and controlling infection:

● Legionella risk assessments had been not been completed and no legionella testing had taken place. This meant that people were at risk of water borne infection. Flushing and descaling of taps and shower heads can help in the prevention of legionella. We were told taps were flushed regularly but this had not been recorded as to which taps had been checked or when this had taken place. Descaling of taps and shower heads had not been undertaken.
● We saw a staff member carrying soiled bedding and clothing. The staff member was wearing gloves but not an apron. This linen should have been transported in a laundry bag to reduce the risk of cross infection.
● Infection control procedures were not always being followed to prevent spread of infection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Domestic staff were working hard to ensure a high level of cleanliness was maintained.
● Staff used Protective Personal Equipment (PPE) such as aprons and gloves. Adequate hand-washing facilities were available throughout the home.

Assessing risk, safety monitoring and management:

● We looked at the fire risk assessment. This stated the kitchen in 'Oakleigh' was not in use and that regular fire drills were completed. During the inspection we saw this kitchen was used for cooking and staff told us fire drills were not held.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had a clear understanding of what actions to take in event of a fire.
● At the last inspection we asked the provider to make improvements in relation to fire safety. We also asked the local fire service to visit. Following their visit, the fire service issued an enforcement notice to ensure a comprehensive fire risk assessment was completed. This had been done and the enforcement complied with.
● Staff had a good understanding of what to do in case of fire. Staff who had moved to Ennis House from the sister home told us they had received detailed instructions of fire procedures and what actions to take in case of fire.
● Several people at the home smoked. There was a lounge in 'Oakleigh' where people were able to smoke indoors. Regular checks of the smoking lounge took place to ensure all cigarettes had been extinguished and waste bins did not contain paper. Staff told us about some people who did not always smoke in designated areas. Systems were in place to monitor this where appropriate included supervising people

when they smoked.
● Regular fire checks took place, and this included fire alarm tests. Personal Emergency Evacuation Plans (PEEPS) were in place.
● There were risk assessments for people's care needs including risks associated with mobility, nutrition and mental health. One person had a risk identified if they did not attend a health professional to receive regular medication in relation to their mental health. This was detailed, with prompts to advise staff what behaviours to look out for and actions to take if these were observed.

Staffing and recruitment:

● Staff records did not contain all the information needed to demonstrate that staff were appropriate to work at the home. One staff file did not include photographic identification, another did not have a full employment history and concerns identified on one member of staff's Disclosure and Baring Service (DBS) checks had not been risk assessed.
● One staff member told us they had been asked about the gaps in their employment at interview.
● The provider told us any areas of risk identified had been discussed with staff prior to them starting work at the home but this had not been documented, so management could assess the suitability of recruitment practice at a future date.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DBS checks had been completed before staff started work at the home.
●There were enough staff working to ensure people received support in a timely manner. People and staff told us staffing levels were good and there were always enough staff to meet people's needs in a timely manner.
● Staff were available when people needed help and responded promptly.

Using medicines safely:

● There were systems to ensure medicines were ordered, stored, administered and disposed of safely.
● Protocols were in place for people who had been prescribed 'as required' (PRN) medicines. People only took these medicines when they needed it, for example if they were anxious. These were well written and described when PRN medicines were needed. For example, one person had been prescribed a medicine for anxiety. The protocol included the specific words the person would use that would indicate they were anxious.
● Only staff who had completed medicine training and been assessed as competent gave medicines. There were medicine care plans which informed staff about guidance in place and they had a good understanding of people, the medicines they had been prescribed, and how they liked to take them.
● We saw people received their medicines when they needed them, in the way they chose.

Requires Improvement

Is the service effective?

Our findings

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations have not been met.

At the last inspection in February 2018 we asked the provider to take action because the home was not always clean and had not been properly maintained. At this inspection we found although the home was clean, we still had concerns in relation to poor maintenance of the building. At this inspection we also found concerns in relation to consent.

Adapting service, design, decoration to meet people's needs:

●The provider had not ensured the home had been properly maintained. Since the last inspection redecoration had taken place in some bedrooms, bathrooms and communal areas including the hallway. However, we found a number of areas identified at the last inspection still required repair. This included staining from water leaks to hall ceilings, decoration to bathrooms, bedrooms, hallways and communal areas.

●We found one bathroom had torn flooring, a bath panel was held in place by tape and a wall was marked where piping had been removed. A stairway window on the first floor did not close securely and the door in the dining room could not be locked.

● Although the home was clean, this was hindered by areas of the home that had been poorly maintained, for example, flaking paint on pipes in some bathrooms and toilets, torn, or stained flooring and broken window frames. Some areas of the home did not smell fresh. For example, the stairwell and area surrounding the smoking room smelt heavily of cigarettes. Some bedrooms and communal areas had a stale odour.

●The provider and staff were aware improvements were required but these had not been addressed in a timely way. There was no plan in place to identify how this was to be prioritised and achieved.

● There were cleaning products seen in the Oakleigh kitchen. The door to this kitchen was not locked. This should have been stored securely under the Control of Substances Hazardous to Health Regulations (COSHH) 2002. COSHH products are products which can be considered harmful, if for example it was swallowed.

● Consideration had not been given to people who had recently moved into the home and were living with dementia. There was no pictorial signage on some doors to help guide people around the home.

● Ensuring people live in an environment that is clean and well-maintained helps them to improve and maintain their mental and physical health. Although people told us they were happy with the home the provider had failed to recognise the potential impact the lack of upkeep and refurbishment to the home may have on people.

These issues are a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some bedrooms had been redecorated and staff told us people had been involved in these decisions.
● Staff told us they were pleased with the redecoration that had taken place and were involved in redecorating the home. All staff were eager for improvements to continue and told us they enjoyed painting and improving the home.
● There was a lift, which provided level access throughout. Bathrooms and toilets had been adapted with rails and raised seats to help people retain their independence.

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

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● Mental capacity assessments had not been completed in relation to key decisions that had been made regarding people's care. There was no information about whether people had capacity or whether decisions had been made in their best interests. For example, some people had restrictions in place regarding access to cigarettes and snacks. No evidence was found in care records to show how this decision had been made or who had been involved in this decision. Staff were also unable to tell us how these decisions had been made.
● One person had been found smoking in a restricted area. This person's cigarettes were now kept in the office. This person then went to the office to ask for a cigarette when they wanted one. We saw a number of other people also had their cigarettes in the office. Staff told us some of these were by people's choice, others were to keep people safe because they needed support from staff when smoking. However, staff could not tell us how these decisions had been made or who had been involved. There was no evidence of discussions having taken place, or decisions having been made in the person's best interest.
● Some decisions had been discussed with the person's family or next of kin, however, staff did not know who had a legal right to be involved in decisions about a person's care including who had a Legal Power of Attorney (LPoA). We were told best interest meetings had taken place in the past to discuss people's care needs, but these had not been documented.
● DoLS applications had been made for some people. Staff were unsure who had a DoLS application authorised or in progress. We were shown two differing lists and new staff were unable to tell us definitively who had a DoLS authorisation or the reason each application had been made. The provider was aware of some applications but was unclear if all were in place or awaiting authorisation. We were unable to find any documentation in care files relating to current referrals in progress and the provider was unable to locate the documentation.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout the inspection we saw staff offering people choices and asking their consent before they were offered care and support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience

●People's needs had been assessed before they moved into the home. Assessments had been completed before people were moved onto Ennis House from the sister home when it closed. These assessments had been completed with the assistance of staff at the sister home who knew people's needs.
● Care and support was delivered in line with current legislation and evidence-based guidance. For example, people's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow risk assessment.
● Additional assessments had been completed, for example nutritional assessments. These identified people's dietary needs including likes, dislikes and foods which people did not eat according to their religion.
● People were supported by staff who had ongoing training, this included medicines, mental health awareness and infection control.
● It had been identified that staff from the sister home were not up to date with their training. The care manager was working with staff to ensure these were completed and had a good oversight of what was needed.
● Due to people with dementia moving into Ennis House from a sister home, the care manager had identified that current staff required dementia training. We were reassured following the inspection that this was in the process of being arranged.
● Practical training such as moving and handling had been provided face to face. Other training was through a workbook system which was sent to an external company for marking. If staff did not achieve a certain grade they were required to redo the training.
●Staff who gave medicines had completed formal competency assessments. However, formal competency assessments had not been completed for any other training.
● We recommend the provider introduce formal competency assessments to demonstrate staff understanding of the training they had received and were always following best practice guidelines.

●Staff had not been receiving regular supervision. This had been identified, there was a plan in place and one to one supervision meetings had just started. We were told that all staff would be having supervision as part of the new process. Staff told us they would be comfortable speaking to the provider or senior staff if they had any concerns.
●Staff who had moved to Ennis House from the sister home had not received a structured induction. However, staff we spoke with told us they had been shown around and completed one or two shifts prior to starting work fully at the home. They had also completed fire safety training.
●People told us that staff knew them well and how to support them. We saw staff respond promptly to people when they became anxious or upset.
● Staff were able to tell us about people's needs and how they liked their care to be provided, for example, one person did not like to eat in a busy area, staff were aware of this and approached the person in the lounge and asked if they would like a table to eat where they were sat.

Supporting people to eat and drink enough to maintain a balanced diet:

● People were supported to eat a wide range of healthy, freshly cooked meals, drinks and snacks each day to meet their individual nutritional needs and reflect their choices and preferences.
● People told us they enjoyed the food and we saw freshly cooked meals were provided. There was only one main option for lunch, we saw that people were provided with alternatives if requested. People who did not wish to eat lunch, or those who wished to go out had meals saved for them to eat when they chose.
●People chose whether to sit at the dining tables or in the lounge, staff ensured people had access to the correct equipment to enable them to eat independently. One person ate using a bowl and spoon, another had a small plate and smaller portions of food.
● Staff gave people time to eat their meals independently but were observant and provided support when needed.
●People who were at risk of poor nutrition had achieved good outcomes evidenced by weight gained. When people had lost weight, staff were aware of this and took appropriate steps, including contacting other agencies if required.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●People were supported to maintain their health and were referred to appropriate health professionals as required, for example one person told us they were supported by staff when they visited an external mental health professional regularly.
● People's daily care records showed staff had encouraged them to visit a GP when they became unwell and the community nurse confirmed they were contacted when a person required support with their catheter or wounds.

Good

Is the service caring?

Our findings

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Despite ongoing issues with the environment and governance people did not express any worries in relation to the day to day care and kindness they received.

Ensuring people are well treated and supported; respecting equality and diversity:

- People told us they were happy living at the home and were looked after by staff. One person told us they were very happy and well looked after. They said, "What more can I want, I have this (bed)room, good food, staff to look after me, I have everything I need."
- Staff had developed good relationships with people. Staff were able to talk to us about people's physical, emotional and health needs, their likes and choices and what was important to each person. Staff could tell us about the people they cared for, their personal histories and how this affected people on a day to day basis.
- Staff from the sister home were continuing to develop relationships with people, and staff from Ennis House were doing the same with people who had moved from the sister home.
- Staff ensured people received support from staff they felt comfortable with. They recognised that people's choices could change from day to day and adapted their approach as necessary.
- Staff recognised how people's mental health and dementia could affect them on a day to day basis. One staff member told us about a person who did not like them on that day. They told us other staff would support the person. One person had started to display behaviours that may challenge, a staff member approached the person, but they did not respond. A second staff member approached, and the person became calm and went with the second staff member.
- There was an emphasis at Ennis House on ensuring people were treated fairly and equally. Staff had a good understanding of dignity, equality and diversity. Some people were living with long-term mental health conditions. Due to this they had been used to living in environments with very structured routines. This meant they did not always like or accept changes. Staff told us how they supported people with changes. For example, when new chairs were brought into the home these were introduced slowly (one or two at a time) so people could get used to them.
- People were supported with their spiritual and religious choices. There was information in people's care plans about people's beliefs and how to maintain them. For example, one person wanted staff to take them to church if they wanted to go.

Supporting people to express their views and be involved in making decisions about their care:

- People were supported to make their own decisions and choices each day. They got up and went to bed

when they wished. They were able to spend their days as they chose. We saw some people eating their meals in the lounge. We asked staff why they were not eating at the table. A staff member said, "It's their choice, we ask, and they choose." The staff member went on to tell us how as staff they were here to support people each day, but the decisions made were people's own.

● Care plan reviews took place regularly and people were encouraged to be involved in these. Records showed whether people had chosen to be involved or not.

● Throughout the inspection staff offered people choices about what they would like to do, and their choices were respected.

Respecting and promoting people's privacy, dignity and independence:

● Care plans informed staff of where people needed support and how to provide this, whilst maintaining people's independence.

● People were helped to maintain their own personal hygiene and wear clothes that were well laundered and of their own choice. Some people experienced episodes of incontinence but declined support to manage this. Staff told us how they ensured people's bedding, including duvets were changed and laundered each day. This was done discretely and maintained people's dignity and promoted their independence.

● People's privacy was respected. Those who wished to and were able had a key to their bedrooms. For some people staff only went into their bedrooms if the person agreed. People were able to spend time in their bedrooms if they wished to have time alone.

● People were supported to maintain relationships with family and friends who were important to them. Care plans included information about who was important to people. One person had an agreed time when they would phone their relatives and staff supported them to do this. Another person asked staff if their relative was due to visit that day and staff phoned the relative to find out and reassure the person.

● People were supported to develop new relationships. We saw people together in friendship groups. One person was supporting another, who was new to the service and directing them to their meal table and helping them with cups of tea. Where necessary assessments had taken place to ensure relationships were appropriate for those involved.

● People were able to make themselves hot and cold drinks throughout the day. Some people were able to make their own drinks in the kitchen. For others, flasks of hot water were provided, and people helped themselves when they wished.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection in February 2018 we asked the provider to take action to ensure people were able to engage in activities that they enjoyed and reflected their interests. At this inspection, we found improvements were still needed to ensure meaningful activities were available to each person.

Requires Improvement: People's needs were not always met. Regulations have not been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- Supporting people to take part in a variety of activities helps them to maintain good mental and physical health. Consideration had not been given to the individual needs of people who had moved from the sister home into Ennis House. These people were living with dementia. Staff told us about activities that people enjoyed at their previous home. This included some group activities, such as quizzes and ball games. These were not provided for them now they were living at Ennis House.
- Since the previous inspection, care plans had been updated to show what activities people enjoyed. For example, some people enjoyed painting and others enjoyed music. However, there was no guidance about how to support people, or whether people needed support, to maintain these activities and interests. Daily notes did not include specific details of activities people had engaged in during the day, which may also have provided guidance for staff.
- Whilst some people were able to occupy themselves during the day, others were less able. As there were a number of new staff working at the home, this lack of guidance meant the provider could not be sure people received the person-centred care and support they needed and would chose.
- Staff told us group activities had previously been offered but people lost interest in these after a while therefore they had not continued. Staff had not received training in how to support people with meaningful activities.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they had enough to do each day. We saw people watching television, engaging in conversations and pursuing their own interests. People who were able went out of their own. Where people were unable to go out on their own staff supported them and went out with them. One staff member who was new to the service told us, "One of the best things here is that people can go out when they like."
- People's care plans contained information about people's needs in relation to personal care, mobility, mental and physical health and these were regularly reviewed. There was information to show whether the person wished to be involved in their own reviews. The provider told us, people were able to see their own care plans whenever they wanted to.

● Each person had a care plan that was written in their own words. This was completed with staff and reflected each person and what was important to them. For example, one person didn't like noisy environments, but wanted to be somewhere, 'with a bit of life.' We saw this person sitting in a quiet area of the lounge, but with other people. This helped to demonstrate people were involved in planning and developing their own support and care.
● All organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss.
● Whilst staff had not received any specific training on the accessible standards, there was guidance in care plans about people's communication needs. For example, one person was reluctant to talk and when they did it was very quiet. There was guidance for staff to listen to what the person had to say, this is what we observed.
● Staff told us how they supported people, who were less able, to read their letters or explain any information to them in a way they could understand.

Improving care quality in response to complaints or concerns:

● The provider had a complaints policy.
● There was a record of complaints that had been raised. Where people had raised concerns, these had been written by staff, using the person's own words. These were responded to and copies of the response was seen.
● Throughout the inspection people approached staff when they had any concerns and staff responded.
● There were comment cards at the front entrance which people, visitors and staff could complete to raise any concerns if they wished.

End of life care and support:

● As far as possible, people were supported to remain at the home until the end of their lives.
● Care plans showed that people's end of life wishes had been discussed with them. These were sensitively written, they were detailed and included information about people's feelings about dying. Some people became distressed, and there was information not to discuss further at this time.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection in February 2018 we asked the provider to take action to ensure people were able to engage in activities that they enjoyed and reflected their interests. At this inspection, we found improvements were still needed to ensure meaningful activities were available to each person and to the environment.

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care;

- The provider had overall responsibility for the home. He was supported by a care manager who had been given day to day charge of the home. The care manager was supported by senior care staff.
- The care manager was not working during the inspection and it soon became clear that there was a reliance on the care manager for guidance and oversight of what happened at the home as records, audit and analysis had not been completed in their absence.
- There was a handover at each shift change. Whilst staff were updated about changes to people's needs, or any changes at the home, this was not recorded. Staff told us if they had been off for a few days they would have to read each person's daily notes to catch up with any changes.
- The quality assurance system was not robust and did not identify all the shortfalls we found. Where improvements were identified there was no information about whether these had been made or not. These included a wide range of different areas: Environmental improvements were needed. Quality assurance checks had identified some areas where maintenance or re-decoration were needed. They did not identify all the areas we found. Where improvements were needed there was no information to show whether the work had been completed or when it would be done.
- There was no oversight to show what improvements to the environment had taken place during the past year, what was still required and when and how this would be addressed.
- It had not been identified through the auditing and monitoring process the shortfalls we found in relation to mental capacity assessments, best interest decisions or who could consent on a person's behalf. DoLS information had not been updated and therefore staff did not know who had a DoLS authorisation or if an application had been made.
- Shortfalls in relation to induction for staff from the sister home had not been identified. Staff from the sister home were unable to tell us where information about PRN medicines or emergency evacuation plans were kept.
- There was no overview of staff files and recruitment procedures. This would have helped to identify the shortfalls we found.

● Accidents and incidents that had been recorded did not show what actions had been taken to prevent a reoccurrence. There was no analysis and no overview of safeguarding referrals, incidents and accidents. Therefore, repeated incidents were not identified as a potential safeguarding. Senior care staff were unaware of actions or outcomes after incidents and safeguarding's had occurred.
● Risks for one person stated that staff should provide two to one care, but no rationale had been recorded to explain this decision. This meant new staff did not have all the relevant information provided to ensure care could always be provided safely.
● Environmental risk assessments had been completed. However, these had not taken into account the risks associated with passive smoking or the impact the lack of maintenance may have on people's health and well-being.
● A recent five year electrical safety check had been completed. The provider told us that work was required to ensure standards were met but was unable to provide us with details of this the work needed, or when this would be completed by.
● After the inspection we spoke with the care manager by telephone. She had a good oversight of the home, people and staff. She was able to tell us about incidents and safeguarding's and how these would be managed. However, there had been no analysis or records that made this information available to all staff.
● There was no overview of complaints that had been received. This meant themes and trends across individuals and the home were not identified
● After the last inspection we asked the local authority Market Support team to contact the provider to help them make improvements we had identified. We were informed by the Market Support team that the provider had not responded to their invitations for discussion or support. This meant opportunities for learning, development and improvement had been missed.
● The use of technology can be used to improve and develop services. There was no Wi-Fi at the home and staff did not have immediate access to a computer. The provider and manager's office was on the top floor and staff needed to go there to use a computer or access the internet. Staff told us this meant they could not immediately access information when they needed it, or to make, for example, safeguarding referrals or send CQC notifications.
● Areas for improvement identified at the previous inspection had not been addressed There were a range of policies in place. However, the safeguarding policy had not been updated to reflect the new categories of abuse domestic violence, modern slavery, discriminatory and self-neglect as defined by The Care Act 2014.
● Although the provider, as far as possible, kept staff up to date about what was happening at the home the lack of records meant not all staff received the same or consistent message. There was an over reliance on the care manager to have oversight of the home. Although her knowledge was good this information was not available for staff as it had not always been recorded.

These issues are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The rating of the previous inspection was not displayed at the home. The provider told us he was not aware this was a requirement. This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the provider told us they had printed copies of the last report and they gave them to people and visitors. They also gave a copy to anyone who wished to move into the home.
●The provider told us he would rectify this and we will follow it up at the next inspection.

● Following the previous inspection, the domestic staff had developed their own checklist to ensure the home was clean. These provided a good overview of what had been done. It showed where people had declined to have their rooms cleaned, but comments were added to show that staff had seen the bedroom

and that it was clean. There was also a monthly report that domestic staff completed to show when and which bedrooms had been deep-cleaned.
● Since the sister home, run by the provider, had closed, the care manager from that home was also working at Ennis House. They told us their role was to support the care manager. However, at the time of the inspection there had not been enough time for this role to be formally established. Staff were clearly committed to working together as a team to improve and develop the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Areas for improvement identified at the previous inspection had not been addressed. There had been no formal feedback from people, relatives, visiting professionals or staff. We were told people did not participate in formal feedback. For example, resident's meetings had stopped because people did not attend. The provider said in the PIR that people had been encouraged to have input into their care and the environment through one to one discussions with staff. However, there was no record of these conversations or evidence of how people's feedback had been used to improve and develop the home.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

● People told us they were comfortable with staff and could discuss anything with them. This was evident throughout the inspection.
● There was a positive culture at the home. Staff spoke highly of the provider and their colleagues. They told us they felt supported by the provider and could discuss any concerns with him or the care manager.
● There was an emphasis by the provider and all staff that Ennis House was people's home and that anything that happened must be for the benefit of people.
● The provider, care manager and all staff were committed to ensuring people were well supported and able to live the lives they chose.

Working in partnership with others:

●The provider and staff worked in partnership with other services, for example GP's, social workers and mental health teams to ensure people's needs were met in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received support that met their needs and reflected their preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the service was working the service was working within the principles of the Mental Capacity Act (2005)

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 ensured systems were in place to protect people from the risk of infection. 12(1)(2)(h)

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 systems were in place to protect people from the risk of abuse. 13(1)(2)(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the home was properly maintained. 15(1)(b)(e)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

Warning notice.