Salutem LD BidCo IV Limited

Roman House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Roman House is a residential home to support people living with a learning disability and with a physical disability or sensory loss. The home supports up to 26 people between a main residential building and two bungalows on the same site.

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 outcomes for people using the service did not fully reflect the principles and values of Registering the Right Support. People did not always have meaningful activities and were not always supported to develop their life skills to promote their independence. People were not always treated with respect by staff.

The service was larger than current guidance and the building did not meet people's needs. The shared living space was noisy and some people with a sensitivity to noise did not want to use it.
Not all areas of the service were easily accessible to people without support, such as entering through the front door, getting into the garden or kitchen.

People were not safe from the risk of fire. Actions from a fire risk assessment had not been completed within indicated timeframes.

The provider had identified that work was required to meet all expected standards and regulations, however audits and quality checks in place had not identified all issues identified on our inspection.

Rating at last inspection:
This is the first inspection of this service since it registered with a new provider on 30 April 2018.

Why we inspected:
This was a routine scheduled inspection of the service after their registration with the Care Quality Commission.

Enforcement:
You can see actions we told the provider to take at the end of this report.

Follow up:
We follow up on actions required by the service. We will re-inspect the service within the published timeframe for services rated requires improvement. We will also continue to monitor the service through the information we receive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Roman 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 carried out by one inspector, an assistant inspector and an 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.

Service and service type:
Roman House is a residential service registered to support people living with a learning disability and with physical disability or sensory loss.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 26 people. At the time of the inspection there were 17 people receiving support.

Accommodation was spread between a main building which could accommodate up to 18 people, and two four-bedroom bungalows. This is larger than current best practice guidance and the size and design of the service was having a negative impact on people's independence and quality of life. The service was clearly identifiable as a care home and did not fit with nearby residences.

Notice of inspection:
The inspection was unannounced. Inspection site visit activity took place on 13 and 14 March 2019

What we did:
Before the inspection we looked at information we had about the service. We reviewed the Provider information return – key information about their service, what they do well, and improvements they plan to make. We looked at notifications we received from the service – the law requires providers to notify us of

certain events that happen during the running of a service. We checked the provider's website.

During the inspection we spoke with 10 people who used the service, the area manager, the interim quality improvement manager, and seven members of staff.

We looked at three people's care records, activity plans and meal plans. We looked at staff records, including training records. We looked at records of accidents, incidents and complaints.

We looked at audits, quality assurance reports and other records, including policies and procedures. We reviewed the home's facilities and made observations in communal areas of the home of how staff supported people.

We reviewed the provider's service improvement plan and discussed what the key priorities were for improvement.

After the inspection the service sent us additional evidence and documentation to review.

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 may or may not have been met.

Assessing risk, safety monitoring and management

- People's risks were not always assessed and there were not always detailed support plans to keep them safe.
- The main residential building was not safe from the risk of fire.
- On 26 January 2019 a fire risk assessment was completed, which Identified a number of actions necessary to ensure the home was safe. Some of the actions identified had not been completed. The actions required had not been incorporated into the maintenance or improvement plans.
- For example, one action related to gaps surrounding fire doors to the boiler room in the main corridor which would not prevent the spread of smoke into the main residential corridor and main evacuation route for residents in the main building. The area manager acknowledged this work had not been completed.
- Automatic fire detectors had not been upgraded. The fire risk assessment identified that these were more than 10 years old and so would be less reliable. The risk assessment noted "it is of concern that this has not been noted on the service provider's worksheet" and the priority was "as outlined in previous report".
- The provider did not always follow national guidance in respect of risks relating to bedrails. Some people used bed rails due to their risk of falling from bed or based on their preference. Risk assessments were in place which considered how well the bed rails were maintained and reviewed risk areas, such as gaps between the mattress and the bed rails, or the gap between the bed rails and the headboard due to the risk of entrapment and serious injury.
- However, the risk assessment did not take into account one person was epileptic. National guidance recommends bed rails are not used for people living with epilepsy. Alternatives to bed rails, or equipment to mitigate risks, such as lower bed frames, mesh rail guards or crash mats were not considered.
- One person was living with diabetes. Their care plan did not identify signs of low blood glucose levels and actions staff could take in this event.
- One person, who was living with epilepsy, had a bathing support plan which identified that they should not be left alone in the bath. The support plan did not advise staff what to do if they had a seizure in the bath. This was updated and sent to us after the inspection.
- This person also had a seizure chart which was to be completed with the length and frequency of seizures. This had not been completed since February 2018, staff confirmed they had had seizures after this date.

Risks to people's safety were not always managed appropriately or acted upon. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● The service was not always clean.
● We observed equipment and the carpet were dirty and smelt of faeces. This was not cleaned later in the day when inspectors reviewed the same areas. We raised this with the interim management team who took action to ensure the carpet was cleaned.
● The garden and areas by the refuse bin storage were littered with cigarette butts. We confirmed with the Area Manager that this was waste from staff smoking, rather than people living in the home. The Area Manager agreed to ensure a smoking policy was circulated to all staff.
● Infection control audits identified that there was a cleaning schedule and checklist in place but that this was not consistently completed by staff.
● The service was due to recruit a cleaner in April 2019 to support staff with maintaining the cleanliness of the home.
● Personal protective equipment was available to staff and was used. We observed staff using good infection control practices during medicines administration and when supporting people with meals.
● The 'bungalows' were clean and well maintained on the day of our inspection, however one person told us, "The bungalow is [often] quite dirty and needs more cleaning." They added, "'The bathroom and toilet and the floors. It's only cleaned once a week and needs doing two or three times more."
● The kitchen was clean and tidy. The home had achieved a five out of five food hygiene rating from the food standards agency in December 2016.

The service was not always clean. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● There was a safeguarding policy and procedure in place which was available to staff.
● There was a safeguarding lead in place who was very knowledgeable.
● Training was provided to staff in the principles of safeguarding.
● There was evidence that concerns were reported and were being investigated.

Staffing and recruitment
● During our inspection there were enough staff deployed to keep people safe.
● The service had a high number of staff vacancies, but were actively recruiting.
● The service used a high number and proportion of agency staff to cover staff vacancies and absences. Regular agency staff were used wherever possible to ensure people's needs were met.
● Some people told us the agency staff changed often and sometimes had to explain their needs to staff. One person told us, "There's so many agency staff, It's different every day."
● Staff pre-employment checks were carried out, such as obtaining references of their conduct in previous employment, however; prospective staff had gaps in their employment history which were not always explored and explained.

Using medicines safely
● People received medicines in a safe way.
● Staff were trained and had their competencies assessed before they could administer medicines.
● Staff administered medicines in pairs and undertook checks beyond the minimum requirements before administering medicines.
● People had medicines support plans in place which detailed which medicines they were on and what they were for.
● Any 'as needed (PRN)' medicines were detailed in protocols which described how and when they could be

used, maximum doses and when to escalate to the GP, if temporary symptoms persist.
● Medicines audits were undertaken, and stocks were checked regularly to quickly identify if any errors had occurred. Any issues were reported and investigated.

Learning lessons when things go wrong
● There was evidence of incidents being reported by staff.
● There was evidence that incidents had been investigated and actions had been identified to reduce the likelihood of re-occurrence.
● There was some analysis of incidents relating to people's behaviours, however this was new and was not fully embedded yet. Some incident reports had not been fully completed and so did not support identification of causes and triggers. The area manager told us they were working with staff to improve recording of these incidents.
● Managers encouraged an open approach to reporting incidents and issues. There was evidence of lessons learnt being shared with staff.

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 may or may not have been met.

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

- The arrangement of the service was not in line with guidance for 'Registering the Right Support' (RRS). The principles of RRS are that people living with a learning disability should live the life of any other citizen. Homes should provide accommodation for a smaller number of people, usually around eight people or less. Homes should also fit with the local community, not stand out as a 'care home' and should allow people to be part of their community.
- The home did not appear as a residence in line with nearby houses.
- The main building accommodated up to 18 people, 11 people were living in the main building at the time of the inspection.
- Rooms were arranged along one corridor on a single level and people shared one living and dining room space, which was very noisy during our inspection.
- One person told us, "The noise can be terrible, so I go to my room and shut the door."
- The service had enabled some people living in the home to use a second bedroom as a private living room, though this was not possible for everyone.
- We encountered areas of the home where people in wheelchairs often blocked each other's way and they had to wait for others to move.
- Many of the bathrooms were not adapted to be used independently due to a lack of handrails and space to turn wheelchairs. People could not easily move into some areas of the home independently, such as the kitchen or garden as the doors required someone to push and hold them open.
- The buildings were being redecorated and updated, though there were still many areas which were worn, damaged or outdated.
- There was limited signage or labelling of rooms so that these were easily identifiable in an easy to read way.
- The area manager told us the renovation of the premises was a priority and they had a works schedule they were working through. They also told us they were liaising with the Local Authority to look at options for the longer term future of the service to meet people's needs.
- People's rooms were personalised with their belongings and painted in colours they had chosen.
- One person told us, "Look, I don't have any curtains and that's what I'd really like."
- The area manager told us they were in the process of re-decorating all of the rooms and asking people what they would like.
- There were two purpose built bungalows on the same site.
- Each of the two bungalows accommodated up to four people, with four people living in one and two in the other at the time of our inspection.

● The bungalows were built to meet people's physical needs and were fully wheelchair accessible, including the kitchens. However, equipment and bins had been placed on top and under lowered worktops which would have prevented wheelchair users from using these spaces.

The service was not suitable for the purpose for which it was being used and did not take account of national best practice. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices had been assessed and care plans were detailed and personalised.
● Best practice guidance was followed in creating behaviour support plans for people, these outlined people's triggers and how staff should support people in the least restrictive way possible.
● We saw some staff supporting people with positive responses to their emotional needs and expressed behaviours.
● Not all risk assessments to identify people's needs met good practice and national guidance.
● Not all regulatory requirements and guidelines had been met in the delivery of care with regards promoting people's independence and making reasonable adjustments to the premises to meet people's needs.

Staff support: induction, training, skills and experience
● Staff had inductions into the service when they started.
● There was evidence that staff employed by the service had regular support and supervision to develop their skills and knowledge.
● Staff told us they had had basic training, such as safeguarding people, health and safety, fire and infection control.
● The area manager told us they were rolling out further training for staff to develop their skills to enable them to better support people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People's eating and drinking needs and preferences were assessed and people were supported to eat and drink enough.
● Where people had risks of malnutrition, dehydration or choking their support plans highlighted how these risks could be reduced.
● People could have meals when and where they wanted them. Kitchen staff were aware of people's needs and preferences and catered for these.
● Some people told us the quality of the food was not always good.
● One person said, "I don't feel I have much choice within the building. The food they buy is cheap; it's about saving money and the portions are small. The breakfast cereal is like chewing cardboard and tastes of nothing. I have to eat bread and butter to fill me out."
● One person told us they like fish and chips. We asked if they made a good fish and chips, the person told us "its ok, if it's not good I don't eat it".

Staff working with other agencies to provide consistent, effective, timely care
● People had 'hospital passports' which gave an outline of their needs and preferences, including for communication, should they need to go to hospital.
● Some people had been supported to explore their options for the future as they did not need the level of support provided in a residential care setting, and could have more independence in a supported living setting – in their own home.

● Some people told us they did not know what their options were and had not had their options for the future explored with them, such as moving to a supported living setting, or having a personal budget and being supported to manage it.
● The provider explained they were going through a process of supporting each person to create a future plan.

Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare services that they needed, such as opticians, GPs and dentists.
● People's physical health needs were identified in their support plans to enable staff to identify where people were at higher risk, and what other services were involved in people's care.

Ensuring consent to care and treatment in line with law and guidance
● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
● People's capacity to consent to their care had been assessed.
● On the inspection we identified that capacity assessments had been undertaken for most decisions, except for the use of bed rails for people.
● Capacity assessments and discussions of best interest decisions were completed following the inspection and sent to us regarding the decision to use bed rails. However, these capacity assessments and best interest discussions focussed on the risks of not using bed rails, rather than the risk that using them posed to people becoming entrapped, resulting in serious injury. This did not ensure people were making informed choices, or that decisions made were in people's best interests considering all of the risks.
● 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 Mental Capacity Act application procedures called the Deprivation of Liberty Safeguards (DoLS). We found the service was working within the principles of the Mental Capacity Act. Any restrictions on people's liberty had been authorised and any conditions on authorisations were being met.

Requires Improvement

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

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always treated with respect.
- Although some staff were respectful and spoke with people as equals and were compassionate, this was not the case for all staff.
- We observed two members of staff referring to one person as a "good boy" or "good little boy". The person was an adult and referring to them in this way was not respecting them as an equal.
- Another member of staff spoke about someone, referring to the way they treated staff, in front of them.
- One person told us they did not always feel valued, they said, "I'm not sure if I matter, I think I might do to one or two people, but I don't know."

Supporting people to express their views and be involved in making decisions about their care
- People had a range of communication needs, which were outlined in their support plans and hospital passports.
- Not all staff were fluent in the use of communication methods and aids, for example some people used Makaton to communicate. Makaton is a system of communication using gestures, signs and spoken words. Not all staff knew Makaton and we did not see this in regular use with these people.
- One person came to get the attention of the inspectors twice as they could not work their TV and staff did not appear to pick up on the person's communication.
- Information was frequently produced in an easy to read way, so it was more accessible to people.
- Staff worked with people to gain their views on their support plans and on the care being provided on a regular basis.
- Families and others who were important to people were involved in decision making about their care, where appropriate.
- Three of the people we spoke with told us they knew they had care and support plans and had been involved in saying what their needs were.
- One person said, "'Staff help me write [my care plan]. Sometimes it gets changed or things get added."
- Another person told us that they felt comfortable talking to some staff, but not others, due to their personal history.

Respecting and promoting people's privacy, dignity and independence
- People's privacy was respected by staff.
- Staff respected people's personal space and knocked before entering their bedrooms.
- One person told us, "'Staff help me to shower and they do my washing. It's done nicely.'

● One person had visual impairment, staff used "hand over hand" support to help them wash.
● Some people had independent advocates to support them in making choices.
● People's independence was not always promoted through the design of the service, empowering people with information about their options or with development of their life skills.

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People did not always receive personalised care which reflected their interests and preferences. People did not always have maximum choice and control of their lives.
● Some people had regular activities that they enjoyed and were able to go out into the community. Some people did not have regular activities evidenced in their daily records, some days their activity records were not completed or documented no activities for several days.
● Some people told us they were bored and were observed moving round the home without purpose.
● One person told us, "The transport is broken. I don't know if we are getting new ones. Staff are always at meetings and it's hard to do anything."
● One person said, "I have a care plan, but I'd like more choice as I don't do much."
● Some people told us that the number of agency staff affected how the care met their needs.
One person told us, "There's no consistency of staff. I go to town on the bus but there's not much to do."
● Another person said, "'Every day nearly I have to say what my needs are."
● Another person told us, "I don't get the same staff to get me up. It's frustrating and tiring."
● One person said, "I went to a show some years ago. I'd like to go to another one."
● Some people fed back more positively about their choices and activities.
● When telling us what choices people could make one person told us, "I can decide what I want to wear. Staff paint my nails."
● Another person said, "I go out every day. I always find something to do."
● Staff supported people to keep in touch with their families. One person told us, "'Staff help me to write letters.'
● People's care plans were reflective of their physical, religious, health and social needs and included their preferences and goals.
● The service improvement manager told us they were working to look at what activities people had tried before, what they liked about it or didn't like and what they would like to try. This had been completed for some people.

End of life care and support:
● People did not always have their wishes around end of life care and care after death recorded.
● There was no-one in receipt of end of life care at the time of our visit and the service would not routinely provide end of life support, though they would support people living in the home should they wish to stay in the home for the end of their life.
● It is good practice for services to explore people's wishes around the end of their life and their wishes after death and enable them to express their preferences.
● A number of people living in the home were older adults. People's wishes had not always been discussed

or recorded around end of life.
● One person said, "I'm worried because I started to work with a staff member and then it stopped because she didn't have the time. I know what I want and it's about buying a plot of land (for a burial). I've been told [how much it will cost] and I don't have the money. I want to be buried. I can't find out if there's another way, but I don't have anyone who has time to help me. There's so many agency staff so it's different every day."
● The quality improvement manager told us this was an area they were working on and were researching training to support staff to have sensitive conversations. Following the inspection, the service sent two advanced decision plans which would identify people's wishes – however these were largely blank, awaiting input from people's families.

People did not always have access to meaningful activity and people were not always supported to develop life skills to meet their needs and ambitions. People's wishes around their end of life care were not always explored and reflected in their support plans. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The service had a complaints policy and procedure which were appropriate.
● The complaints policy was available to people in an easy to read format.
● One person told us, "Staff listen and I can go to the office to ask if I'm worried about anything. They're good like that."
● We saw the service was putting up a "you said, we did" display with responses to feedback from people. Other feedback from people had been identified in the service improvement plan for the future.
● One person told us, "It's easy to complain or if I have a problem but often I don't feel there is any result.'
● Another person said "I know I can go to the Office but sometimes it's difficult to complain, especially if it's about the staff.

Requires Improvement

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality assurance measures in place were not sufficient to meet regulatory requirements and keep people safe.
- The service had implemented "management service checks" daily, however some days were blank and it was unclear when an issue was identified, how the action was followed up or what the timeframe for completion was.
- The service had an extensive action plan for improvement for the service and some progress had been made against these actions. This was reviewed weekly by the provider with senior managers.
- Further work was required to meet all regulatory requirements and national guidelines. Not all required actions had been clearly identified on the action plan to ensure people were safe.
- Information was not always readily available for inspectors, sometimes this was difficult to find or in some cases could not be located.
- Audits and quality checks in place were not sufficient and had not identified all of the issues highlighted in this report in order for the provider to take appropriate and timely action.
- The interim quality manager told us they had "a lot of support here" and a "massive level of support from the quality team". They felt the senior managers wanted to "get it right".

Audits and quality checks were not operated effectively and had not identified issues highlighted on this inspection; clear actions were not always in place. This is a 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

- Managers took an open approach to reporting and investigating where things had gone wrong and were open with inspectors about the improvements needed in care.
- Families were informed when things went wrong and the provider's duty of candour responsibilities were met.
- Management support had recently been put in place due to the absence of the Registered Manager. There was also support from the Area Manager, though they covered a large geographical area of services for the provider which limited the time spent at the service.
- The future plans for the service were not yet clear and so there was no clear vision or ambition for the service, though the area manager told us they wanted to ensure people were in the most appropriate setting

for them to promote their independence and freedom.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics and Continuous learning and improving care

- The service had regular meetings with the people living in the service to gain their views.
- One person told us, "I go to Customer Meetings but they're boring so I don't go much now."
- The area manager told us that people's families were involved where possible, but they largely lived some distance away and so were not all able to come to the service often.
- The managers acknowledged that there was a lot of ongoing improvement work to do to the service and had identified some key priorities.
- There was a schedule of decorative improvement works to be undertaken.

Working in partnership with others

- The service was working with other agencies and the local authority to ensure people had access to opportunities.
- There were some links into the local community through services people accessed, such as those provided by the voluntary sector, however this could be further developed to ensure all people living in the home had opportunities and felt part of their local community.

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 People did not always have maximum choice and control of their lives. There were not always meaningful activities for people based on their interests and preferences. People were not always given information and options for their future and relating to their wishes at the end of their life.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always kept safe from the risk of fire. Identified actions from a fire risk assessment had not been completed. People's risks had not always been fully assessed and there were not always support plans with appropriate mitigating actions.

The enforcement action we took:

We have issues the service with a warning notice