Ms Catherine Sleightholm

Rainbow Lodge

Inspection report

15 Trinity Road
Scarborough
North Yorkshire
YO11 2TD

Tel: 01723375255

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Rainbow Lodge is a residential 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service supports people with a learning disability or autistic spectrum disorder and can accommodate a maximum of four people. At the time of inspection, there were three people living in one adapted building. The service is run as a family home, with people living at the service as part of an extended family unit. Care is provided primarily by the provider. The provider's family assist with the running of the service.

The inspection took place on 27 June 2018 and was announced. We gave 48 hours' notice of the inspection visit because it is small service and we needed to be sure people would be in. At the last inspection, there were breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not thoroughly assessed, monitored and mitigated risks to the safety of people who used the service. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the safe and well-led domains to at least good. At this inspection, some improvements had been made to assess environmental risks and complete some training. However, the provider had not taken sufficient action to resolve the two breaches or improve their rating.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The provider is an individual 'registered person'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not know what two medicines were prescribed for. This meant they did not know what effects the medicines should have and would not have known any side effects they may cause. Where people had medicine that was being regularly reviewed and gradually increased by a health professional these changes were not recorded on the medication administration records, to show the dose taken or evidence the medication was being given as prescribed. When people were assisted to manage specific health conditions, there was no care plan in place to identify how to support the person if their health needs changed. The provider did not document checks to make sure medicines were stored at a safe temperature.

There had been a delay of at least one year in DBS checks relevant to Rainbow Lodge being requested to help reduce the risk of unsuitable people working with vulnerable adults.

Where people had needs or made choices that could put them at risk, these were not formally assessed. This meant we could not be certain the provider had considered these risks or knew what course of action to take if concerns occurred.

Staff had completed some training, but had not covered important areas such as the Mental Capacity Act 2005 to inform their knowledge and understanding of how to support those living at the service to make decisions for themselves. When training had been done, the provider did not have a policy for when this should be renewed.

People's backgrounds and needs were understood in detail. Care files did not always contain information the provider knew about people and were not always up-to-date.

The provider did not have current policies and procedures in place. Policies did not always reflect practices that were happening at the service.

The provider did not use a formal audit system, which meant we could not see that a full range of checks had been made across the service to identify where actions and improvements were needed.

The provider had informal systems for staff communications and people and relatives raising any concerns or complaints. Records did not evidence that people were consulted and involved in the running of the service.

There were breaches of regulation relating to safe care and treatment and the governance of the service. You can see what action we told the provider to take at the back of the full version of this report.

People were happy and relaxed at the service. They could access indoor and outdoor spaces at the home and had privacy when they wanted it.

Relatives told us they felt their family members were safe. The provider was aware of any accidents and incidents which had occurred in the home and had taken immediate action when accidents had occurred.

People and relatives spoke enthusiastically about the food offered at the service. People were given varied meals and had access to drinks and snacks throughout the day.

When people needed to see a doctor this was arranged promptly.

People received emotional support when they needed it, including if they were anxious or upset about past events. The provider understood the relationships that mattered to people and supported them to maintain these. People participated in activities which reflected their interests.

People's communication needs were understood, but the provider was not familiar with accessible information guidance. We made a recommendation about this.

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.

The provider had a limited understanding of how to manage and administer medicines safely.

Care plans were not in place to support people with specific health conditions.

Specific risks to people were not formally assessed.

There had been a delay in DBS checks relevant to the service being requested.

The provider was aware of accidents and incidents in the home and addressed these promptly.

Is the service effective?

Requires Improvement

The service was not always effective.

Training in key areas had not been completed.

People enjoyed varied, balanced meals, which reflected their preferences.

People were supported to see the doctor when they needed to.

Indoor and outdoor spaces at the home were accessible.

Is the service caring?

Good

The service was caring.

The provider understood and supported people's emotional needs.

People were treated with dignity and respect including when being prompted with personal care tasks.

The provider understood people's communication needs and supported them to express their wishes and views.

People were encouraged to be independent and contribute towards the household.

Is the service responsive?

Good

The service was responsive.

The provider had a detailed knowledge of the people living at the service.

The provider adapted care delivery when people's care and support needs changed.

People were supported to maintain relationships with those that were important to them.

People accessed activities of their choice.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have policies and procedures in place that were relevant to the service.

No formal audits had been used to show checks carried out across the service.

People and their relatives were not consulted and involved in the running of the service.

Rainbow Lodge

Detailed findings

Background to this inspection

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

The inspection took place on 27 June 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the provider is often out of the office providing care. We needed to be sure that they would be in.

The inspection team consisted of one inspector and one inspection manager. Before the inspection we reviewed information we had about the service including the action plan from the last inspection, the provider information return (PIR) and contacted local authority commissioners. The PIR is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two people that use the service, two people's relatives, the provider and a support worker. We spoke with one professional that had experience of working with the service.

We looked at three people's care files and medication records. We looked at staff training records and maintenance checks completed. We had a tour of the service, including looking in people's bedrooms with their prior permission. We observed the meal time experiences of those living at the service and spent time observing their interactions with the provider and support worker.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, there was a breach of regulation relating to safe care and treatment. This was because the provider had not thoroughly assessed risks and done all that was reasonably practicable to minimise risks. We could not be sure steps had been taken to keep people safe at the service. At this inspection, the provider had made some improvements to safety. However, further improvements were required.

At the last inspection the provider did not have a policy and procedure about retaining training certificates and DBS checks. They had not checked whether DBS checks were transferrable or assessed the risks associated with those people working in the service. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands and help reduce the risk of unsuitable people working with vulnerable groups. At the time of the inspection the provider had consulted with another care provider, but had not completed any DBS checks relevant to Rainbow Lodge and was asked to submit these. Following the inspection the provider showed us evidence DBS checks had been requested. This meant that the provider was taking action to ensure the suitability of staff and any risks they may pose to those living at the service. However, there had been a delay of at least one year when staff had been working with people unchecked.

A medication policy had been put in place. However, this was not specific to the size and type of service. The provider told us the policy was not always followed. This meant we could not be certain which elements of the policy and practices were being observed by the provider to ensure the safe, effective and consistent use of medicines. Following the inspection, the support worker informed us the medication policy was being reviewed and would be bespoke to the service.

At our last inspection, the provider had not actively monitored the temperature at which medication was stored. At this inspection, there was no thermometer available to check the temperature of medicine storage. This meant we could still not be sure medicines had been stored within a safe temperature range.

The provider and support worker had completed medication training. However, the provider had a limited understanding of medicines. The provider did not know what two medicines were prescribed for and struggled to find this information. There was no medicine care plan in place for the person or reference to one of the medicines in the person's care plan. This meant the provider did not know how to ensure the medicine was given correctly, what effects it could and should have and was not monitoring the effectiveness of the treatment. When we spoke to the person they told us they were experiencing discomfort and wanted to look at their medicine being changed. Had this information not come to light during inspection, the provider would have continued to administer the medicine, unaware of its intended use or impact on the person.

Where a person had medicine that was being regularly reviewed and gradually increased by a heath professional these changes were not recorded on the medication administration records (MARs) to show the dose taken or evidence the medication was being given as prescribed. We could not be certain this medicine was being given appropriately.

People's care files did not contain current and relevant details about them and their support needs. One person's care plan had no detail of their mental health history, which was important to understanding the person's background and current support needs. When there were changes in people's needs, such as their health conditions, care plans had not been updated to reflect the level of support required. One person had fallen, but did not have a mobility care plan in place to consider any changes in their mobility needs or support arrangements.

When people were assisted to manage specific health conditions, there was no medication or health condition care plan in place to identify the course of action staff should take if the person's health deteriorated. The provider described incidents where they had acted to support the person to good effect. It was not clear if staff should attempt any other interventions and the timescales that were permitted for this. We could not be certain the provider was taking a consistent, safe approach to supporting the person with their medical condition and would seek medical attention for the person in a timely manner should this be needed.

The last inspection highlighted that the provider had not thoroughly assessed risks to people. During this inspection, some people living at the service had specific risks associated with their needs and choices. One person chose to regularly access the community independently when they wished and enjoyed forming friendships in the local area. The provider described the person receiving items in the post from several people not known to them. The provider had not formally assessed any risks associated with the person going out or being befriended. There was no risk management plan in place to show how any issues would be responded to.

Failing to ensure the proper and safe management of medicines and assess and mitigate risks to people's safety was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they felt the service was safe. One person was aware staff were arranging for new seating for them to help keep them safe. They said, "I'm getting two new chairs, one up here [their bedroom] and one downstairs." This showed people were involved in managing risks. Relatives told us they felt their family members were safe. One relative described the home as, "Very safe and secure; it's ideal." Relatives felt people were given their medication safely. One relative said, "They are given their medication on time."

At the 2017 inspection the provider did not have a robust understanding of their safeguarding responsibilities. A safeguarding policy and procedure was now in place. The policy included information on different types of abuse and indicators. The provider had completed safeguarding training to help them understand their responsibilities. The support worker confirmed no safeguarding concerns had been raised by the service.

Previously the provider had not explored risks associated with the home environment. At this inspection several improvements had been made. Window opening restrictors had been fitted throughout the home to avoid any risks associated with people falling from heights. A gas safety certificate showed gas appliances had been assessed as safe to use. Monthly checks had been completed to test the temperature of the hot water and radiators throughout the home. Where radiator surface temperatures were too high, action had been taken to resolve this. The risk of legionella had been assessed and the hot water system had been flushed monthly to reduce the risk of this.

A contingency checklist was in place. This identified how staff would respond to different emergency

situations, such as gas supply failure. The contact details for relevant utility suppliers and maintenance workers were included.

Fire safety equipment such as fire alarms, extinguishers and emergency lighting were maintained and tested regularly. A fire evacuation plan was on display. Fire drills were undertaken every six months at different times of day to prepare staff and people who used the service for how to respond in the event of fire.

The service had suitable numbers of staff to support people to stay safe and meet their needs. The provider was always available to assist when needed. A support worker provided additional support. Other ancillary members of staff assisted with maintaining the home.

An environmental services visit had been completed. The provider had acted on recommendations made in their report, including action to avoid any food contamination risks.

The small nature of the service and the level of involvement from the provider meant they were able to respond to any safety issues arising and be attentive to people's needs. The provider was aware of any accidents and incidents occurring in the home. Where people had fallen, the provider had checked the environment immediately to identify any potential causes for concern.

Requires Improvement

Is the service effective?

Our findings

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 MCA 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation process for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principals of the MCA and found no one living at the service required a DoLS. The last inspection identified the provider had not completed MCA and DoLS training. The training would help ensure they were aware of the principals of the MCA and how to support people living at the service if they became unable to make decisions for themselves. The provider had enrolled on an e-learning course, but had not completed this and would not know how to assess capacity or support people to make decisions should their capacity fluctuate, for example, if they became unwell.

The provider had developed staff files containing details of the roles and responsibilities of each member of staff. At the last inspection the provider had not completed training. Knowledge and learning was shared informally amongst staff from those who had completed courses within other job roles. At this inspection, some training had been completed in emergency first aid and health and safety. We identified that the provider was providing care to a person with diabetes but had not accessed specialist training. The training would have supported them to develop the knowledge, skills and confidence to deliver this care. This demonstrated training and development plans were not designed around the staff learning needs and the care and support needs of people who use the service. When training had been completed the provider did not have a policy on how frequently this should be renewed to ensure staff were up to date with current guidance. This showed the service did not have a consistent approach to supporting staff to maintain and develop their professional skills or knowledge of best practice. We have addressed these concerns in further detail in the well-led domain.

We observed meal time experiences at the service. People were given varied meals and enjoyed discussing their preferences for other meals. The provider did not follow set menus, but offered flexibility with meals, depending on people's wishes. Drinks and snacks were available for people throughout the day. We could see what people had eaten from their food diaries. A relative told us, "[The provider] feeds them well, they are a good cook." One person talked enthusiastically about their tea. They showed us their meal, which was accompanied by a large fresh mixed salad. The person proudly told us how much they had eaten and how they were now willing to try new food options. This was significant to this person as previously they had not enjoyed food and were being supported to gain weight following weight loss. The way in which they spoke about food showed they had developed a more positive approach towards meals and their enjoyment of these.

When people needed their weight monitoring this was considered in the context of their wider health needs. People were supported to be weighed at the GP surgery and the provider identified if a response was needed following this.

The provider and support worker engaged in a constant dialogue and informal 'catch-ups. Both confirmed that they spoke together daily at a minimum when the support worker was at the service. Due to the small staff team and close working relationships staff supervisions were not required.

The provider had a good understanding of the roles of other agencies and when to involve them to improve people's care and support arrangements. One professional had worked alongside the service to suggest additional support and safety measures. They told us, "The provider said my suggestions would be looked at as part of their renovations. They gave appropriate reassurance and support to the person I visited." For another person the professional said, "The provider had a really nice relationship with [person's name], enabling them to be part of conversations without interrupting or taking over."

Hospital passports were in people's care files. This meant basic information about people would be shared should they need to go to hospital.

Relatives knew if their family members required medical appointments this would be arranged. One relative said, "[The provider] will always get the doctors if needed". Where people were at risks of developing infections their relatives knew this was monitored closely and doctors contacted in a timely way to prevent infection developing. The provider was aware of healthcare services in the local area and the roles of different healthcare professionals.

The service was run as a family home. The provider had pets, which was a source of enjoyment for the people who lived there. There were indoor and outdoor spaces, which people accessed as they wished. People spent time in private when they wanted to. Relatives felt the home environment was suitable for their family members. One relative told us, "[Person] is happy with their bedroom. The home is suitable and they can get where they want to there." This showed the home was accessible to those living in the service, enabling them to freely move around.

Good

Is the service caring?

Our findings

People who lived at the service had formed relationships with one another based on kindness, respect and compassion. One person said, "We are good mates, we all get on and I am always happy here. Yes, sometimes we fall out and get cross with each other, but it soon gets sorted out." This showed people recognised each other as individuals and when differences in opinion arose they were reconciled.

Staff were aware of people's emotional needs. The support worker described where a person had been asked by a professional to describe their history. Explaining their previous trauma had distressed the person, impacting on their mental health and emotional wellbeing. The person had received reassurance and support from staff who were aware this incident had a long-term impact on them. Staff and the person's family had made arrangements to prevent any similar incidents happening in the future and the person having to relive their past.

When people became anxious, the provider had taken time to understand the cause of the issue. One relative described how a person had presented with behaviour that could put them at risk. The provider found the person was being bullied when they were attending an activity. The relative said, "[The provider] went to the group and arranged for [person's name] to be in a different section."

The provider understood people's individual communication needs. They spoke with people in a way that ensured mutual understanding and used terms familiar to them. People were spoken to in a respectful and appropriate way. Where one person had hoarding tendencies, the provider knew how to approach this in a calm, sensitive manner to prevent the situation escalating and becoming a health and safety issue.

The provider was not familiar with the accessible information standard; the legal requirement to provide accessible information in a way people with a disability or sensory loss can understand. Written information on display in the service, such as the complaints procedure and safeguarding information was not accessible to all those living in the service. We recommended that the provider review current guidance on accessible information.

People within the house were encouraged to be independent. Each person had jobs they chose to do to contribute towards the household. One person went food shopping with the provider, selecting food options for people. The person enjoyed and valued their responsibilities. Another person helped with the washing up, enabling them to retain independent living skills and recognising that keeping their home environment clean and tidy was important to them.

The provider encouraged people to be independent with their care. When people had forgotten to do a personal care task the provider understood how to communicate this discreetly and effectively to them. One person responded to a subtle prompt, which reminded them of what they needed to do whilst respecting their privacy and dignity.

Good

Is the service responsive?

Our findings

Relatives told us when people's support needs changed the provider responded to this. One relative said, "They understand [name] needs more doing for them now. They wash their glasses." One person had left the service since the last inspection. The provider explained this was due to an increase in the person's needs and that the service was no-longer able to safely support them. This demonstrated that the provider made changes to the care provided when needed, but also had an awareness of when the service was no-longer appropriate for individual's needs.

The provider and support worker demonstrated an in-depth knowledge of all three people living at the service. They knew details such as where one person liked to eat their food in a particular order and the importance of this to the person. A professional confirmed this saying, "They had a good understanding of people's preferences, activities and risks." Relatives had confidence in the care being provided and told us people received the support they needed. One relative said, "[The provider] does their best to make sure [name] is fit, healthy and well-fed."

Care plans did not always reflect current needs and the knowledge the provider and support worker had. Record keeping issues are addressed in the well-led section of this report.

The provider had a clear understanding of the relationships that mattered to those living in the service and supported people to maintain those relationships. We saw one person had received a postcard from a relative. The support worker assisted the person to read the postcard. The person was delighted with this and spoke with pride about their postcard to staff and others living at the service. The provider arranged to support another person to keep in contact with their relative in a setting and for a length of time that suited them. This showed people were supported to maintain their relationships and have the level of contact they wanted.

One relative felt that the 'family run' set up of the service benefited their family member. They said, "It's homely. It's good for [person] seeing the family, it gives them social contact." This showed the service gave people the experience of living as a family. For this person their relative told us the family arrangement gave them social opportunities in a safe environment. Regular contact with the provider's family prevented the person from becoming socially isolated.

People were supported to participate in as many activities as they wished. One person chose to spend time in the home, but liked to go out to have their hair cut. Another person chose to volunteer at local charities. When one voluntary opportunity had ended the provider had worked with the person to find and trial another activity for them to attend. Their relative told us, "[The provider] makes suggestions. [Name] doesn't like to be indoors, they are out every day and kept very busy." The person had developed a wide social circle from their voluntary work and other interests. This showed the service was promoting the person's wellbeing.

A complaints procedure was displayed in the home, with complaint forms available next to this. The

provider used informal means of people being able to raise any concerns and complaints. People discussed their likes and dislikes when they were sat together at meal times. These served as an open forum for people to raise any issues. We observed people and the provider discussing a soup they had not enjoyed. The provider acknowledged and agreed with people's comments and reassured them it would not be purchased again.

The provider had received a number of 'thank you' cards. One person living at the service was fond of sending cards to the provider. They said, "I thank them when we go to the garden centre. I thank them when we go to different shops." This demonstrated the person could spend meaningful time with the provider and access parts of the local community they would have not been able to do independently.

Relatives felt the provider asked their views on any major decisions affecting their family members. However, they did not feel they were involved on a routine basis and understood the reasons for this. One relative said, "If there is anything troubling us we'd speak to the provider. I can speak openly." This showed that relatives respected the provider's knowledge, skills and experience in supporting people but felt able to raise any concerns if needed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in June 2017, the provider had not assessed, monitored and mitigated risks to the safety of people who used the service. This was a breach of regulation relating to good governance. At this inspection, improvements had been made in some areas, but other concerns had not been addressed. There were ongoing concerns about the governance of the service.

The provider did not have up-to-date policies and procedures in place. At the last inspection they had been asked to develop a policy and procedure around staff and risk assessing whether those who 'helped out' at the service required more robust recruitment checks. The provider and support worker had sought advice on DBS checks, but remained unclear about when these were needed and whether DBS' completed with previous employers were transferrable. Following the inspection the support worker showed new DBS checks had been requested for staff. However, there had been a delay of over a year since the last inspection in this information being requested, which showed the provider had not acted in a timely way to make necessary improvements.

There was no policy relating to staff training to identify what training different staff required for their respective roles. While the provider had completed medication and safeguarding training, they had not undertaken training in key areas for example, MCA. The provider did not have a policy in place about how frequently training should be updated. This showed the provider was not fully aware of their responsibilities to govern the service and was not leading the service in a way that ensured the consistent delivery of high quality care. The provider relied on the support worker to identify and facilitate access to training and other learning opportunities. Without the support worker's assistance training needs would not have been identified. This demonstrated that the service did not have a clear and accountable governance framework where responsibilities were clear and regulatory requirements understood and managed.

Where policies were in place, they were not always appropriate to the service and the provider's ways of working. For example, the medication policy did not reflect the practices in place for storing and administering medicines. This meant we could not be sure the provider was following best practice or what the evidence base was behind their approach.

The provider directly monitored the service, but did not have a formal system of audits in place. This meant there was no evidence of the full range of checks they had completed. Records were not up to date and there was no evidence any audits had been completed to identify and address these issues. For example, one person was receiving support to manage their weight loss, which was not detailed in their eating and drinking care plan.

There were no formal arrangements for documenting conversations with people living at the service, relatives and amongst staff. This meant it was difficult to see where they were engaged, consulted and involved in the running of the service. We could not tell where discussions had led to changes and improvements being made or considered.

Failing to have policies and procedures in place and to maintain complete and contemporaneous records for people living at the service was a continued breach of regulation 17 good governance under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is an individual, therefore there is no requirement for them to have a registered manager. The provider was very knowledgeable about the needs of the people living at the service and experienced at supporting them. They understood how to use their skills and adapt them according to the needs of each person.

The provider had a clear vision of operating as a 'family home'. There was an open culture, that was inclusive to all those living at the service. The provider was approachable and there was a constant dialogue between them and people to ensure their needs were catered for. People were respected as individuals and encouraged to lead independent lives and had a good quality of life.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risks to health and safety of service users and done all that is reasonably practicable to mitigate any such risks. They provider had not ensured the proper and safe management of medicines. (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to assess, monitor and improve the quality and safety of the service, mitigating any such risks. The provider did not maintain complete and contemporaneous records in respect of each service user. (1)(2)(a)(b)(c)