Care Quality Commission

Key inspection report

Care homes for adults (18-65 years)

Name:	Rosedene
Address:	128 Franche Road Kidderminster DY11 5BE

The quality rating for this care home is:	zero star poor service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	**Date:**							
Debra Lewis	1	7	0	7	2	0	0	9

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Adults (18-65 years) can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

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Information about the care home

Name of care home:	Rosedene
Address:	128 Franche Road Kidderminster DY11 5BE
Telephone number:	01562861917
Fax number:	
Email address:	
Provider web address:	

Name of registered provider(s):	Minster Pathways Limited
Name of registered manager (if applicable)	
Mrs Anita Homer Golden	
Type of registration:	care home
Number of places registered:	5

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
learning disability	5	0
mental disorder, excluding learning disability or dementia	5	0

Additional conditions:

The maximum number of service users to be accommodated is 5.

The registered person may provide the following category of service only: Care home only - Code PC, to service users of the following gender: either, whose primary care needs on admission to the home are within the following categories: Mental disorder, excluding learning disability or dementia - Code MD; Learning disability - Code LD.

Date of last inspection	0	4	0	2	2	0	0	9

Brief description of the care home

Rosedene is a care home providing personal care for up to 5 people, male and female, with a learning disability, a mental health need, or a combination of both needs. It is an ordinary house in a residential road in Kidderminster. Within the home there are ensuite bedrooms for 5 people, 2 with their own living area as well. There is a shared kitchen, dining area and living room. The house is no-smoking, but there is a covered area in the garden for some people who do smoke. There are facilities such as shops

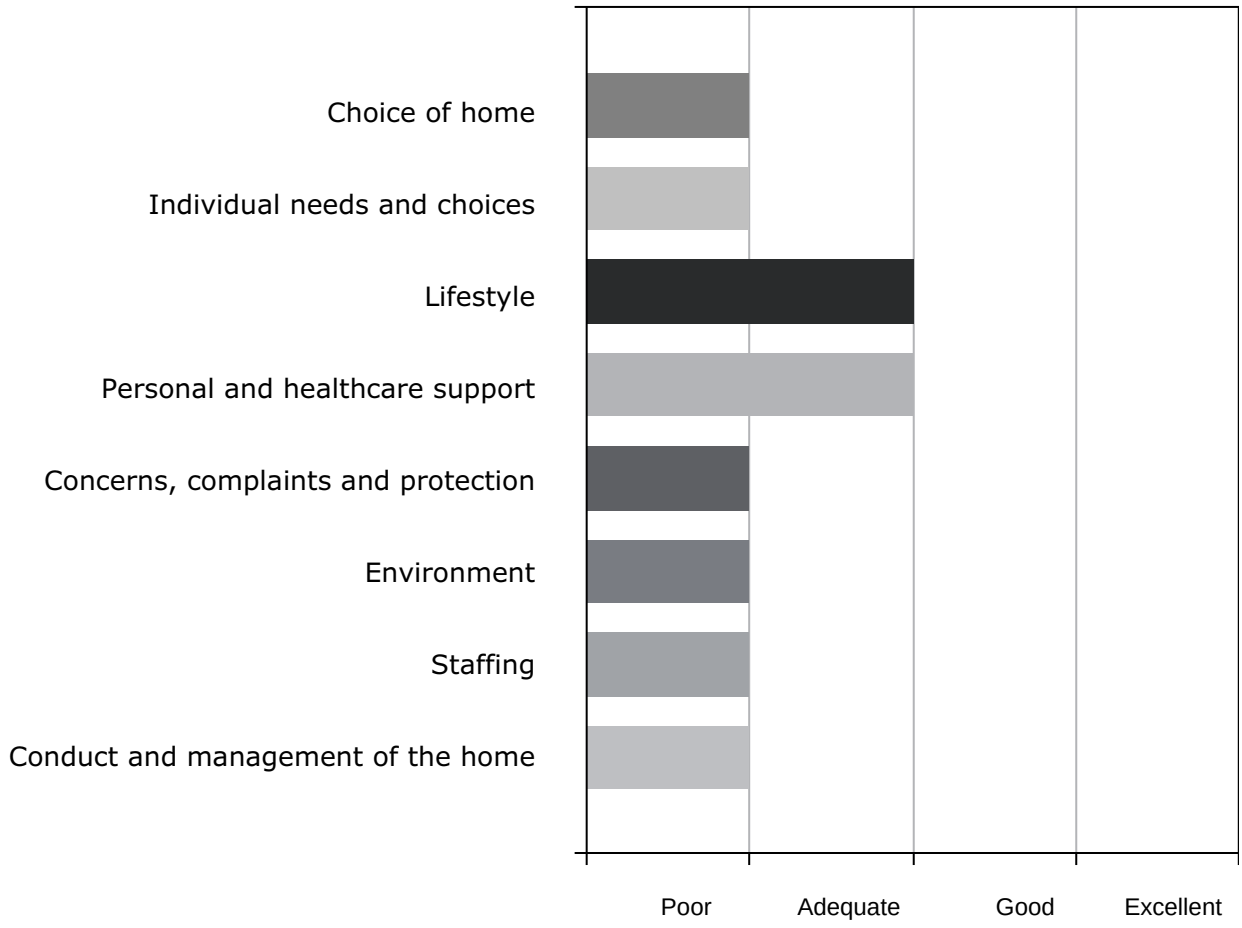
Brief description of the care home
and pubs nearby, and bus services into central Kidderminster. The home is owned by Minster Pathways Limited. The responsible individual for Minster Pathways Ltd is Mr Colin Farebrother. Ms Anita Homer-Golden has been the registered manager of the home since December 2008. Before this she was the acting manager for over a year.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	zero star poor service

Our judgement for each outcome:



How we did our inspection:

This was the home's third inspection in 2009. It was a Key Inspection. This means that we checked all of the standards that have most impact on people living in the home. This report includes findings from the visit to the home, as well as any relevant information that has been received about the home before this inspection. This includes details from a report on the home provided by the manager. The last Key Inspection of the home was in February 2009, when we found that the service was Poor. We then inspected the home again in June 2009 to check on what they had done to improve things. This was a Random Inspection. Some things were better, but some things were still as bad as they were in February. We have included some information from the June visit in this report. In July we were in the home over two days. 3 inspectors were at the home, including a pharmacist inspector. Staff did not know we were coming. The manager was not there as she was on sick leave. We met and talked with the 4 service users, with several staff on duty, with senior staff, and with an area manager from the company that runs the home. Surveys were distributed to the

people living in the home and 3 responses were received. Surveys were also sent to staff and 5 were returned. We received one survey from a professional who has contact with the people in the home.

Following this inspection, the Commission is considering whether to take legal action because the service has not made the changes necessary to provide a safe and reliable service to the people living there.

What the care home does well:

People living in the home like the food. They can usually go out when they want, and see friends and family.

People living in the home like the staff and can tell them if they don't like something.

The home is clean and well decorated. Each person can arrange their room as they want it.

What has improved since the last inspection?

The home has made improvements to how they look after medication for the people living there.

Staff have had some training since the last inspection.

What they could do better:

This service has not met its legal requirements in several areas, despite repeated requests for them to do so. This is leaving the people in the home at risk of poor practices and possible abuse. Following this inspection we have referred the service to our enforcement team to consider taking legal action if the service does not significantly improve.

The written information about the home is inaccurate, so people who may want to find out about living there don't know enough information to make a good choice.

The home does not keep good enough records of what support people need. This means people living in the home may not always get the care they need, in the way they want it. There is no particular emphasis on people being involved with choices and decisions about their lives.

The home still needs to make sure all staff know how best to protect people living in the home from being treated badly, or abused.

The manager still needs to make sure they keep a record of checks they have done on all staff who work there. This is to make sure proper checks are done before anyone works in the home, so it is less likely that an unsuitable person would get a job there.

Staff still need more training, to make sure they know how to look after people in any situation.

The company should be working to improve the home, using the information from surveys they have done. They should also make things better when problems are pointed out by other people, such as this Commission.

The company needs to make sure the manager gets the training and support she needs to be able to run the home well for people who live there.

If you want to know what action the person responsible for this care home is taking

following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk. You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line 0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them, what they hope for and want to achieve, and the support they need.
People can decide whether the care home can meet their support and accommodation needs. This is because they, and people close to them, can visit the home and get full, clear, accurate and up to date information. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between the person and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Information provided about the home is out of date and inaccurate and does not contain enough information to help people make an informed decision about living in the home.

Evidence:

The senior staff member told us that the home had no new service users and no new people referred to the service since the last inspection, so we did not look at pre-admission assessments of people's needs. However these have been obtained in the past.

Written information about the home was available in a Statement of Purpose, which should be an accurate description of the service provided. However we found it was inaccurate and out of date in several areas, such as the details of the manager, and did not include all required information, such as details of staff training. It therefore did not give a true description of the home and its services, for people who may live there or for their representatives.

Evidence:

Written information about the home was available for people who may wish to move into the home, in the form of a service users' guide. We found this lacked most basic information about the home which is required, so did not give a full picture of the home for people to consider. We recommended in February that this should be updated but the service has not done this.

Individual needs and choices

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's needs and goals are met. The home has a plan of care that the person, or someone close to them, has been involved in making. People are able to make decisions about their life, including their finances, with support if they need it. This is because the staff promote their rights and choices. People are supported to take risks to enable them to stay independent. This is because the staff have appropriate information on which to base decisions.

People are asked about, and are involved in, all aspects of life in the home. This is because the manager and staff offer them opportunities to participate in the day to day running of the home and enable them to influence key decisions. People are confident that the home handles information about them appropriately. This is because the home has clear policies and procedures that staff follow.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People living in the home can not be confident that their needs and wishes are known to all staff. This is because written information not regularly updated, and does not always include information about important aspects of people's care needs.

Sometimes staff limit people's choices without any evidence of attempts to ascertain their wishes. People living in the home have little opportunity for their views and opinions to be recognised or taken into account. Staff do not necessarily choose the least restrictive approach to reducing risks to people living in the home.

Staff are not always careful about keeping personal information secure.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff, including senior staff and an area manager for Minster Pathways Ltd.

We had found at the last key inspection that care plans did not contain enough detail

Evidence:

to describe what support was needed by each person. They were also not always up to date. We made a requirement for the home to ensure plans were improved, in order to meet legal requirements and so that people living in the home could be confident that all staff know what support has been agreed with them.

We went back to the home in June and found that some plans were being changed, but others were unavailable as they were being checked by a senior manager.

On this inspection, we looked in detail at care plans and noticed that staff found it very difficult to find the most relevant plan for each person , as they were still in the process of being changed. We had required this to be finished before April 2009. Of the plans that we saw, many were insufficient to ensure people received the right care. They were not person-centred. For example, we saw plans which did not mention people's choices and wishes regarding who provided their care, and times they preferred for morning routines. We saw plans which did not say what support someone needed to choose a diet which was necessary to help them manage a health condition.

Plans were sometimes not signed by the person they belonged to, or by their representative, and were sometimes undated. We saw a plan for supporting a male service user with his periods. It was not clear why this was in place. Some blank care plans had been signed and dated by the person they belonged to and by staff, which suggests that they are a paper exercise rather than a meaningful attempt to ascertain and record people's needs and wishes so that all staff provide the agreed support to each individual.

We were told it had been a long time since there had been any house meetings for people who lived there to express their views. One person said the last they could recall was summer 2008. A senior staff member could not find any minutes of any residents' or house meetings.

We saw risk assessments which the senior manager had made notes on in May 2009, to show staff what needed to be amended, but the assessments were still not updated.

We saw folders containing daily notes about people living in the home, left unattended in the living areas of the home. This means that people can not feel sure that confidential information about them is being kept securely.

Lifestyle

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They can take part in activities that are appropriate to their age and culture and are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives and the home supports them to have appropriate personal, family and sexual relationships. People are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. Their dignity and rights are respected in their daily life. People have healthy, well-presented meals and snacks, at a time and place to suit them.
People have opportunities to develop their social, emotional, communication and independent living skills. This is because the staff support their personal development. People choose and participate in suitable leisure activities.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

In some ways daily life in the home is relaxed and comfortable. People like the food, and family visitors are welcome. Some people have active lives. Others who need different support do not always get the help they need to choose and take part in activities. People living in the home do not have independent access to the home, although staff do not restrict their access.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff, including senior staff and an area manager for Minster Pathways Ltd.

People living in the home had some involvement with the local community, such as shops, pubs and restaurants. Staff were not often available to encourage or support certain individuals to get involved with other activities, as there were frequently only 2 care staff on duty, who were needed within the home. Staff and people living in the

Evidence:

home said there were not enough staff and that this sometimes limited what people could do.

The home had plans for supporting people with their leisure interests. These showed a limited amount of effort had been put into encouraging some people's interests. One person had a records showing a variety of interests which could be facilitated by staff in or outside the home, such as going to see films, going out to coffee shops, reading magazines. However the record of their activities for July showed they had only been offered the opportunity to go to the pub or the shop. We have commented in previous reports that staff have not had training in working with people with mental health needs, and that support for people lacking in motivation has been limited.

People living in the home told us of family contacts and we saw from other records that visits took place.

Daily routines in the home were not necessarily restrictive in general, however some people who were able and willing to come and go as they pleased did not have keys to the home. In order to go out they had to ask staff to unlock the door. Staff did not see this as a problem as there was always someone on duty. People did not complain about this, however it does not encourage a sense of independence and control.

People living in the home told us they liked the food, and could have a choice. We saw the menus, which were changed on a 4-weekly rotation. No options were recorded, but staff and people living in the home said they could have something else if they did not like the meal on the menu. We noted that a suggestion previously mentioned by someone living in the home had been included in the menu. Some days it was unclear how people would get their recommended healthy diet of 5 portions of fruit and vegetables, for example a day's food was a breakfast of cereals with juice, lunch of boiled egg on toast, dinner of chicken curry and rice with jam tarts for pudding, and supper of toast and cheese biscuits.

More importantly, it was unclear how the home was meeting people's dietary needs. On the first day of the inspection there was no record of anyone's likes and dislikes regarding food. This was produced on the second day. However there was still no plan for meeting people's health needs if they were in need of a special diet.

Personal and healthcare support

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People receive personal support from staff in the way they prefer and want. Their physical and emotional health needs are met because the home has procedures in place that staff follow. If people take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it in a safe way.

If people are approaching the end of their life, the care home will respect their choices and help them to feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home is not careful enough to make sure that staff give personal care in the way that people prefer, and in a safe way. They do not always make sure people's health care needs are met. Medication kept and given by staff is being kept safely.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff, including senior staff and an area manager for Minster Pathways Ltd. The pharmacist inspector visited the home on 16th July 2009 as part of a key inspection to check the management and control of medicines within the service.

Intimate personal care was given by staff of both genders, and staff were unaware of any policy governing how this was done. Some staff expressed some concern about the vulnerability of people living in the home, as well as the vulnerability of staff who provided this care. We saw care plans for personal care which did not include information about people's choices about staff, or any safeguards regarding giving personal care.

Evidence:

The home was not taking care to ensure that health care needs were reliably met, for example we saw plans for dietary needs for one person which did not even mention their medical condition (which permanent staff told us required a specific diet).

On a more positive note, we did find that improvements had been made to the way medication was being managed in the home, following our requirements at the inspection in June. We saw that medication was stored securely in locked cupboards, which remains the same since the previous inspection. We were informed that a new medicine trolley was being delivered by the pharmacy, which would be kept locked in the main house. At the previous inspection we saw medication, which requires special storage arrangements under the Misuse of Drugs (Safe Custody) Regulations 1973, was not stored according to legal requirements. At this inspection we found that the service no longer stored this medication, however we were informed that correct and suitable medication storage was on order from the head office in order to ensure legal requirements were met.

We looked at the medication administration records and overall found that they were well documented with a signature for administration or a reason was recorded if medication was not given. We saw current records for the receipt and disposal of medication.The date of opening of boxes and bottles of medicines were recorded and balances of medication were usually carried forward from old records to new records. These records helped to ensure there was a clear audit trail of medication. We found that counts and checks made on medication were accurate, which showed that people who live in the service were being given medication as prescribed by a medical practitioner.

At the previous inspection we saw that one person sometimes went out on social leave at lunchtime, which was documented onto their medication chart. A plastic envelope was being used to transfer the medication from the service to home. At this inspection we saw that the service has changed and improved the system for managing medication when it is taken out for social leave. The service had contacted the pharmacy who now prepare and label individual boxed medication for the person to take out with them. We saw the boxes of medication which were clearly labelled and ensures safe control of medication. This is safe practice and ensures that the correct labelled medicine is available to administer.

Information relating to medication was available in the care plan. For example, one resident was prescribed a tablet for agitation and was to be given when required. We saw written information to inform staff under what circumstances the tablet should be given. We saw that the tablet had been given on one occasion in June 2009. We found

Evidence:

documentation, on the medication administration record and on a behaviour incident form, stating the reason why it was administered. This means that there was clear written directions in the care plan which helped to ensure the the health and wellbeing of people living in the service was protected.

Concerns, complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them, know how to complain. Their concern is looked into and action taken to put things right. The care home safeguards people from abuse, neglect and self-harm and takes action to follow up any allegations.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People living in the home feel they can tell staff about concerns they have. It is not clear how the home handles minor concerns.

The company's guidance to staff in the event of suspected abuse of people living in the home is no longer misleading. However staff have not all had suitable training in this area, and some do not understand the proper procedures,which increases the risk of abuse to people living in the home.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff, including senior staff and an area manager for Minster Pathways Ltd.

The home has a suitable policy for dealing with complaints, which is available in a form that is easy to read. It needs to updated to reflect the change of regulator to the Care Quality Commission. There have been no complaints about the home in the past year. It would benefit the home to encourage recording of all concerns, even seemingly minor ones, as this will ensure they are able to pick up on any possible areas where they need to improve. This was recommended in February.

The home's arrangements for ensuring that people who live there are protected from abuse as far as possible, are insufficient. Staff have not had good quality training in this area and do not always understand the issues. The manager and the provider

Evidence:

have shown no urgency in arranging for suitable training to take place. Some training was booked but no staff turned up for it. We were told a variety of different reasons for this. Further training has been booked.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, comfortable, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it. People have enough privacy when using toilets and bathrooms.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home is in parts quite pleasant, but it is not always maintained well. More importantly, it is not always kept safe for people who live there.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff. We looked at some parts of the home, including most shared areas and one bedroom.

The home was reasonably clean and tidy. People had their own belongings in their rooms. The shared areas of the home were rather impersonal, with little feeling of it being a home. More could be done to make it more comfortable, such as more pictures, plants, carpets etc. There was no private area for visitors or consultations.

The home was not always being maintained well, or safely. In June we noticed an office window which did not close securely or lock, causing the office and medication and personal information to be stored insecurely. The manger told us she had never noticed this window did not close properly or lock. The window was fixed after we pointed it out. When we inspected in July, we noticed a bedroom without blinds, causing a difficulty with maintaining the privacy for a person living in the home. Staff explained there was a delay in replacing the blinds because of their unusual

Evidence:

measurements, but there was no interim window covering. More seriously, we found that hot water had been provided at an unsafe temperature in the upstairs bath for some months, without being rectified.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent, qualified staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable. People's needs are met and they are supported because staff get the right training, supervision and support they need from their managers.
People are supported by an effective staff team who understand and do what is expected of them.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People living in the home like the staff they have. Staff do not have enough good quality training, so they may not always know the best or safest way to support people living in the home. When new staff , or agency staff, are employed, the manager does not always make sure she knows if they are really suitable to work with people living in the home, which means that people living in the home are at increased risk of being supported by unsuitable staff.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff, including senior staff and an area manager for Minster Pathways Ltd.

Although the home has made some effort to arrange some training, we found significant gaps in training done by staff in the home. (Lack of adequate staff training has been identified as a weakness in the home as far back as February 2008.) For example, staff untrained in food hygiene prepared meals. Staff without fire safety training worked night shifts alone. Staff without an understanding of the correct procedures for responding to concerns about abuse were responsible for some very vulnerable people. There was no clear training plan, and staff training within the home has also been infrequent and disorganised. This has at times been caused by the Minster Pathways Ltd's practice of arranging training provided by their own managers

Evidence:

rather than specialist training providers, which has led to training being ineffective, or cancelled as the managers have to attend to matters within their own services. Minster have also arranged training in 3 or 4 topics in one day, which means staff cannot recall what they have learnt, and training in any one subject can only be brief. However it is also the case that records within the home of what training has been done, or what is needed, are hard to find and not well organised. On one occasion up to 8 staff missed very important training as they all went to the wrong venue. It is not clear exactly how this happened and we were told more than one version of events.

This lack of attention to regular good quality training increases the risk of poor practice or mistreatment to people living in the home.

A further risk to people living in the home was the home's careless approach to employing staff without evidence of their suitability to work with vulnerable people. This has been identified, in different ways, each time the service has been inspected since it opened. When we inspected the home in June 2009, we found a new staff member without any records of his recruitment checks. The manager told us he was from an agency. On this occasion his records were now in place but he appeared to be employed by the home, not by an agency. We found several other staff working in the home with incomplete or absent records of recruitment checks. The need to ensure that people living in the home are protected by thorough checks before staff work in the home has been stressed on each occasion we have inspected the home and the situation remains unchanged. This leaves the vulnerable people in the home at increased risk from potentially unsuitable staff, and managers do not appear to be very concerned about this.

People living in the home said staff were nice and helpful and treat them well.

Conduct and management of the home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is run and managed appropriately. People's opinions are central to how the home develops and reviews their practice, as the home has appropriate ways of making sure they continue to get things right. The environment is safe for people and staff because health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately, with an open approach that makes them feel valued and respected. They are safeguarded because the home follows clear financial and accounting procedures, keeps records appropriately and makes sure staff understand the way things should be done.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home is not being managed well in several important ways, although people like the manager. There are things not being done well within the home, which increase risk of harm to people living there. Some of these things have been happening for a long time and the manager has not yet put them right. The company, Minster Pathways Ltd, does not provide the manager with effective supervision and support, so they do not ensure that the changes are made which are necessary to reduce risks to people living in the home. Minster Pathways Ltd do not monitor the quality of the service in any meaningful or effective way.

The home does not reliably keep the service safe for people who live there.

Evidence:

We looked at the home's records, and talked with people who lived in the home, and with staff, including senior staff and an area manager for Minster Pathways Ltd. The registered manager was not in the home during this July inspection, but we spoke with her during the smaller inspection we did in June.

Evidence:

The home's manager is generally well liked by staff and people living in the home. However she has not been managing the home well for some time. This is apparent in the lack of progress made to meet several legal requirements, some of which were issued as far back as February 2008, others which were issued in February 2009. She has had little relevant training regarding people with learning disability or mental health needs, and has not shown herself able to manage the service well. She has had little training herself from the provider, Minster Pathways Ltd, and staff training within the home has also been infrequent and disorganised. This has at times been caused by Minster Pathways Ltd's practices regarding the provision of training. However it is also the case that records within the home of what training has been done, or what is needed, are hard to find and not well organised. There is no clear training plan. On one occasion up to 8 staff missed very important training as they all went to the wrong venue. It is not clear exactly how this happened and we were told more than one version of events.

Documents which should be regularly reviewed , such as care plans, risk assessments and information for people who may move into the home, are not regularly reviewed. Vital information is kept in a chaotic way and senior staff say they do not know where records are kept. They should be aware of such matters if they are to have the responsibility of being in charge in the absence of the manager. Staff meetings are not held very often, only twice so far in 2009.

The home's AQAA which was provided before the last key inspection in February was brief and in places inaccurate. There is little evidence of any meaningful attempt to monitor the quality of the home, or to seek and act on the views of people involved with the home, or to act on advice and legal requirements from the Commission. Practices in the home are not centred on the rights and wishes of the people who live there. Surveys were sent out last year and passed on to the company's head office, but senior staff are unaware of any report or response to the views expressed.

Health and safety in the home has been poorly managed in the home each time we have inspected there. Poor practices have in the past included lack of fire training and fire drills, and lack of safety checks on the gas appliances. These poor practices have been corrected after the Commission has pointed them out. On this inspection we found a lack of attention to the risk of scalds from very hot water in an upstairs bathroom, which had been identified for several months without any apparent concern to rectify this hazardous situation.

The manager does not appear to be effectively monitored or supported by senior

Evidence:

management within the company. Following the last key inspection in February, Minster Pathways Ltd told us that the care plans had been reviewed and that the manager was to provide weekly reports to her line manager about them. We found this was not the case. Care plans had not all been reviewed and many were still inadequate. The manager had not been providing weekly reports to her line manager, but had spoken to her on the phone. Management is not effective if poor practices are allowed to continue, and the many poor practices we found on this inspection should have been evident to Minster Pathways Ltd.

There is low morale among staff in the home, many of whom feel the company does not value them or listen to them or provide the home with the resources they need in order to provide a decent service to the people living there. This may well be contributing to the high staff turnover in the home, which is not good in any way for the people living there. The company needs to take swift, positive action to improve their input to the home.

Are there any outstanding requirements from the last inspection?				
	Yes	☑	No	☐

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
1	6	15	Regulation 15. You must keep plans of care needed by each person living in the home, which reflect their current needs and personal preferences, including any restrictions on their choice and freedom. This will enable people living in the home to get the support they need and want.	31/03/2009
2	34	19	Regulation 19(4), schedule 2. When you have staff in the home who are employed by an agency, you must obtain written confirmation from the agency that they have obtained the necessary information and documents specified in schedule 2, and that they are satisfied on reasonable grounds that the references are authentic. This is to reduce the risk of employing unsuitable staff in the home.	03/07/2009
3	35	18(1)(c)	All staff in the home must receive the training they need for their work. This includes (but is not limited to) mental health, food hygiene, safeguarding adults, and infection control. This is to ensure that the people	30/06/2008

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
			living in the home receive a consistent good quality of care.	
4	35	18	Regulation 18(1)(c). All staff in the home must receive the training they need for their work. This includes (but is not limited to) mental health, food hygiene, safeguarding adults, and infection control. This is to ensure that the people living in the home receive a consistent good quality of care.	31/03/2009
5	39	24	Regulation 24(1). The registered provider must establish an effective Quality Assurance system. This is in order to show how the provider is responding to feedabck from the people who live in the home and from the Commission and other interested parties.	31/03/2009

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	23	13	Regulation 13(6). You must make arrangements to ensure that staff in the home are aware of the correct procedures to follow in case of potential abuse or harm to people living in the home. Training in this was a requirement in February 2009 and in February 2008. This is in order to reduce the risk of harm or abuse to people living in the home.	31/07/2009
2	34	17	Regulation 17(2), schedule 4. You are required to keep in the home a record of all persons employed at the care home, including in respect of each person his full name, address, date of birth, qualifications and experience; a copy of each reference obtained in respect of him, the dates on	31/07/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			which he commences and ceases to be so employed; the position he holds at the care home, the work that he performs and the number of hours for which he is employed each week; correspondence, reports, records of disciplinary action and any other records in relation to his employment; a record of all training undertaken, including induction training. This was required in February 2009 and in February 2008. This is to ensure that all staff have been checked for their suitability before working in the home, and that the manager can plan training to ensure people living in the home get the support they need.	
3	42	13	Regulation 13(4)(a)(b)(c). The registered person must ensure that (a) all parts of the home to which service users have access are so far as reasonably practicable free from hazards to their safety; and (b) any activities in which	31/07/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			service users participate are so far as reasonably practicable free from avoidable risks; and (c) unnecessary risks to the health or safety of service users are identified and so far as possible eliminated. Specifically, you must ensure that water supplies are maintained in a safe condition. This is to ensure the home is safe for the people who live there.	

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	1	You should ensure that any written information available about the home, for service users, possible service users and for professionals (such as the Statement of Purpose and the Service Users' Guide), is accurate and is not misleading.
2	13	You should ensure that enough staff are available to be able to encourage (and accompany if necessary) each person living in the home, when they wish to take part in any activity outside the home.
3	14	Everyone living in the home should be enabled to enjoy the leisure activities they choose, and staff should actively and carefully support and develop such opportunities. This was recommended in February 2009.
4	16	An assessment should be made (and recorded) of the benefits of people holding their own keys to the home, and every effort made to facilitate this while addressing other

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
		risks, in discussion with the people concerned and their representatives if appropriate.
5	22	You should ensure that any concerns are taken seriously and acted on, by updating your complaints policy and procedures and by recording any minor concerns, along with the outcomes for the person involved.

Helpline:

Telephone: 03000 616161
Email: enquiries@cqc.org.uk
Web: www.cqc.org.uk

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