Housing & Care 21

Housing & Care 21 - Rowan Croft

Inspection report

Rowan Croft Extra Care Court
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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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The unannounced inspection took place on 7 and 9 of September 2015. This was the first inspection since the service registered with the Care Quality Commission (CQC) on 9 October 2014.

Housing & Care 21 – Rowan Croft is an extra care service consisting of 45 individual apartments within the building. There is an office base and care staff provide people with a range of services including; personal care, medicines management, shopping and cleaning services. Not everyone in the building receives services from the provider and not all services are regulated by the CQC. At the time of the inspection 34 people lived independently and received care and support from the provider.

Summary of findings

The service had a manager in post who had joined the organisation in April 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some shortfalls in the safe management of medicines. For example, medicine administration records were not completed correctly as per current guidance and 'as required' medicines had not been recorded correctly.

People felt safe receiving support from the service. Staff were able to demonstrate a working knowledge of both safeguarding and whistleblowing procedures.

Accidents and incidents were recorded and dealt with appropriately but not formally monitored by the provider to help them identify any trends. We also noted that risk assessments were not always completed.

The principles of the Mental Capacity Act 2005 (MCA 2005) were followed and staff understood the meaning of obtaining consent.

Staff appraisals, supervisions and training were not all up to date, although the manager was striving to rectify this.

There were sufficient staff to provide care which met people's needs. Appropriate recruitment procedures were followed to ensure that suitably qualified and experienced staff were employed.

People were supported to eat and drink sufficient amounts to ensure their dietary needs were met. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals, as required.

People and their relatives told us the staff team were caring in their approach to them and respected their dignity.

Care and support plans needed to be revised and additional work put into them to ensure they were up to date and contained person centred, relevant information.

A new manager was in post and they were addressing some of the shortfalls they had identified. However, additional issues were identified as part of the inspection process that needed to be reviewed.

The provider admitted that robust quality check and audits were not always in place and that measures were to be taken to rectify this.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to medicines, staffing and good governance. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe

The procedures for the safe management of medicines needed to be improved.

Risk assessments were not always completed, particularly for those people at risk of falls.

Staff understood their safeguarding responsibilities and were aware of procedures.

Requires improvement

Is the service effective?
The service was not always effective

Staff appraisals, supervisions and training were not all up to date.

Staff had good understanding of people's capacity and how this can fluctuate. The provider respected people's rights to consent to treatment and supported people in line with the Mental Capacity Act 2005.

People were supported to eat and drink sufficient for their individual needs.

Access to other health care professionals in order to maintain people's general health and wellbeing was supported by staff at the service.

Requires improvement

Is the service caring?
The service was caring.

Care staff treated people with compassion, kindness, and respect.

People were encouraged to remain as independent as possible and told us they were not hurried by the care staff providing them with support.

Good

Is the service responsive?
The service was not always responsive.

People's care and support records did not always explain in detail how staff should provide a particular area of care and these records had not always been reviewed regularly.

People were supported to make choices and express any concerns they might have. When necessary, the provider took appropriate action in response to complaints.

Requires improvement

Is the service well-led?
The service was not always well led.

Requires improvement

Summary of findings

A new manager had taken up post at the service and was addressing a number of areas that required improvement.

Accidents and incidents were not robustly monitored by the provider, but during the inspection the head of extra care sent the manager procedures to follow in order to rectify this.

Quality checks and audits were not always robust.

Housing & Care 21 - Rowan Croft

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 9 September 2015 and was unannounced. The inspection was carried out by one inspector, a specialist advisor and an expert by experience. A specialist advisor is a person who specialises in a particular area of health and social care, for example medicines, moving and handling or quality assurance. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor at this inspection concentrated on quality assurance and staffing and the expert by experience spoke with people on the telephone to ascertain their experiences of the service.

Prior to carrying out the inspection, we reviewed all the information we held about the service. We did not request that the provider complete a provider information return (PIR) because of the late scheduling of the inspection. A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

We reviewed other information we held about the service, including any notifications we had received from the provider about deaths, police incidents and serious injuries. We also contacted the local authority commissioners and safeguarding teams for the service and the local Healthwatch. **Healthwatch** is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection. On the day of our inspection we spoke with a district nurse and an occupational therapist who were visiting the service.

We spoke with 11 people who used the service and seven family members. We also spoke with the manager, the head of extra care, the regional extra care manager, senior administrator, nine members of care staff and four staff from other services that worked within the same building. We observed how staff interacted with people and looked at a range of records which included the care and medicines records for ten people who used the service and five staff personnel files. We also looked at health and safety information and other documents related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People told us they received their medicines on time and had not had any problems. However, when we checked the records there were some shortfalls found.

One person's records showed they preferred to have juice with their medicines, but the risk assessment completed stated they liked water. Another person's records showed that they were to be prompted for medicines. There was no risk assessment in place, yet this person was self-medicating and was registered blind and partially deaf. This meant there was a risk the person could take the wrong medicine at the wrong time.

Most people that received support from staff with their medicines had them delivered in a medibox. A medibox is a container where a number of medicines (in tablet form) are placed together on the specific day they should be taken. We observed staff administering medicines to some people they supported. We noted the medibox was recorded on medicines administration records (MARs) as a single entry when in fact a number of medicines had been administered to the people in question. This meant staff were not checking to ensure that the individual medicines being administered were correct and were signing MAR's for the total medibox entry. NICE guidelines state:

Care home providers should ensure that medicines administration records (paper-based or electronic) include:

- the full name, date of birth and weight (if under 16 years or where appropriate, for example, frail older residents) of the resident.
- details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration).
- known allergies and reactions to medicines or their ingredients, and the type of reaction experienced.
- when the medicine should be reviewed or monitored (as appropriate).
- any support the resident may need to carry on taking the medicine (adherence support)
- any special instructions about how the medicine should be taken (such as before, with or after food).

NICE is an organisation called The National Institute for Health and Care Excellence. They provide national guidance and advice to improve health and social care. We discussed these concerns with the head of extra care who told us this issue had been raised previously and that she would take this back to the provider as she said the medicines policy was currently being reviewed.

We noted that not all 'as required' medicines had been recorded correctly as per the providers own guidance or in line with NICE guidance. For example, one person's records did not show what the 'as required' medicine was for and another person's record was not clear on the dosage and simply stated 'as directed', with no further instructions.

These were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Returned medicines records were seen from May 2015 onwards and these had been signed and collected by the pharmacist and were in order. Medicines administration competency checks were carried out with all staff and records showed they were generally up to date.

People told us they felt safe or felt their relatives were safe in their environment, both with the care staff and within the complex. Comments from people included, "This is the safest place I could be"; "I moved from my house after being hospitalised to here, it's great"; "Absolutely safe here. I feel comfortable and secure" and "I am safe when they [staff] are around!"

When we asked staff about their understanding of safeguarding, comments included, "Ensure people we look after are as safe as possible and to report anything we feel may not be right, such as abuse happening"; "To make sure people we're looking after are safe, that there's nothing there to harm them. If I had concerns I would go to line manager, it's similar to whistle blowing" and "Protecting the vulnerable and identifying any abuse (physical, neglect, financial, isolation). I would document it and report it to the manager." There were safeguarding policies and procedures in place to further support staff should they need it.

When we asked staff what they understood about whistleblowing, comments included, "If you see something about a member of staff acting inappropriately I'd go to the manager or above if needed" and "If I thought someone is in danger from anyone I would go to my line manager or next level up."

Requires improvement

Is the service safe?

Do not attempt cardio pulmonary resuscitation (DNACPR) forms were not in a prominent position in people's files, which made it difficult for staff to confirm if a person had such a documents in place, should an emergency arise where the need for resuscitation was considered. The manager confirmed that these would be immediately placed at the front of every person's file that had one in place.

Not all risk assessments had been completed, particularly for those at risk of falls. Although we found general risk assessments were mostly completed, including those based on people's environments, including for example ironing and vacuuming. We discussed this with the manager and they confirmed it was an area they needed to address.

Regular checks on fire equipment and procedures were carried out and the provider had produced a fire risk management system for staff to follow if a fire were to occur. People's personal evacuation plans were completed. These documents support emergency services if there was ever a need to remove people from the building, for example, in the event of a fire. All of this information was in the main office near reception and would be easily accessible, if required.

Staff had documented on people's records who to contact in the case of an emergency. For example, a son or daughter. This meant that information was available to ensure relatives were able to be contacted quickly, if necessary.

We saw there was a coded entry system into the building and watched while a delivery of equipment to one person was made. The delivery men were not allowed into the building until staff had checked all their credentials, including the delivery papers they had brought with them. This confirmed that people were secure within their own living space and protected from unwanted visitors.

The provider had suitable recruitment processes in place and staff confirmed the provider had followed safe recruitment practices when they were interviewed and accepted a role. The recruitment records for staff showed that practices were thorough. We viewed completed application forms with no gaps in employment, interview notes, photographic proof of identification and satisfactory references from previous employers. The provider also checked with the Disclosure and Barring Service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. Job descriptions were not always found in staffing records, but the manager said she would rectify that.

Where staffing issues had arisen, these were dealt with effectively by the manager and the provider. One person told us about a concern they had with a member of staff's behaviour towards them. They told us it was reported. We discussed this with the manager and they told us that the staff member no longer worked for the organisation.

People told us they felt there were enough staff to meet their needs. We asked people if staff had ever missed a call and they confirmed staff were usually on time. One person said, "Yes they arrive on time and no, they have never missed a call."

We looked at the lists of alarm call out's by people using the service and checked these with the daily records of the people where this had occurred. We found that staff were prompt with their response and incidents were dealt with effectively. For example, one person had fallen and staff had attended to them quickly and made them comfortable, with no need for further intervention.

Requires improvement

Is the service effective?

Our findings

We found that staff training was either out of date or the service was unable to confirm staff had received training in a number of areas. Moving and handling records showed that only three staff had up to date training. We also noted that safeguarding, medicines and infection control training were also out of date. Although staff had received training through their induction, most staff had not been given the opportunity to further develop their skills.

Recent training for moving and handling, safe handling and administration of medicines and safeguarding of vulnerable adults had been cancelled and we were told that a new date was being planned. The manager told us that a small number of staff required support with their IT skills around eLearning. To support them and to ensure they completed their training, the manager said they intended to bring them into the office so that staff would be around to help them while they completed any outstanding eLearning.

Staff told us they received supervision bi monthly generally, although some staff supervision were overdue. When we checked annual appraisals four staff had received an appraisal in September 2015 with other staff still outstanding. One member of care staff reported they had never had an appraisal and another member of care staff said, "I last had it at the beginning of January 2014." The manager confirmed that she was working her way through appraisals to ensure that every member of staff had one.

These were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff how their competency to perform various tasks was checked, including the administration of medicines and any moving and handling they had to do to support people. One staff member told us, "Manager comes to watch medication and personal care spot checks every 2-3 monthly, they used to just turn up." Another member of care staff said, "Spot checks, seniors constantly watching us on double ups."

People thought care staff were good at their jobs and had the right attitudes. Comments included, "The carer is excellent"; "I am very happy with the care and yes they check how I am getting on" and "They [staff] seem to know what they're doing." One relative said, "I am happy with my mother's care. I am a carer myself so know what I am talking about. They are fantastic with mum."

We asked staff about the induction they had when they first started and comments included, "Medication, moving and handling, safeguarding, health and safety, first aid update, food hygiene. It was very intense. I also shadowed a senior for a week";

People told us they had given consent, allowing staff to administer their medicines and have access to MARs, communication records, and GP details.

The Mental Capacity Act 2005 (MCA) is designed to empower and protect people who may not be able to make some decisions for themselves which could be due to living with dementia, a learning disability or a mental health condition. The Alzheimer's Society state, "People should be assessed on whether they have the ability to make a particular decision at a particular time."

Staff had a good understanding about people's mental capacity and when we asked staff to explain, comments included, "Mental capacity can change at different times, depending on a number of things, including if they have been suffering from an infection and may not always be the same. We need to be aware of each person's needs and protect them when we have to"; "What capacity they have themselves, different levels of capacity in here, I would record it and it would need assessing by a doctor, the person may need more help or intervention or they could have an infection" and "Whether or not a person is able to understand what has been said and their capacity to make a choice, I would report it to my manager and get a GP to come out for mental capacity to be checked." The manager was aware of the need to refer to the court of protection for this type of service. The Court of Protection helps people who are mentally incapable of making their own decisions. It does this by making decisions for them about their money, property, health or welfare.

Staff supported people in their own flats within the building if they required support with cooking and nutrition. The building had a restaurant situated near the main reception and staff were seen bringing a number of people (at their request) down to this area so they could have a meal there. Where people required support with their nutritional needs, this was documented in their care

Requires improvement

Is the service effective?

records. Details included how staff should support the person and what their likes and dislikes were. We asked one staff member what they would do if they were concerned about nutrition with any person in their care. They told us they would report this to the senior or the manager who would look into the matter immediately. This meant that people's dietary needs were being monitored and any concerns were being reported appropriately.

Where people needed support to make and attend medical appointments, staff would support them with this in order to maintain their personal health. One person was visited by their GP during the inspection and staff confirmed they helped the person make the appointment.

Good

Is the service caring?

Our findings

Everyone we spoke with described their care as excellent or very good. People said that the care staff were friendly, polite, and engaged in conversation during their time with them. Peoples comments included, “Absolutely marvellous they are”; “I think they’re very kind”; “Excellent, brilliant the carers. They are polite and competent” and “They go the extra mile and are like my family.”

Staff showed us many compliments and examples of praise they had received from people using the service or from relatives whose relation had sadly passed away. The praise and compliments all focussed on the care that staff had shown people.

When we asked people about how their care was provided, one person said, “I don’t feel rushed at all.” Another person said, “The staff take their time when they need to. I know I am limited to the amount of time I get, but it does not feel like that.” One relative said, “You cannot fault the staff, it’s a hard job and they do it very well.” Another relative said, “The staff are smashing. Lovely, kind and caring people.”

People had weekly timetables which staff completed to explain what support was provided on any given day and at what time. This included, morning, lunchtime and tea time support with help for additional calls recorded also. The timetables included information on how staff should knock and enter people’s homes. For example, one person’s records stated that staff should knock, enter and call out their name to alert person that staff had arrived.

We asked people if they were respected and if their dignity was maintained. One person said, “They care for me with respect and dignity.” Another person said, “They listen to me and I never feel embarrassed by what they do for me. I think it’s the way they go about it.”

The people and relatives we spoke with all confirmed that the staff communicated with them appropriately. Staff bent down to the same level as people when speaking with them so that they could hear what was being said. We observed that people understood and responded by communicating back to staff.

The provider had a vacant bedroom within the building which, we were told by staff, could be used by visiting relatives or friends. A member of care staff told us that the bedroom was used from time to time and said, “It’s nice that there is a place for relatives to stay if they need to.”

One person told us they were encouraged to stay independent and said, “I can do things for myself.” A staff member told us, “We always encourage people to do as much as they can for themselves”. Care plans we looked at highlighted that where possible staff should encourage people to be as independent as possible regarding daily living tasks. During our inspection we saw people going out of the complex independently and returning with shopping. People told us that they attended to their laundry needs and where possible prepared meals. This highlighted that staff knew it was important that people’s independence was maintained.

We observed notice boards in communal areas and saw that information about the service and any upcoming events was displayed. There were leaflets and information about numerous health conditions, such as diabetes and high blood pressure. In addition, we found detailed information for people and relatives about living with depression, dementia or other mental health conditions.

Requires improvement

Is the service responsive?

Our findings

People's needs had been assessed before they started to use the service. People told us and records confirmed that they were regularly involved in reviewing their support plans. We saw that records were updated to reflect people's views. They contained details of people's life histories and who they wanted to maintain relationships with.

Staff we spoke with were aware of people's preferences and gave us examples of how they supported people in line with these wishes. For example, one person preferred to have their own separate domestic and another liked to be taken downstairs to have lunch in the restaurant.

We noted that even though people's support needs had been identified, the way a person was to be supported was not always recorded in a person centred way. For example, one person's care records stated they needed to be supported with a shower. The records did not explain how staff would do this or how the person preferred to be showered and what equipment or materials staff should use.

A small number of people's care plans had not been reviewed recently, including one since May 2014. We were able to confirm that people were not at risk and their needs were still being met, although records did not always correspond with this. The manager told us they had started to work their way through people's care and support records in order to ensure that they were all up to date and contained the correct amount of person centred information and other appropriate details.

We sat with staff during the shift handover. Senior staff had a list of people's names and discussed each person individually, passing on any details of their care or support that was pertinent. The handover was designed to ensure that staff starting the shift had all the detailed information they needed to ensure they were responsive to the individual needs of people they supported and cared for. We noted that staff did not have any written information, which meant that there was a possibility of relevant and important information being missed by accident.

We spoke to staff from another organisation who rent part of the building in order to hold a day service. Talking about the staff at Housing & Care 21 – Rowan Croft, one staff member said, "Staff go that extra mile for the people they work with and are respectful of our role here." They told us that some of the people that live in the building attend the sessions, along with people from the local community and staff at the service encourage this.

There were a number of activities taking place within the extra care complex. We confirmed that a strawberries and champagne day had taken place when Wimbledon took place. We saw from 'resident' meetings that the manager continued to liaise with local schools with the aim of encouraging them to visit and do manicures. We were told that the manager's hope was to have a continuous programme of activities which involved school children. One person we spoke with told us that bingo, dominos, singers and showings of 'old style' films took place.

People told us they had choice and staff never forced them to do something they did not want to do. One person said, "Yes you can choose, I said I would like only so and so and they listened." Another person said "Carers listen all the time and offer options."

The provider had a complaints policy and this was displayed around the service. One person said, "They look after me - no complaints." One person, who had previously used the service told us, "I have no care needs, staff just say hello, but they used to take care of my husband. I have no complaints." A relative told us, "I know how to complain but never had reason to." We noted that there had been one formal complaint in January 2015 and this had been investigated thoroughly and responded to by the provider in appropriate timescales. There had been a small number of informal complaints which, again, had been dealt with quickly.

The provider had a system in place to ensure that important information about people was transferred between services. People's records held a hospital admission sheet, which staff told me would go with people, should they be admitted to hospital. Information included the contact details of the person's nearest relative, their medical information and a separate sheet containing the details of the person's medicines.

Requires improvement

Is the service well-led?

Our findings

There was a manager who had been in post since April 2015. They were being supported by a regional extra care manager during their induction period. People told us they knew who the new manager was and they thought they were good. People told us they had seen lots of improvements since the new manager came in to post. They told us that when they had a minor complaint or a question to ask, the manager listened and put corrective measures in place. One person said, "I do see the manager she asks how I am getting on." Another person said, "Most of the carers are great it's with the new manager that things have improved."

The manager told us that they currently did not keep an accident and incident log to monitor any trends forming. The head of extra care was present at the time of the discussion and said they would e-mail over the 'accident/ incident tracker' for the manager to start using. As the provider was not fully monitoring accidents and incidents for trends they would find it difficult to identify people who were more at risk after (for example) a series of falls. The manager confirmed that when people had a number of falls, they quoted three, then a referral would be made to the falls team. It appeared that the current system relied on senior staff recognising that a number of falls had taken place from accident records rather than from any formal analysis.

We found care plan and medicines audits had only recently been undertaken since the new manager had taken up their post. For example, where medicine audits had been carried out, MAR's had been checked for their completeness and staff competencies had been verified. Overall, audits and checks, including those by the manager and the provider, were not robust. The consequences being that people may have been put at risk from missed issues arising within various areas, including medicines. The head of extra care confirmed that further work needed to be completed in this area at the service.

We were given a copy of a blank audit report that would be completed by the regional extra care manager and the head of extra care at their six weekly and three monthly respective visits. The report included checks on staffing, care, safeguarding and health and safety. Also included were discussions with people who used the service. Part of the head of extra care's checks included a 'resident surgery', where people could speak with them and discuss any concerns they had. We noted that a 'surgery' was advertised to take place in the coming weeks.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were positive about the management of the service. One staff member said, "The manager is very approachable and supportive" Staff told us they now received allocated breaks as part of the new roster that the manager had introduced. We were told staff did not have an allocated break prior to this and took a break only if they were able.

We noted that many of the issues we had found had been inherited by the new manager and that she was already working to put new process's in place, including the implementation of a list of senior tasks to complete on a daily, weekly and monthly basis. The manager confirmed that there was still lots of work to do. The head of extra care told us the manager would be given additional support to rectify any issues outstanding.

Staff confirmed they had the opportunity to discuss any issues with the management team and play a part in the running of the service. Staff meetings were currently held every two months and included a range of topics for discussion. From the minutes we were able to confirm that holidays, various activities, use of a suggestion box and issues including how to reset the fire alarm had been discussed.

There were mechanisms in place to communicate with people and their relatives and involve them in decision making in relation to the service. Minutes of meetings held and plans of those to take place were seen. Discussions included conversations about staffing and times of visits. People were comfortable to report their views on the staff care (which was positive). People told us that meetings were a good place to bring any concerns to, if they had any, and they confirmed they were able to have their say in the running of the service.

We were shown the results of the 2015 people's satisfaction survey which showed a 93% satisfaction score. The manager told us that they had undertaken one people's survey and planned to roll this out to 10% of people living at the service every month.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was not proper and safe management of medicines procedures in place. Regulation 12 (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured that robust quality assurance systems were in place, including monitoring of accidents and incidents and regular service and provider audits. Regulation 17 (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate or sufficient training, supervision or appraisal from the registered person. Regulation 18 (2) (a)