Titleworth Neuro Limited

Rowland House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our inspection of Rowland House took place on the 30 April 2018 and was unannounced.

Rowland House Care Home is registered to provide care, support and accommodation for up to seven people who have an acquired brain injury. At the time of our visit there were seven people living at the home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

At the time of our visit a registered manager was present and in post. 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 that there was no over view or system of recording and monitoring all of the incidents and accidents. We also found that when certain events occured, the provider had failed to notify CQC where necessary. You can see what action we told the provider to take at the back of the full version of the report.

Relatives told us they felt their family member was safe living at the service. Staff had received training in relation to safeguarding and were able to describe the types of abuse and processes to be followed when reporting suspected or actual abuse. Risks to people were assessed and considered consistently.

There were sufficient staff present to safely meet people's needs. We observed staff being consistently present with each person throughout the day. We also saw that safe and correct checks had been completed in the recruitment process for all of the staff.

Staff were seen to check the medicine administration record (MAR) to check what medicine was required at what particular time. When medicine was given to people, staff explained what it was and made sure they had a drink, or other fluid to make it easy to swallow. People were protected against the risk of the spread of infections. The home environment was clean with no malodours.

Peoples' needs and choices were assessed to make their care, treatment and support as effective as possible. In two care plans we saw clear and detailed pre admission assessments which assessed the care required for people. People's relatives were very positive about the food at this service. We observed that people's nutritional ad hydration needs were being met.

All staff had been trained in areas relevant to their role which was in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. All staff were supported with frequent supervision by the manager.

We saw evidence of people being supported to access healthcare professionals when needed. The home had a gym in the basement which was frequently used by people and occupational therapists (OTs). The environment was suitably adapted for the people living there.

Where there were restrictions in place, staff had followed the legal requirements to make sure this was done in the person's best interests. Staff consistently sought consent from people. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure decisions were made for people in the least restrictive way.

Relatives told us that they felt staff treated their family member with kindness, respect and compassion. Staff promoted people' privacy, dignity and independence. Peoples independence was promoted.

Where there had been complaints made there had been clear action taken to address the concerns.

There were plans in place for person centred end of life care in each care plan. We saw one care plan which had a detailed booklet specifying the steps, contacts and relevant facts to one person and their preferred arrangements. People had access to a wide range of activities specific to their interests.

There was a clear vision and credible strategy to achieve good outcomes for people. This was to rehabilitate people and promote their independence so that they could be discharged. Since the last inspection in 2016, five people have been discharged to either live with their families or independently with partners.

Staff were positive about the manager and the culture of working at this service. We saw minutes of meetings held with staff where they discussed ideas about the home relating to people's care, staffing and training. People, the public and staff were actively engaged and involved in the service.

Quality assurance checks were completed around the home, to spot where areas of improvement were needed. Health and safety checks were completed on a weekly and monthly basis. Areas covered included cleanliness and infection control, fire safety checks, including reviewing the last evacuations, and condition of the environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of what abuse was and the processes to be followed when abuse or suspected abuse had been identified. Staff were quick to react to any incidents or accidents.

There were enough staff to meet people's needs.

People's medicines were managed safely.The provider had robust systems in place to reduce the risk of infection control.

Risks to people were routinely assessed with clear plans to keep people safe.

Is the service effective?

Good

The service was effective.

People were involved in decisions about their care which was delivered in line with good current standards and evidence-based guidance.

Staff received appropriate, relevant and frequent training. The manager supported staff with regular supervision.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People had involvement from external healthcare professionals as well as staff to support them to remain healthy.

People were served foods that they liked and that met their individual dietary needs.

Is the service caring?

Good

The service was caring.

People told us they felt they were looked after by caring staff.

People's care, treatment and support was planned and delivered in line with their care plan. People's privacy and dignity was respected.

Staff were knowledgeable about the people they cared for and were aware
of people's individual needs and how to meet them.

Is the service responsive?

Good

The service was responsive.

Where people's needs changed staff ensured that people received the correct level of support. Care plans were person centred and regularly reviewed.

People were able to go out and take part in activities that interested them.

People and their relatives knew how to make a complaint and a complaints procedure was available at the home.

Is the service well-led?

Requires Improvement

We found that there was no over view or system of recording and monitoring all of the incidents and accidents. When events occurred that required to be notified to the CQC this was not always being done.

There was a clear vision and credible strategy to achieve good outcomes for people.

Staff were positive about the manager and the culture of working at this service.

Rowland House Care Home

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 was carried out on 30 April 2018 by two inspectors and it was unannounced.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We reviewed the information the provider sent us in their Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with three relatives. Due to the health conditions of people we were unable to gain views of the service. We observed the care that people received and how staff interacted with people. We spoke with the registered manager and five members of staff. We read care plans for two people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at two staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits.

Good

Is the service safe?

Our findings

Relatives told us they felt their family was safe at the home. One relative said, "The small environment is safe. Staff always know where he is and what he is doing." Another relative told us "She's as safe as she can be." Another relative told us, "They always ring me and let me know if there is an incident. It's always kept in the incident book, they are very transparent."

People were kept safe because staff understood safeguarding processes and their roles in protecting people from abuse. All staff had been trained in safeguarding and demonstrated a good understanding of the signs of abuse, as well as the procedures for escalating any concerns that they might have. One staff member said, "If I suspected it was happening I would speak to the people and listen to what they said and then tell my line manager. They would open an investigation and inform the appropriate people like the police, GP, or social services."

Risks to people were assessed and considered consistently. Risk assessments were carried out regularly in response to individuals needs in specific areas such as falls. For example, one person was at high risk of falls due to their general mobility and medical condition. To manage the risk staff had documented in their care plan that they needed a helmet and a walking frame to move safely around the home. We observed staff ensuring that this people had both the helmet and walking frame every time they stood up to go somewhere. This showed the risk of this person falling was being managed in a way that promoted their independence whilst keeping them safe.

We also saw that each person had a personal emergency evacuation plan to be used in the event of a fire.

Equipment was in place to minimise risk of harm. For example, one person's care plan had a risk assessment about how they sometimes got out of bed at night with behaviour that put them at risk. A sensor mat had been put into place to alert staff as to when they got out of bed so that they could check if they needed assistance.

There were sufficient staff present to safely meet people's needs. One relative said, "I think there are enough staff…they are always there." We observed staff being consistently present with each people throughout the day. Whenever one staff member needed to leave a room they always checked that another staff member was able to replace them. One staff member told us, "Yes, I think we have enough. We are trying to get two more permanent staff, but we use agency to cover if needed. We try to get the same agency staff so they know the people, if we don't, we make sure they have an induction before they start."

People's medicines were stored safely and well organised at correct temperatures in locked cabinets in people's rooms. Although no one was able to self-medicate this gave them some ownership of their medicine, and reduced the risk of medicine errors as only one person's medicine was prepared at a time. Staff were seen to check the medicine administration record (MAR) to check what medicine was required at what particular time. When medicine was given to people, staff explained what it was and made sure they had a drink, or other fluid to make it easy to swallow.

People did not have their activities affected due to having to take medicine at set times. Where people went out and their medicine was due to be taken, there was a system in place to manage this. The medicine was signed out by the staff member removing it from the blister pack and given to the person that was taking the people out. This would then be signed on the people return to record whether the medicine had been given or not while out.

People were protected against the risk of the spread of infection. The home environment was clean with no malodours. We observed cleaning staff cleaning the home during our visit. The provider conducted regular audits of infection control which resulted in appropriate action plans. People's clothing was regularly cleaned and systems were followed that reduced the risk of cross-contamination. Staff were observed consistently washing their hands before and after supporting people. Staff were also observed using personal protective equipment (PPE), such as gloves, before providing care to people. Hand sanitizer was also available throughout the home and we observed people making use of it. One staff member told us, "I do the audits around infection control. I look at the environment, making sure cleaning materials are not left out, that there is no mould on windows, mattresses are not ripped or worn. I check two rooms each week. I also check on staff handwashing practice, and how clinical waste is disposed of."

Staff responded appropriately to accidents or incidents and the records supported this. For example, one person was at high risk of falling and regularly fell over during care. In response to each incident staff provided first aid, took the person to hospital if necessary and reviewed their care plan. One staff member said, "We look at why something happened, and what we had in place that should have stopped it happening, for example (people) refusing to use their walker and falling. We reflect on what we did and look to see if we could do anything different. With (person's name) we have given her hip protectors to protect her when she bumps into things."

Although the service responded to individual incidents well, there was no robust management overview of incidents and accidents as a whole. The impact of this was limited however due to the fact that there were only seven residents and the staff knew all of them very well. We raised this with the registered manager who assured us that they would start creating an analysis and over view of incidents going forward.

Good

Is the service effective?

Our findings

People's needs and choices were assessed to make their care, treatment and support as effective as possible. Care plans had detailed pre admission assessments which detailed the care required for people.

All staff had been trained in areas relevant to their role which was in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff received extensive training which included syndrome and disease specific courses. One relative told us "They have all had training on Huntingdons disease and so they have a lot of knowledge."

We saw records of recent individual staff supervision being carried out along with team meetings for the staff.

People's relatives were very positive about the food at this service. One relative told us "She eats really, really well. At home she was losing weight and it was very difficult to provide her with food, at the home she eats really well. Her weight has been stable and increasing." We observed staff supporting people with individual cutlery and mugs specific to their needs. Each care plan included weight, and BMI records to monitor each people's diet and health. One staff member told us, "We make sure they have their five a day. People have decaffeinated drinks to help with their health, and they all know this. They can have caffeinated drinks whenever they want though. We make sure they know and have agreed to have de-caff drinks."

We saw evidence of people being supported to access healthcare professionals when needed. The home had a gym in the basement which was frequently used by occupational therapists (OTs) with people. Where one person had recently become unwell, we saw a note in the incident report to show the GP had been contacted immediately. All care plans showed evidence of appointments with the dentist and district nurse. One staff member said, "We have OT's and SaLTs (speech and language therapists) visit. When (people) came to us from another home, he had really high needs, and was on a lot of medicine to manage his behaviour. He is so much better now in that his walking has improved, and his medicines have been reduced." We saw two people use the gym with staff during the day to develop their mobility.

The adaptations and design of the home met people's needs. People had enough space to move around the home with walking aids. We observed people using walking frames and wheelchairs. Rails and bars were installed throughout the home to provide people with something to hold onto for balance. There was a lift in place to enable people to get upstairs and down to the gym in the basement. For people that required a hoist there were ceiling rails for hoists in their bedrooms. There were height adjustable work surfaces in the kitchen, and height adjustable tables in the dining room to accommodate people that used wheelchairs. There were also low sinks, mirrors, door handles and fire call points around the home so people in wheelchairs could easily reach them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the guidance of the MCA. We spoke to staff who were able to explain and describe essential parts of the MCA and its application in the home. For example, one staff member said, "MCA is about seeing whether they are able to understand and make their own decision or if someone else has to make the decision in their best interest. DoLS is about when we may have to restrict someone from doing something as they may not understand that their choice may not be safe, such as going out on their own."

Staff were seen to ask peoples permission before carrying out any treatment such as placing on protective head gear. We saw one staff member ask a person, "Do you want me to help put your hat on if you are getting up?" The person nodded in agreement.

Records contained evidence of decision specific mental capacity assessments, identifying where people were unable to make decisions themselves. For example, in one persons care plan there was a detailed best interests decision around them having bed rails. The person was bed bound and had been assessed as lacking capacity but was at risk of falling out of bed. Best interests decisions were made in consultation with people's relatives, healthcare professionals and staff. Where restrictions were to be placed upon people in order to keep them safe, an application was made to the local authority DoLS team.

Good

Is the service caring?

Our findings

Relatives told us they felt staff treated the people with kindness, respect and compassion. One relative said, "They do a lot of keywork with (person) to ensure that he is involved with his care. They talk to him as a person and they understand him. That's why sometimes the input from the staff is very good as they adapt their behaviour to suit his." Another relative told us, "They (staff) always talk to the people."

When asked what they enjoyed most about working at the home one staff member said, "No two days are the same. I like the challenge and seeing people improve. We talk to them to get to know them. When they come here they will have a small care plan, but we develop it with them as we get to know them. The keyworkers (staff allocated to people) spend time talking to people during keyworker sessions …we have to treat people as if they are in 'their' home, not in 'a' home."

We observed positive interactions between people and staff during our inspection. People looked relaxed and comfortable. Staff engaged in conversations with people and waited for them to respond to their questions. People had access to all communal parts of the home including the kitchen. Although some people were required to wear protective head gear when moving, it was not necessary when they were sat down. We observed that staff commented to them (and helped if needed) to brush their hair when the hats were taken off. This ensured they looked presentable with their hair being tidy and not dishevelled.

The registered manager explained to us upon our arrival that the homes aim was to improve and rehabilitate the people' health and mobility. We saw this in practice as staff were proactive in assisting one people in going out with their friend and another had friends visiting. Staff were friendly and helpful with all of the friends that came into the home in that they offered tea and made sure everyone was comfortable.

Staff promoted people' privacy, dignity and independence. People were appropriately dressed for the activities they were doing throughout the day. For example, staff made sure that one people wore his coat to go on a trip to the shops. Staff also knocked on peoples doors and waited for a response before entering their rooms consistently throughout the inspection.

One friend of a person told us, "I used to take (the person) out in his wheelchair. They (staff) have now given him a better one after reviewing it. They also suggested we go out in the car on trips." We could see that staff were actively engaged in supporting people in living their lives independently and with dignity.

In one care plan we saw clear details where independence could be promoted by staff. It detailed what the people could do for themselves and what staff should do to encourage this. For example one care plan states, "I can put on my own (clothes) if they are held out in front of me facing the correct way." We also observed people being dressed and prepared for trips with their families and friends throughout the day.

Good

Is the service responsive?

Our findings

Relatives told us that there were a good range of activities for the people to take part in each week. One relative told us, "They provide a lot of activities at the home." Another said, "There are lots of activities available. He (their family member) doesn't like joining in very much, they always encourage him to join in though." We saw the activities schedule which included companion cycling in the park, community walks, quiz's, scrabble, dominoes, connect 4 and trips to the café. We also observed staff playing games with people in the lounge throughout the day.

People received personalised care that was responsive to their needs. One staff member told us, "The keyworker session involves people in their care plans, they and their families have an input into them, and it's designed for them." We saw that care plans were detailed and person centred. They were written in a positive way, focussing on what the people could do for themselves, and where staff would need to support them. The care plans had been reviewed regularly with the last review taking place within 15 days of our inspection.

The care plans comprehensively covered people' support needs. Areas covered included vision, hearing, continence, toileting, skin integrity, pain management, and communication. The communication section gave good guidance for staff on key words the people may use and their meaning, for example for one person a term they used meant that the person felt tired or dizzy. We observed staff using several different methods of communication throughout the day which were tailored to different people's needs. For example, some people used a tablet computer to point at pictures of what they wanted or how they made a decision whilst others used thumbs up or thumbs down. In each case, the staff were receptive and proactive in encouraging the people to communicate and be involved in their own care.

There had been eight complaints since January 2017. In each case we could see action had been taken to address the concern. For example one relative was worried that their family member could not see out the window now they were cared for in bed. This was resolved by turning the bed around and moving the television. Another relative told us they had complained about a fold up chair being a danger to their family member in their room. The staff swapped the chair for a safer option within minutes of this being brought to their attention. One relative told us, "They contact me regularly. They keep informed."

There were plans in place for person centred end of life care. We saw one care plan which had a detailed booklet specifying the steps, contacts and relevant facts to one people and their preferred arrangements. The information included their religious beliefs and the relative who would need to be contacted so that arrangements could be made.

Requires Improvement

Is the service well-led?

Our findings

We found that there was no overview or system of recording and monitoring all of the incidents and accidents. Having an over view would enable the service to identify patterns or trends in incidents such as falls. However, it was clear from the individual incidents and accidents records that staff were maintaining the safety of the people by contacting their GP (general practitioner) or the hospital when injuries occurred.

The provider had not met all of the requirements of their registration. When certain events occur, such as safeguarding, injuries or deaths, the provider is required to notify CQC of these. We found that in some cases notifications had not been submitted to CQC when required. For example, there had been over 20 notifiable incidents/accidents in the last five months and none of these had been referred to CQC. Notifications are important to give CQC oversight as a regulator. Since this inspection the registered manager has started notifying CQC and safeguarding of incidents.

The failure to notify CQC of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a clear vision and credible strategy to achieve good outcomes for people. One staff member told us, "It's about rehabilitating or maintaining health with the people that have Huntingtons. We aim to get them out and living independently where we can, but this is also a home for life as long as we can meet their needs. Since I have started working here we have had four people move on to more independent living." One relative said, "His (their family members) walking has really come along. There is great rehabilitative support here." We observed people being taken to the gym by staff and using different machines or movements to assist with their mobility. Since the last inspection in 2016, five people had been discharged to either live with their families or independently with partners. This was a positive result of the rehabilitation at this service.

Staff were positive about the manager and the culture of working at this service. One staff member told us, "We have regular team meetings so if there is anything we can think of to change we can talk about it….I have a good rapport with the manager. She's good at listening and gives the pros and cons of why we can or can't do something." We saw minutes of meetings held with staff where they discussed ideas about the home relating to people's care, staffing and training.

People, the public and staff were actively engaged and involved in the service. During keyworker sessions people feedback on specific aspects of their care and support were asked. For example in one keyworker review a person was asked if they felt their complaints or comments were taken seriously or if the manager had time for everyone. They had communicated 'yes' to each question. The service had sent out surveys to relatives and people but the responses had been sent back to the provider and not yet analysed at the time of inspection.

The service had some measures in place to learn and improve. Staff responded to a questionnaire sent out in 2017. The results had been compiled into a report and an action plan put into place to address specific

comments. For example one of the suggestions around training was that staff felt they needed more training around Huntington's. This was arranged and a specialist nurse gave the training to staff in August 2017. One comment from staff in relation to suggestions made was, "We are listened to and we discuss as to whether the suggestion is achievable or not."

Quality assurance checks were completed around the home, to spot where areas of improvement may be needed. Health and safety checks were completed on a weekly and monthly basis. Areas covered included cleanliness and infection control, fire safety checks, including reviewing the last evacuations, and condition of the environment. Where areas for improvement had been identified these had been addressed. Two issues highlighted in the last audit included a broken chair and non working lights. These were seen to have been resolved at the time of our inspection.

We saw the service worked effectively with other agencies such as health care professionals and social care professionals. For example, occupational therapists regularly attended people in the gym to assist them in rehabilitating their mobility.

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 18 Registration Regulations 2009 Notifications of other incidents The failure to notify CQC of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009