Roborough House Ltd

Roborough House

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?	Good

Summary of findings

Overall summary

This inspection took place on 29 January and 1 February 2018. Roborough House is a 'care home' trading as Roborough House Ltd which is owned by CareTech. CareTech community services is a large national organisation providing a wide range of social care services for people, with a head office in Hertfordshire. 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.

Roborough House is registered to provide accommodation for 51 people who require nursing and personal care. The service currently has a capacity of 44 whilst accommodation is being re-furbished. At the time of the inspection, 40 people were living at Roborough House.

The service is a specialist unit and provides nursing and personal care for people with complex needs such as mental health disorders including Schizophrenia, progressive diseases such as Huntington's and Motor Neurone, acquired brain injury and Korsakoff's disease (brain injury due to alcohol) and learning disability. The registered manager also told us how links had been made with a local stroke specialist unit and a new rehabilitation partnership was planned, to offer further placements for people affected by strokes who required more long term rehabilitation outside a hospital environment. The premises is a large, spacious building with accommodation and communal spaces over three floors. There are three units, Maristow 17 people, Bickham 10 people and Lopez 13 people, accessed using electronic key pads, which those people, who are able, have access to. The registered manager, who was newly employed at the time of the last inspection in December 2016, said they were pleased to have the opportunity to turn the home around since the last inspection and they enjoyed the challenge. They welcomed our inspection to show us what improvements had been made.

During the last inspection in December 2016 we found the areas of safe, effective and well led required improvement with a breach of Regulation 11, Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time people's capacity was not always assessed and best interest processes were not always followed in line with the principles of the Mental Capacity Act. In December 2016, aspects of the service were not always safe. Infection control practices were not always safe and some areas of the service were visibly dirty. People were not always kept safe within the environment, due to potentially hazardous items not being securely stored. Some areas of people's healthcare needs were not always effectively monitored. At that time, audits were carried out, but the actions taken were not always documented and views on staff morale were mixed.

During this inspection we found that all regulations had been met. We found Roborough House to be providing a good service, especially in meeting people's very individual and complex needs, often on a one to one basis. A visiting psychiatric nurse told us they had no concerns about the complex support provided to people they visited at Roborough House. They told us, "I think the staff do a good job, we work together as a team. They are accommodating to suggestions and have their finger on the pulse, nothing is too much

trouble." The premises required extensive re-furbishment to promote a more homely, less institutional feel to the large spaces but this was confirmed by the operations and registered manager as having been approved by the provider and scheduled for March 2018 in phases. The premises were therefore slightly shabby, however areas were clean and hygienic. We discussed the décor with the registered manager who assured us they were in the process of promoting a more homely feel, removing institutionalised notices, improving signage and creating individual door plaques for people's rooms as on-going work rather than waiting for the completion of the re-furbishment. Recruitment was an on-going issue due to the specialist, complex nature of the work and the rural location. However, consistent, regular agency staff were used to ensure there were sufficient staff to meet people's needs and there was a clear, information sharing process in place. The recruitment effort was on-going and was reviewed regularly, for example incentives had been introduced.

There was a registered manager and deputy manager employed at the home who were clearly passionate about providing a high quality, individualised service. 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 and associated Regulations about how the service is run.

People were supported by kind, caring and compassionate staff who, along with the management and administration team knew people very well. This was important as people often displayed complex behavioural needs which relied on personalised care and understanding to minimise the risk of distress or behaviour which could be challenging for staff. This understanding of people's needs enhanced people's quality of life and wellbeing and we saw examples of how people's quality of life had benefitted since living at Roborough House.

Staff as a whole, supported by the four activities co-ordinators, were passionate about providing people with support that was based on their individual needs, goals and aspirations. They were pro-active in ensuring care was based on people's preferences and interests, seeking out activities in the wider community and helping people live a fulfilled life, individually and less often, in groups. As people often required one to one input and support due to their individual needs or funding arrangements, to go out or engage in activities, the registered manager was carrying out an audit of activities provided to ensure that each individual had regular opportunities. By the second day of the inspection, two additional activity co-ordinator posts and increased hours had been approved by the provider to enable this and an audit commenced. Some people were able to go out independently and staff supported people to do this safely whilst respecting their choices.

Staff were happy working in the home and felt supported in their role. The service employed a mix of registered general nurses as well as registered mental health nurses. They told us they both learnt from each other and worked well as a team. They were clear about their individual roles and responsibilities and felt valued by the registered manager, deputy manager and the wider provider, senior management team. The registered manager said, "Staff came with me when I started, we hit the ground running and just got stuck in." There was a pro-active effort to encourage ideas from staff to further benefit the people in their care and maintain a strong, stable staff team with a shared goal. Staff mentioned difficulties with maintaining a stable staff team due to slow recruitment but felt management made efforts to ensure staffing levels were maintained, for example to cover absences with agency staff. We noted in one area there was a number of people who required assistance with eating and drinking. The meal times were fluid and enabled people to stagger meal times but if each person wished to eat at the same time this could be an issue (we did not see people waiting for support during our inspection), which care workers raised. We fed this back to the registered manager and by the second day of the inspection an additional care worker post had been

approved by the provider to act as a 'floater' across the units. We saw people receiving timely care in a person centred way depending on people's daily routines.

People were safe living at Roborough House. There were enough staff to meet people's care needs safely and also to provide individualised support in and out of the service. Some people received funded one to one care due to their individual needs to keep them and other people safe. Risks were identified and assessed, showing staff how to manage them effectively. Where there were risks to others, the registered manager had referred to relevant health professionals and safety measures were put in place.

There was a culture within the home of treating people with respect. Staff were busy but visible and listened to people and their relatives/friends, offered them choice and made them feel that they mattered. For example, the administrator and chef had both won awards within the company for 'excellence' and we saw they also showed they had good rapport with people living at Roborough House. Staff spent time with people to get to know them and their needs. This ensured that behaviours that could be challenging for staff and distressing for people were minimised. People and the staff knew each other well and these relationships were valued. We spoke to the registered manager about the accessible information standard. This ensures people's communication needs are identified and met. Care plans provided good information and the registered manager discussed plans to more formally include the standard in their assessments, hospital passports and information sharing within the wider staff team.

People's equality and diversity was respected and people were supported in the way they wanted to be. Care plans were person centred and held full details on how people's needs were to be met, taking into account people preferences and wishes. For example, some people liked to live with strict routines to help them remain well and staff knew and respected those. Information included people's previous history, including any cultural, religious and spiritual needs.

Staff had received appropriate training in line with nationally recognised qualifications and regular supervision to provide them with the necessary skills and knowledge to provide people with effective care. Not all staff had received specialist training in some conditions but we saw this had been identified and was already booked for the near future. It was not unusual for some people to gain independence during their time at the service to enable them to return to live in the community with support, or enable them to become more independent within the service. People received their medicines when they needed them. Timely action was taken by the staff when they were concerned about people's health.

People received a nutritious diet and enough to eat and drink to meet their individual needs. People were able to take meals when they wanted to, with meals put back for them and a flexible meal time. However, due to trying to promote a homely feel, a formal mid-morning coffee time and mid afternoon tea and cake time/round was not in place, with staff responsible for offering individuals drinks throughout the day. Whilst people were receiving enough to eat and drink, this did not enable people to enjoy or be guaranteed regular offerings depending on what staff were doing. Staff said they often spent time looking for biscuits or particular drinks. We discussed this with the registered manager as formal snack times would promote community and a sense of occasion, ensuring each person had consistent access to regular mid-morning drinks and biscuits and celebrate tea time. It would also ensure each person had pro-active access to snacks and engagement without having to ask whilst still enabling flexibility around a routine. This could also free up individual staff from making numerous drinks throughout the day by allocating the task to named staff, whilst still responding when people specifically asked. The registered manager agreed and was looking at ways to incorporate formal 'rounds' in a homely way, such as with a café feel.

There were effective systems in place to monitor the quality and safety of the care provided. People felt able

to raise any concerns and be confident they would be addressed. Where concerns were raised by people, relatives or through regular auditing we saw the home took them seriously and took appropriate actions to focus on learning and improvement for the benefit of the people using the service.

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.

Risks to people's safety had been assessed and actions taken to reduce the risks of them experiencing harm.

Systems were in place to protect people from the risk of abuse.

There were enough staff to meet people's needs in an individualised way and to keep them safe whilst enabling them to make informed choices.

People received their medicines when they needed them.

Is the service effective?

Good

The service was effective.

Staff and management had the knowledge and skills to provide people with care to meet their individual needs.

People's rights were protected by staff who understood their legal obligations including how to support people who could not consent to their own care and treatment.

People had a choice of appetising and nutritious food and drink and they received enough to meet their individual needs.

People were supported by the staff to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and compassionate and understood people's needs striving to improve people's quality of life.

People and their relatives where required, were involved in making decisions about their care.

People were actively encouraged to make choices about how

they lived their lives and the focus was on promoting independence and wellbeing.

People were treated with dignity and respect at all times.

Is the service responsive?

Good

The service was responsive.

Staff provided individualised care to people protecting their equality and diversity, which clearly had improved people's quality of life and wellbeing.

People's individual care needs and preferences had been assessed and were being met whilst encouraging new opportunities and promoting independence.

People could be confident complaints and concerns were taken seriously and dealt with appropriately to promote improvement.

End of life care was well managed with support from external health professionals.

Is the service well-led?

Good

The service was well-led.

There was an open, inclusive culture promoted within the home where people, relatives/friends and staff were listened to and felt that they mattered.

Management was pro-active in sourcing ideas from the staff team to further benefit the people in their care.

Good leadership was demonstrated and staff concerns were acknowledged, the management team were hands on, supportive and visible.

Quality assurance systems ensured people received a good quality service driven by responsive improvement.

Roborough House

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 29 January and 1 February 2018 and was unannounced on the first day. The inspection team consisted of one adult social care inspector, one expert by experience and a bank inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the last inspection, we requested that the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider in December 2016 and we did not request another for this inspection. We also reviewed information that we held about the service such as the on-going service improvement plan which showed what actions had been taken since the last inspection. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During the inspection, we spent time with 15 people living at Roborough House. We spoke to two visiting relatives, two visiting health professionals, the registered manager and operations manager. We spoke with the clinical nurse lead, a registered nurse, a bank nurse, six care staff, the occupational therapist, an activity co-ordinator, the administrator and a domestic as well as the chef, laundry person and maintenance person. Due to most people living with mental health disorders or cognitive disabilities, some people did not wish to or were unable to share their experiences of living at Roborough House directly. Two people were able to speak with us. Therefore, we spent time taking lunch and observing care and interactions with staff in the communal areas on both days.

The records we looked at included seven people's care records, people's medicine records and other records relating to people's care, four staff recruitment files and staff training records. We also looked at

maintenance records in respect of the premises and records relating to how the provider monitored the quality of the service such as audits and quality assurance surveys.

Good

Is the service safe?

Our findings

At the last inspection in December 2016 this area was rated as requires improvement. This was because not all aspects of the service were safe at this time. Infection control practices were not always safe and some areas were visibly dirty, hazardous items were not always securely stored. During this inspection in January 2018, these issues had been fully addressed.

All of the people we spent time with told us they felt safe living at Roborough House. People told us they felt safe in the care of the staff. Although some said they would prefer to not be in a home, they were happy to remain there and did feel safe and cared for. One person with complex mental health needs said, "Yes, I like it here" and went on to smile with staff who admired an item the person had recently bought. Staff enabled people to move safely around the building, whilst being vigilant noticing people's interactions with each other. They told us how nice it was that one person was out feeding the chickens, who had previously been very frail but was now independent.

The registered manager told us how the pre-assessments were very detailed, which we saw, and people were visited in the community or in hospital over time with management and clinical staff, to ensure Roborough House could meet their needs, bearing in mind the needs of current residents. For example, where people required particular equipment this was sourced prior to admission or key staff were introduced to people before they moved in. This was important as many people had particular preferences and routines and it was essential to understand their history to minimise behaviour which could be challenging for staff and distressing for people. There were few incidents and any were recorded and actions taken to minimise events for the future. The registered manager also ensured there were no admissions on a Friday and initial care plans were completed following policy in the first 72 hours.

There were systems in place to protect people from the risk of abuse and avoidable harm. Staff knew how to keep people safe. This included from the risk of abuse. There was a provider head of safeguarding who oversaw any safeguarding issues and shared learning. For example, sensory equipment was on order which could help some people remain calm. Staff knew the different types of abuse that could occur and told us they would not hesitate to report any concerns they had to senior staff. They added they would also report any concerns outside of the home if they felt this was appropriate. Staff and the registered manager understood the correct reporting procedures and we saw these had been followed when necessary using the local authority safeguarding process. For example, staff were vigilant in ensuring people's behaviours which could be challenging for staff and others, was minimal. This was because staff knew what people liked and what events could trigger behaviour which could be challenging or raise people's distress levels. For example, some people liked to always stay in their rooms with minimal input, staff respected this and we saw staff returning later if people were not ready to eat or wash when support was offered. Where people chose to spend a longer time in bed, this was also respected but staff knew how to interpret people's behaviour to enable them to find positive ways of encouragement or offer new opportunities. Some people moved to the home with aspects of self-neglect. This was clearly described in people's care plans and staff were discreet and gentle in promoting well-being at people's own pace. Some people had had dramatic transformations since their admission and looked well cared for and happy.

Risks to people's safety had been assessed and actions taken where necessary to mitigate these risks. This included risks in relation to falls, not eating and drinking, developing skin pressure damage and social isolation. There was clear information within people's care records providing staff with guidance on how to reduce these risks. Staff were clear that the least restrictive method was sought and regularly reviewed. For example, where people displayed aggressive behaviour responses, staff had identified this and referred to relevant health professionals. Two people had one to one support and this was given in a discreet, friendly way and regularly reviewed whilst keeping others safe. The registered manager told us how this behaviour had greatly reduced and people were increasingly able to enjoy the communal areas and interactions with others.

Staff told us the importance of making sure the environment was safe and clear of any obstacles when people were walking around the home. This was to protect them from the risk of falls and also to maximise independence. There were large open spaces which helped people's independence and protected their personal spaces. A falls audit and fall champion had reviewed falls and delivered falls prevention training. The registered manager felt falls had decreased, having actioned aspects such as checking people's footwear was correct.

Some areas were slightly too sparsely decorated and the registered manager had a plan to create more homely spaces and décor as part of the re-furbishment. They had discussed equality and diversity issues such as using dementia friendly colours, flooring and signage to aid people with cognitive needs remain more independent. By the second day of our inspection new chairs and perching stools had been ordered and notice boards were being audited to ensure information was for people living at the home, not staff. The service also offered student occupational therapist placements who would be looking at improving the home brochure, displaying photos and producing a welcome DVD for people and families in the future. Nursing and mental health student preceptorship and university student placements were also being planned. Some students had already had placements and the registered manager said, "They love it here, we have had good feedback."

In respect of the premises, we saw that fire doors were kept closed and the emergency exits were well sign posted. They were clear of any obstacles so that people could easily reach the exits if needed. Testing of the fire equipment and the fire alarm system had taken place regularly. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire or when someone became unwell. They confirmed that they had received training within these areas. Each person had a personal protection evacuation plan (PEEP) giving staff and the fire brigade easy access to important information about individuals. The equipment that people used such as hoists including slings, had been regularly checked and serviced in line with the relevant regulations to make sure they were safe to use.

The premises, although slightly shabby, were clean and there were no visible dirty areas. Staff understood and had been trained in infection control. They used appropriate personal protection equipment such as gloves and aprons. One person was being supported in their room whilst they had an infection. This was well managed with good warning signage and accessible equipment to minimise cross contamination.

Any accidents or incidents that took place were recorded by the staff and investigated by the registered manager. We saw action had been taken when any accidents or incidents had occurred to prevent reoccurrence. Staff balanced 'real risk' and promoting people's independence well. Some people organised going into town, the pub or shopping independently which was risk assessed and encouraged.

There were sufficient numbers of suitably qualified staff to keep people safe and meet their needs. Registered nurses were supported by a shift leader and support workers. People told us there was enough

staff and if they rang their call bell someone would come in good time. A new call bell system was on order to reduce any intrusive noises for people. Staff told us there were opportunities for people to go out and staffing levels were adjusted to enable this on a daily basis. There was a minibus driver, a receptionist and two administrators as well as kitchen, maintenance and laundry staff, therefore each staff member had a defined role. Roborough House focussed on independence and enabling, this was enhanced by an in-house occupational therapist and physiotherapist. They worked with individuals to promote independence and safety. For example, one person had been unable to have a shower on admission and through therapist input was now able to enjoy showers for the first time.

We observed staff meeting people's requests for assistance consistently in a timely manner during the inspection but also pro-actively going and spending time with people, dancing, chatting, offering things to do and generally enjoying time together. The registered manager told us the number of staff required to work was calculated based on the needs of the people who lived in the home and was kept under regular review. For example, if one to one care was needed for someone at the end of their life, the service would provide it. If a person said they fancied going out for lunch then this would happen. One person wanted a safe place to live where they could go out every night and this is what they did. Although the service had heavy agency use, this was through a regular agency. One agency worker told us they chose to come and work at Roborough as it was not 'your typical care home' and they enjoyed working with the diverse needs. Agency staff were given handouts summarising people's needs as an aide memoire and shift leaders gathered their staff together for a 10 @ 10am and 8pm meeting each day to ensure all staff had a full handover.

Staff files showed that the relevant checks had taken place before a staff member commenced their employment. This included criminal record checks (DBS), gaps in employment and the service asked for at least two references including previous employer. This was to make sure potential new staff were safe to work with vulnerable people. The registered manager told us how people living at Roborough were also involved in the interview process which gave valuable insight into recruiting suitable staff. They said, "People ask hard hitting questions and say 'yes, I like that person'". Qualifications and the right to work in the UK checks were also completed. The registered manager said they made sure potential staff were aware of the complex needs, especially people's mental health needs when they applied as the work could be challenging but rewarding.

People received their medicines in a safe and caring way. Due to a recent incident the local authority quality team had been monitoring medication management. A specialist pharmacist had been supporting the home. They said they were happy that the home had in place sufficient safeguards that should protect people from medication errors. They recognised that the recent incident had occurred through an unlikely series of events that was unlikely to be repeated but that the home had put into place increased steps to prevent any reoccurrence. The specialist pharmacist said, "This is my fourth visit, each time practice has improved. The clinical lead appears knowledgeable. I am happy about the situation." There were systems and policies in place so that people could look after their own medicines if they wished, and it had been assessed as safe for them. There were clear records of medicines administered to people or not given for any reason. This helped to show that people received their medicines correctly in the way prescribed for them. There were separate charts with instructions for staff to record the use of creams or other external items. Medicated patches were recorded on separate charts detailing where they had been applied.

There were clear protocols for each person to guide staff when to offer or give medicines prescribed 'when required' to help make sure people received these medicines correctly, and when they were needed. Occasionally there were agreements in place for staff to give people their medicines covertly. This meant staff could disguise the medicines in food or drink to make sure the person took them. Safeguards were in

place to protect people and make sure this was in their best interest.

There was an audit trail of medicines received into the home and those sent for destruction. This helped to show how medicines were managed and handled in the home and medicines were stored safely. The medication fridge was kept locked and the temperature was monitored. Staff completed medicines checks and audits to help make sure that medicines were managed safely. We saw that any issues with medicines were picked up, reported and handled appropriately. We observed part of a medication round and this was carried out to common standards of good practice. For example, a person suffering from an infection had their medication done last to minimise opportunities for cross contamination.

Good

Is the service effective?

Our findings

At the last inspection in December 2016 this area was rated as requires improvement. This was because not all aspects of the service were effective at this time. Where people had lacked capacity to make certain decisions, assessments had not always been recorded to underpin these decisions and people's healthcare was not always effectively monitored. During this inspection in January 2018, these issues had been fully addressed.

People received effective care based on best practice from staff who had the knowledge and skills required to enable them to carry out their roles. People said they felt the staff were well trained. Some staff had not yet had training about relevant conditions such as Huntington's disease but staff and the management team were very knowledgeable about people's individual needs and further training was already booked for the near future. We found Roborough House to be providing a good service, especially in meeting people's very individual and complex needs, often on a one to one basis. A visiting psychiatric nurse told us they had no concerns about the complex support provided to people they visited at Roborough House. They told us, "I think the staff do a good job, we work together as a team. They are accommodating to suggestions and have their finger on the pulse, nothing is too much trouble." They said staff had good understanding, for example about regular injections required by some people to maintain their wellbeing. They said that people were able to do what they wanted to do because staff understood.

Staff felt they had received enough training to provide people with effective care. We observed the staff providing people with effective care and demonstrating good care practice throughout the inspection. Staff talked to us about the support and supervision they received. They said they felt well supported within the home and that there was always someone to go to for advice. A registered nurse said it was good to have the mix of general and mental health trained nurses and they, "Learnt something as a team every day." New staff received a comprehensive induction programme and training was a mix of face to face, e-learning and DVD. Staff had completed training in a number of different subjects such as safeguarding adults, dementia, medicine management, tissue viability, nutrition and hydration. They said they were given opportunities to attend training in areas that reflected the needs of the people who lived at Roborough House. For example, a community stoma nurse had delivered training in stoma care (a surgical opening for continence). Training was also shared with local mental health services such as epilepsy training with staff from the provider's independent hospital. The registered manager said this encouraged good communication and learning between acute and community services. Through the provider's other services the operations manager said they could access expertise such as neuro-rehabilitation, acquired brain injury and mental health training. Staff had achieved, or were working towards 'Care Certificates'. These are a set of recognised standards that health workers adhere to in their daily working life to provide safe, compassionate care.

People were supported to maintain good health and had access to healthcare services as necessary. People were referred in a timely way and saw healthcare professionals such as their GP, dentist, optician or chiropodist when they needed. If people chose to access health care appointments independently this was arranged. For example, some people visited their own GP surgery. Staff had developed good relationships with community specialists. The healthcare professionals we spoke with told us the staff were very

knowledgeable and always referred people to them in a timely way if they had any concerns about their health needs. We saw staff greet professionals and quickly access records and information to update them. For example, people who developed skin damage were referred to the local tissue viability nurse. Staff had sourced appropriate specialist beds and equipment to minimise pressure damage. A health professional told us how a person's wound from surgery had healed well with cohesive health team involvement.

The service employed a part time physiotherapist as well as a part time occupational therapist. Anyone with needs could be referred to them. There was a physiotherapy and occupational therapy room with equipment and people receiving therapy had clear direction and goals. There was new stroke pathway training for staff being overseen by the occupational therapist. The registered manager said it was a big boost as they had been approved to pilot a new stroke rehabilitation scheme in care homes. This would support people to be discharged from hospital following a stroke, who were not yet ready to go home. Staff referred and asked questions using the OT communication book to benefit people. For example, staff wrote if they noticed someone's mattress was not suitable or equipment was required such as a higher shower chair. One room had a specially designed automatic door for disabled access. These staff also shared good practice with staff such as reminders that a wheelchair was only for transport, not longer periods.

Team meetings were held regularly. Staff training needs were on each agenda and there was opportunity for staff to make suggestions and have input. For example, all heads of department had access to the service improvement plan and were able to update any actions taken as a 'live' document. The provider director visited and the staff team were able to discuss any issues. There was a multidisciplinary team meeting every week where people's individual needs were discussed. The registered manager said, "It always comes back to the person."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA).The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff clearly understood the importance of seeking people's consent and offering them choice about the care they received. Where people lacked capacity to make some decisions, the staff were clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests.

They gave us clear examples and records showed how they supported people to make decisions. We observed staff asking for people's consent throughout the inspection. For example, showing simple choices of menu, clothes and drinks and understanding why people made the choices they did. Records showed that people's ability to consent to certain decisions had been assessed and best interest decisions made. These had involved the relevant individuals such as the person's family or a healthcare professional. There was clear information within these records to give staff guidance on how they needed to support people to make a number of different decisions about their daily lives.

People received support with eating and drinking and to maintain a balanced diet. People we spoke with and visiting relatives told us the food was of a good quality. People were offered two choices of main meal and hot and cold desserts. The chef was very involved with people and each plate was individually plated up in a way that people liked and would encourage them to eat. A list of likes and dislikes was completed on a person's admission. There was also a list of people's dietary requirements, documenting food consistencies

required. The descriptions were complicated and did not reflect speech and language terminology so the chef was streamlining this to ensure staff had clear information in all dining areas about people's correct diets. They were also ensuring any meals put back for later were clearly labelled with the person's full name and diet type to avoid confusion and risk.

Food in fridges were covered and dated. There was an adequate stock of dried foods. Meals were cooked freshly in the kitchen and transferred to wherever people wanted to eat. There was a large dining room on the ground floor by the kitchen hatch as well as smaller kitchen dining areas. People enjoyed eating at the table or by the TV or in their rooms and the timings were very flexible, meaning people could go about their day as they liked.

We took lunch with people in three areas. Meal time was a social and enjoyable occasion for those who liked company. People were encouraged to use the dining rooms but could eat wherever they pleased. Meals were served at laid tables with condiments available and a choice of fruit juices. Tea and coffee was offered after their meal but people could also help themselves from a hot drinks area anytime. We noted in one area there was a number of people who required assistance with eating and drinking. The meal times were fluid and enabled people to stagger meal times but if each person wished to eat at the same time this could be an issue (we did not see people waiting for support during our inspection), which care workers raised. We fed this back to the registered manager and by the second day of the inspection an additional care worker post had been approved by the provider to act as a 'floater' across the units. We saw people receiving timely care in a person centred way depending on people's daily routines.

However, due to trying to promote a homely feel, a formal mid-morning coffee time and mid afternoon tea and cake time/round was not in place, with staff responsible for offering individuals drinks throughout the day. Whilst people were receiving enough to eat and drink, this did not enable people to enjoy or be guaranteed regular offerings depending on what staff were doing. Staff said they often spent time looking for biscuits or particular drinks. We discussed this with the registered manager as formal snack times would promote community and a sense of occasion, ensuring each person had consistent access to regular mid-morning drinks and biscuits and celebrate tea time. It would also ensure each person had pro-active access to snacks and engagement without having to ask whilst still enabling flexibility around a routine. This could also free up individual staff from making numerous drinks throughout the day by allocating the task to named staff, whilst still responding when people specifically asked. The registered manager agreed and was looking at ways to incorporate formal 'rounds' in a homely way, such as with a café feel. Some people had negative relationships with food so any risks were also being taken into account.

Support workers were aware of the importance of good nutrition and hydration and were observed reporting any concerns to the shift leader. This information was recorded and analysed to see if the care being provided was effective. Where changes were required, advice was sought from an appropriate healthcare professional such as the GP, dietician, speech and language therapist or diabetic specialist nurse. The records showed that any suggestions made by these professionals were followed by the staff. For example, some people at risk of losing weight were having their food fortified with extra calories.

Good

Is the service caring?

Our findings

There was a culture within the home of treating people with respect. Staff were busy but visible and listened to people and their relatives/friends, offered them choice and made them feel that they mattered. For example, the administrator and chef had both won awards within the company for 'excellence' and we saw they also showed they had good rapport with people living at Roborough House. Staff spent time with people to get to know them and their needs and this had ensured that behaviours that could be challenging for staff and distressing for people, were minimised. People and the staff knew each other well and these relationships were valued, including people's relationships with each other. We spoke to the registered manager about the accessible information standard. This ensures people's communication needs are identified and met. Care plans provided good information and the registered manager discussed plans to more formally include the standard in their assessment, hospital passports and information sharing within the wider staff team.

People's equality and diversity was respected and people were supported in the way they wanted to be. Care plans were person centred and held full details on how people's needs were to be met, taking into account people preferences and wishes. This included the staff names who people particularly related to and could further assist if a person became distressed or anxious. For example, some people liked to live with strict routines to help them remain well and staff knew and respected those. One person was anxious near the medication round so staff had stored medicines safely in their room and a staff member was allocated to ensure they were given at the precise time. Another person became anxious if people gave eye contact and staff knew to enable them to have an 'escape' route and not overcrowd. Another person's medication had been changed to a time that suited them with GP input as they liked to get up very early. Information included people's previous history, including any cultural, religious and spiritual needs.

We saw good caring practice. Staff continuing to monitor and respond to people whilst talking to us, for example. Staff spoke kindly with people, including one person who was using inappropriate language. One member of staff spoke with passion about how good the care in the home was. They said "Staff take on a lot, of course, for example one person needed to be very closely monitored when they came here due to aggression. Now they are independent." The registered manager added, "They are like a different person in a good way."

People and visiting relatives told us the staff were caring, compassionate, attentive and dedicated in their approach. They felt welcome. Relatives appreciated the availability of a hot drinks machine and found it a nice touch. We saw staff in all roles spending meaningful time with people and people living at the home and staff had built up good relationships that mattered. Meeting with friends and family was important and as well as taking people to visit family, staff enabled people to use the computer. One person liked to look for people they used to know and these details were included in people's care plans.

Staff knew which people got on with others and those relationships that could make people anxious or initiate behaviour which could be challenging for others. For example, they took care to offer trips out with people who got on with each other.

The continuous training and development staff received had embedded a culture within the home that placed people at the heart of all they did. During our conversations with staff, they demonstrated they cared for the people they supported. Staff showed us how they promoted real independence for people, enabling them to maintain their wellbeing, whilst encouraging self-care and offering new opportunities. Staff assisted people to be as independent as they could and it was not unusual for some people to become so independent that they eventually were able to go home to the community.

We observed throughout the day that people could make decisions about how they wanted to be cared for. This included areas such as making choices about where they wanted to spend their time within the home, where they ate and what they wanted to eat. People were actively involved in making decisions about their care and in their care planning. For example, one person felt they would like bed rails to feel more secure in the night and this was arranged following a safety assessment. Relatives told us they were encouraged to visit their family member regularly and to be involved in their care. They said they were always made to feel welcome and that the staff kept them fully informed about their relatives health and wellbeing which was very important to them.

Residents and relatives meetings, took place to obtain peoples' and relatives' views on the care provided. These provided another forum for people to express how they wanted to be cared for. Some people liked to be involved whilst many people liked to keep themselves to themselves and that was ok.

We observed the staff engaging with people in a polite manner and respecting their privacy. People were addressed by the staff using their preferred names and the staff knocked on people's doors before entering into their room. People were surrounded by items within their rooms that were important and meaningful to them and the activities team were working with people to make picture boards for their rooms showing what they liked and to stimulate conversations. Some people made decisions about how they spent their day that were unusual. Staff respected them and we saw staff waiting patiently for one person to indicate they could enter their room. When personal care was being given, the staff made sure that the doors to people's rooms remained closed or prompted people to remember to close their doors. One person with a room off a communal area liked their door wide open and that was respected.

Good

Is the service responsive?

Our findings

At the last inspection in December 2016 we found the domain of 'responsive' required improvement. At the time, people's feedback was mixed about how they were supported to interact, avoid social isolation and pursue their individual interests and hobbies, and further improvement was needed in this area at that time.

The service was responsive and the focus for people living at the home was person centred and ensuring people felt they mattered. Staff had creative ways to support people to live as full a life as possible, mainly through one to one support due to people's mental health needs. The arrangements for social activities, were flexible and often innovative. There was a wide range of activities and events across the units which were accessible for people, their relatives and staff throughout the home. This promoted an inclusive community feel and people clearly enjoyed going out. Activity records were individualised. One person had been to a garden centre for ice cream, collected eggs and cared for the chickens and been out for lunch with others they enjoyed spending time with.

At Roborough House it was important to involve friends and families to ensure staff were able to build a picture of people's likes, dislikes and interests when people were unable to express these themselves due to living with cognitive issues. Records were very person centred including a 'This is Me' document. This was a working document that was added to over time and ensured people were seen as individuals. One relative commented that they really felt the service cared for their loved one on a personal level not 'just another patient'. Staff were mindful about how people moving to the home would affect other people. For example, if someone liked low noise and their own space this was taken into account. One person liked dark lighting and staff respected this, asking if a low light was ok during any tasks and leaving the room as the person liked it.

People could access all areas freely and those who could had access to the electronic key fobs. Staff were vigilant to ensure people were not isolated as many people chose to spend their day in their rooms. Activity staff did one to one sessions with people doing things they liked. This ensured people, especially those living with mental health needs, did not become bored therefore risking the chance of behaviour which could be challenging to staff and distressing for people.

There was a good activity team, an activity co-ordinator and now three assistants. All staff engaged with people, we saw the chef chat to one person about football and initiate a conversation. Because staff knew people and their families so well they were able to provide engagement and leisure opportunities which suited people's needs and preferences as well as promoting new opportunities. For example, when people went out independently they were welcomed home and asked about their trip out.

Thought was given to reviewing how the activities had gone for individuals and whether they were receiving enough engagement and stimulation, an audit was on-going to ensure each person had their needs met. Activities that week included, smoothie making, craft, a visit from the donkey sanctuary, weekly shopping, a cake and tea afternoon and walks and pub visits. One person had enjoyed visiting the nearby moors and

staff were looking towards enabling them to do this more often, possibly independently. One person was enabled to visit their family some miles away and staff took and collected them. There were links with the community. People were enabled to do things they had done before such as go to their local pub, play pool or attend a gym, day centre or church. A local theatre company were visiting during our inspection to stage a performance.

We observed staff being responsive to people's individual needs throughout the inspection. This included responding to them when they requested support with personal care, a drink or if they wanted to go back to their room after lunch. People's care records, with family involvement as necessary, had been recently reviewed and the information within them was accurate and up to date. The staff, including activity staff, had easy access to people's care records so they understood the care that people required. They confirmed that people's needs were reviewed each day during handover meetings and the head of department meetings between the staff to make sure they were aware of any changes that were required to their care.

People were supported by the staff as they approached the end of their life. People who were approaching end of life had their care supervised by registered nurses and an end of life champion who had completed training with a local hospice. This included advance care planning, best interest decision making, symptom control and supporting the families.

When the focus of care changed to making people comfortable, the registered nurse, GP and family compiled an end of life care plan. This included regular repositioning and oral hygiene. 'Just in Case' medication and syringe drivers were made available to ensure people had a pain free and comfortable death. Staff accessed information from the local hospice and kept up to date with end of life care developments. One person had been receiving end of life care but had improved greatly continuing to live a meaningful life. A compliment had been received by the service saying, "The care given to my wife at end of life has restored my faith in human nature. Staff here are wonderful, I stayed in a put you up bed for three nights and it was no trouble."

People and their relatives did not have any complaints about the care being provided although some people expressed they would rather not be in a care home but had needed support. They knew about the complaints policy and open door office. People and relatives told us they felt comfortable to raise a complaint if they needed to and that they felt confident these would be listened to and dealt with. We were therefore satisfied that people's concerns and complaints were dealt with appropriately in a timely way that promoted learning and improvement. For example, the complaints file stated from one person, "I have not seen [person's name] so well and engaged for many years, thank you." Another relative could not thank staff enough for the great care which was 'second to none'. They said staff gave people great care and attention and they were working hard. A complaint had been well managed with the city council and another complainant had been facilitated to discuss issues with their own social worker. One outcome of a complaint was for the service to review their agency induction, introducing an induction pack for agency staff.

Good

Is the service well-led?

Our findings

At the last inspection in December 2016 this area was rated as requires improvement. This was because not all aspects of the service were well led at this time. Audits were carried out but actions taken were not always documented and some staff felt unsupported. During this inspection in January 2018, these issues had been fully addressed.

An open and learning culture based on treating people as individuals had been embedded within the home. The statement of purpose stating the provider aims and objectives said they worked hard to deliver a high quality support in a truly person centred way with independence at its core. We saw this in practice for people with diverse and complex needs. Staff felt supported by the new registered manager and had regular access to the provider management team and new managing director. One staff member said, "[Registered manager's name] appears to be on the ball." For example, the weekly multidisciplinary team meeting in-house ensured all departments met to discuss how they could meet people's changing needs. This included the kitchen and maintenance departments, and helped staff work as a team and learn from each other, promoting person centred care and physiotherapy advice, for example. Each head of department were able to access the 'live' service improvement plan which clearly showed issues needing action and when these were completed. Areas we raised had already been identified such as re-furbishment, specialist training and staffing. The registered manager said they were big advocates of 'growing their own staff' and there was leadership training available with head of department support. There were additional workshops on topics such as the 'This is Me' document and the visiting aromatherapist was working on a project with the activity department. Shift leaders were being 'upskilled' to enable them to undertake additional tasks such as clinical observations, blood taking and wound dressings. Staff had protected time to complete e-learning, read policies and attend meetings.

Good management and leadership was demonstrated. People told us they felt the home was well-led and they could raise issues and concerns without hesitation with staff who were open and approachable. People said they felt listened to by the staff and the registered manager. This was reflected by relatives. There were many leadership meetings and a regular compliance visit by the provider compliance team aligned to CQC key lines of enquiry. For example, agency files had been audited to ensure each staff member was trained appropriately. Accident and incidents were monitored electronically, which highlighted health and safety issues and reporting accidents to the appropriate authorities and equipment checks. The registered manager completed a monthly report of wellbeing, falls, incidents, audits and staffing, for example that was sent to head office. Learning was shared such as recent fire information about the use of paraffin creams.

There were effective systems in place to monitor all aspects of the care and treatment people received. Audits had been conducted regularly by the service and there was continual oversight by the provider head office. These had assessed areas such as the cleanliness and safety of the environment, the accuracy of people's care records, falls prevention, people's nutritional needs and the management of people's medicines. The provider also conducted regular quality performance and compliance reviews to make sure the home provided people with the care they required. These followed CQC standards and regulations including involvement and treatment, meeting nutritional needs and cleanliness.

Incidents and accidents were analysed each month so that action could be taken to reduce the risk of people experiencing harm. For example, some people who were at a high risk of falling had equipment to minimise future risk of falls. The registered manager looked for any patterns, locations each month to minimise risk overall. Any concerns or complaints that had been received were used as an opportunity for learning. This demonstrated that the provider and staff responded to people's feedback to improve the quality of the care they received to enhance their wellbeing.

The staff praised the culture and support they received in the home. They said they felt valued whatever their role at the home. Staff worked well as a team across different staff roles. We observed this throughout the inspection. The staff all worked well together for the benefit of people in their care and treated people and each other with dignity and respect. There was lots of laughter between the staff and they were seen being supportive to each other. There were opportunities for staff to develop within the home and use their skills to enhance people's experiences living there The chef and administrator had just won a provider excellence award. Staff told us the service was well run and the management good and supportive. Management was receptive to ideas about where staff could be better deployed and had responded to our comments about meal time support and activity assistant provision, increasing both immediately.

The registered manager kept up to date with good practice and the home was a member of various provider groups where information was discussed and shared. The management support team attended a variety of conferences and seminars where learning was then shared with the staff team throughout the company exchanging ideas and encouraging focal points. For example, about mental health and neuro-rehabilitation.

When we discussed people's needs with the registered manager they knew details about everybody living at the home and about staff and their needs. For example, before lunch we were told about the needs of the people we would be sharing lunch with. We were then able to have meaningful conversations with them despite them living with mental health needs. Therefore, we were able to understand their repetitive topics and anxieties.

The registered manager's office was not close to the main door but tucked away but there was a manned reception and two administrators and people and relatives could access the manager when they wanted to. The administrator we met also knew about people's needs and personalities.

Staff felt management within the home and the registered manager and deputy manager were open, honest and approachable. They felt listened to and were able to raise any concerns they had without hesitation. In the past, any concerns they had raised had been taken seriously and dealt with quickly to ensure that people received high quality care. There were regular staff meetings as a whole and in units where staff could air their views.

Good relationships with the community and local healthcare professionals had been established. These good relationships enabled people to receive timely care to help enhance their quality of life and look at ways for continual improvement. For example, there was a close relationship with the hospital discharge team, mental health community team, hospice and specialists as well as other provider partners in CareTech services.

The registered manager had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal responsibilities. Where concerns had been raised with them they had sought advice and shared information with the CQC and the commissioners of the service.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.