United Care limited

The Rubens

Inspection report

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19 September 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 18 and 19 September 2017.

The Rubens provides accommodation and personal care for up to 26 older people, the majority of whom were living with dementia. On the days of our inspection the home was fully occupied.

The home had a registered manager. However, they were not present on the days of the inspection. The deputy and the area manager assisted with the facilitation of the inspection. 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.

Medicines were not stored appropriately and there was a potential risk of people obtaining medicines that had not been prescribed for them.

The provider had not maintained fire safety standards as identified by the fire safety officer in January 2017. This meant there remained a risk of people not being able to safely evacuate the home in the event of an emergency.

People were at risk of not receiving a service specific to their needs or preference because they were not involved in planning their care.

People's consent for care and treatment was not obtained, so they were at risk of not receiving a service the way they liked.

The provider offered a service for people living with dementia. However, the environment was unsuitable and added to people's confusion and also had an impact on their independence.

The provider had systems in place to monitor the quality of the service provided to people. However, these were ineffective in highlighting some of the short falls we found.

Sufficient staffing levels were provided to meet people's assessed needs and the provider's recruitment procedure ensured safety checks were carried out before people started to work at the home.

People and their relatives felt confident to share their concerns with the registered manager or staff which would be listened to and acted on.

Staff were caring, kind and attentive to people's needs and provided support in a way that promoted their privacy and dignity.

Systems were in place to enable people and their relatives to tell the provider about their experiences of using the service. Relatives and staff were aware of who was running the home and staff felt supported by the registered manager to carry out their role.

People were cared for by skilled staff who were supported in their role by the management team.

People were supported by staff to eat and drink sufficient amounts to promote their health. People were assisted by staff to access relevant healthcare services when needed.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not stored appropriately to reduce the risk of unauthorised people accessing them. People remained at risk because the provider had not maintained fire safety standards as identified by the fire safety officer.

People were protected from the risk of potential abuse because staff knew how to safeguard them. People were cared for by sufficient numbers of staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

People's consent for care and treatment was not obtained but they were satisfied with the service they received. People were cared for by skilled staff who were supported in their role by the registered manager. People were supported to eat and drink sufficient amounts to promote their health. People had access to relevant healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not involved in planning their care so were at risk of not receiving care and support the way they liked. However, they were supported by staff who were kind, caring and attentive to their needs. People's right to privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The environment was unsuitable for people living with dementia and this added to their confusion. People were supported by staff to pursue social activities that reflected their interests. People and their relatives felt confident to share their concerns

with the registered manager or the staff and could be assured they would be listened to and their concerns acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's quality assurance systems did not highlight the shortfalls we found. Systems were in place to enable people to tell the provider about their experience of using the service. Relatives and staff were aware of who was running the home and staff felt well supported by the registered manager to carry out their role.

The Rubens

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 18 and 19 September 2017 and was unannounced. The inspection team comprised of one inspector.

As part of our inspection we spoke with the local authority about information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

At the inspection visit we spoke with five people who used the service, eight visitors, three care staff, a visiting healthcare professional, the deputy and the area manager. We looked at two care records, medication administration records and records relating to quality audits.

Requires Improvement

Is the service safe?

Our findings

People who used the service were unable to tell us about the support they received to take their prescribed medicines. We observed that when the medicine cupboard was locked there was an opening beneath that compromised the safe storage of medicines. We shared these concerns with the area manager who assured us action would be taken to address this. We looked at a random selection of medication administration records. These had been signed accordingly to show people had been given their medicines as directed by the prescriber. We observed the administration of people's medicines which was carried out safely. The staff member explained to people what the medicine was for and encouraged them to have a drink whilst taking their medication.

The area manager said all staff who managed medicines had received medicine training and the staff we spoke with confirmed this. Access to this training ensured staff had the skills to support people with their medicines. The deputy manager said competency assessments were carried out and staff also confirmed this. Competency assessments reviews medicine practices to ensure people receive their medicines safely. One relative told us how impressed they were that due to staff's approach in managing their relative's behaviour, with the support from the GP they had reduced the use of prescribed anti-psychotic medicines used to manage the person's behaviour.

We were informed by a fire safety officer that in January 2017, the provider was required to remove clutter that had obstructed a fire escape route. The fire safety officer confirmed that at their next visit in May 2017, the provider had taken action to address this. However, on the day of our inspection visit we observed this area was cluttered which, could compromise the evacuation process in the event of an emergency. We spoke with a staff member who told us about the importance to remove clutter to prevent trips and falls. However, they informed us they did not have anywhere else to store equipment that cluttered the corridor. The deputy manager said, "As long as wheelchairs are stored neatly against the wall, they won't cause a problem." However, we observed that wheelchairs and other equipment were not stored neatly. After our inspection visit we shared these concerns with the local fire safety department.

People were protected from the risk of potential harm. Staff had a good understanding about how to reduce the risk to people and told us they had access to risk assessments. They told us these assessments helped them to support people safely. For example, one risk assessment showed the person required the use of a walking stick to assist with their mobility safely. The staff we spoke with were aware of this. We also observed the person using the appropriate equipment as identified in their risk assessment. A care record showed the person required support with their meals to ensure they ate sufficient amounts and to reduce the risk of choking. We observed a staff member assist this person with their meal. This showed the provider had taken measures to ensure staff were aware of how to reduce the risk of harm to the individual.

We looked to see how the provider managed accidents. The deputy manager said all accidents were recorded and we saw evidence of this. This enabled the provider to monitor for trends and where necessary, to take action to avoid a reoccurrence. For example, one person had sustained two falls in a short period.

The person was seen by their GP who identified the reason for this and appropriate treatment was provided. One relative said, "The staff contacted me about my relative having a fall and they told me what action they would take." This demonstrated that accidents and incidents were well managed to reduce the risk of this happening again.

People were protected from the risk of potential abuse because staff were aware of their responsibility of safeguarding them. One person said, "I feel safe here as I know there is always someone around." A relative said, "I feel that [person] is a 100% safe here." Another relative said, "I know [person] is safe here, they are so much happier here. They are always smiling and look well." All the staff members we spoke with told us they would share any information of abuse with the registered manager. They were also aware of other external agencies they could share their concerns with to protect people. Discussions with the deputy manager confirmed they were aware of when to share concerns with the local authority to protect people from the risk of further harm. The provider had not had any recent safeguarding concerns.

People were supported by sufficient numbers of staff. All the staff we spoke with said there were always enough staff on duty to meet people's needs. We observed that staff were always nearby to support people when needed.

People could be confident staff were suitable to work in the home. The deputy manager said all staff have a Disclosure Barring Service [DBS] check before they start to work in the home and staff confirmed this. DBS helps the provider to make safe recruitment decisions. The provider's recruitment process also included the request for references. This showed that the provider's recruitment process was safe.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Discussions with staff and the care records we looked at identified that people were not involved in decisions about their care and treatment. Two people were identified as having capacity to make a decision. However, they had not been involved in decisions about their care. Staff were unable to explain the reason for this. However, one of these people confirmed they were satisfied with care and support they had received. The other person was unavailable to tell us about their experience of using the service.

Further discussions with staff confirmed their awareness of the principles of the MCA and told us how they used this in their work practice. For example, one staff member said, "I always support and encourage people to make their own decision. I show them things to enable them to point at what they want." We observed that staff took their time to explain things at people's pace and allowed them to make their own decision. However, these practices were not consistent to ensure everyone was able to make their own decision about their care and treatment.

The deputy manager said people had access to an advocate and we saw evidence of this in two people's care files. An Advocate is a person who supports and enables people to express their views and concerns. They also support people to access relevant services when needed.

People can only be deprived of their liberty so 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The deputy manager said 11 people had a DoLS in place. These people lacked capacity to make a decision about their care and treatment. The deputy manager said mental capacity assessments had been carried out for these people and we saw evidence of these. This assessment ensured the application for a DoLS was appropriate. We saw that DoLS were reviewed to ensure these were still necessary. For example, we saw that a DoLS had been withdrawn because it was deemed the person had capacity to make their own decision.

People were cared for and supported by skilled staff. A relative said, "The staff appear skilled because they seem to know what they are doing." The deputy manager informed us that staff had access to training and this was confirmed by staff. A staff member said, "Training helped me understand how best to do my job and meet people's needs."

People received a service from staff who were supported in their role by the registered manager. The deputy

manager told us that staff had access to one to one [supervision] sessions and this was confirmed by staff. One staff member told us, "During my supervision we talk about people's changing needs and also my work performance. This gives me some reassurance that I am doing my job properly." Access to supervision assisted staff in their role in meeting people's needs.

We looked at how the provider supported new staff within their role. All the staff we spoke with confirmed they were provided with an induction. One staff member said, "My induction entailed getting to know people's care needs and I had the opportunity to read the provider's policies and procedures." They said this enabled them to understand how to care for people appropriately.

People were provided with a choice of meals. One person said, "The food is excellent and you can ask for anything and they will do their best." A relative told us, "The food is amazing." Discussions with staff identified that some people required a special diet due to their health condition. Staff told us that information about suitable meals for the individual was located in the care records and the kitchen and we observed this. A number of people required support to eat and drink. We observed a staff member assist a person with their meal and this was carried out as identified in the person's care plan. People had access to drinks at all times. We frequently saw staff take the drinks trolley around the home. We heard one staff say to a person, "You haven't been well so we need to make sure you have lots to drink." This demonstrated that staff were aware of the importance of people eating and drinking sufficient amounts to promote their health.

People were supported by staff to access relevant healthcare services when needed. For example, staff had concerns about a person's mental health and the person had been supported to see a community psychiatric nurse. We observed that one person was experiencing difficulty communicating with staff. The staff member promptly identified the person's hearing aids were not working and made arrangements for this to be addressed. One relative told us they were actively involved in meetings with the community mental health team with regards to their relative. A healthcare professional told us that staff were very good in ensuring that people attended follow up appointments. At the time of our visit we saw district nurses and a GP visit the home. Staff informed us that the GP visited the home on a weekly basis. This meant people were appropriately supported to access healthcare services to promote their physical and mental health.

Requires Improvement

Is the service caring?

Our findings

People may not receive a service the way they liked because they were not involved in planning their care. Staff confirmed that people were not involved in their care planning because the majority of them lacked capacity to do so. However, we found that not everyone who used the service lacked capacity and staff confirmed this. Staff said information about people's care and support needs was obtained from people's relatives. This was confirmed by one relative who said, "I sit with staff and discuss [person's] care needs." They continued to say, "The staff know [person] and they know how to calm them down when they get unsettled." The deputy manager assured us that action would be taken to ensure where possible people were involved in planning their care. This would ensure that people's specific needs were met.

People were cared for by staff who were kind and attentive to their needs. One person told us, "The staff really care for me and they are all lovely." Another person said, "The staff are lovely, they will do anything for you, they are really good." A different person told us, "The staff are lovely, very kind and very caring." We spoke with a visitor who told us their friend lived at the home. They said, "They are settled here. Every time I visit they are well dressed and well looked after." A relative told us, "Staff actually spent the time to get to know [person] and the people who visit them. [Person] has always worked with children. When [person] is unsettled staff use a doll that helps reassure and comforts them. Staff know that [person] likes to wear perfume and they always ensure they have a little on." This demonstrated that staff had a good understanding about how to care and support the individual.

We observed that one person appeared unsettled and heard them tell a staff member they had lost their handbag. The staff member listened, reassured them and found it for them. One relative said, "I am so happy with the care and it makes me happy that [person] is always smiling." They continued to say, "It's a lovely home and the staff are very nice." We spoke with a visiting healthcare professional who said, "The care is outstanding."

Staff demonstrated a good understanding of people's care needs. For example, a person's care plan showed they required support with their meals and we observed a staff member assist the person with their meal. We also observed them using the equipment required, to help them to drink. A visiting healthcare professional told us, "The staff know people very well." Staff told us they obtained information about people's care needs from care plans, needs assessments and during the handover of each working shift.

People's right to privacy and dignity was respected by staff. One staff member said, "Sometimes people remove their clothing and we support them to dress in a way that ensures their dignity." We observed as a staff member supported a person with their meal they wiped their mouth to preserve their dignity. The deputy manager said people were asked about their preferences to whether they wanted a male or female carer to assist them with their personal care needs. A staff member confirmed this and said, "Some people respond differently to different staff."

People were able to maintain contact with people important to them. The relatives we spoke with confirmed there were no restrictions on visiting the home. One relative said staff always made them

welcome and their young children were happy and comfortable to visit the home on their own to see their grandparent.

Requires Improvement

Is the service responsive?

Our findings

The provider offered a service for people living with dementia and this was identified on their website. However, we found the environment was unsuitable for people living with this health condition. We observed that furnishings, curtains and flooring were pattered. Doors did not provide signage to promote people's independence in finding their way around the home. For example, we heard one person ask for the 'facilities.' We quickly realised they needed the toilet and although this was nearby, the person was unable to find it. Two staff members told us that one person often tried to pick the patterns off the wall and others would be hesitant when walking due to the change of colour on the flooring. We were informed that one person would not sit on red chairs. Dementia can impact on a person's vision and patterned furnishings and flooring can appear distorted and add to the person's confusion. Although staff confirmed they had received dementia awareness training, they were unaware of 'dementia friendly' environment. They were also unaware of why people behaved the way they did with regards to their environment and the impact this could have on the individual's perception of their home. After our inspection visit we shared this information with the registered manager. However, they did not tell us what action they would take to address this.

Assessments of people's needs were carried out before they moved into the home. However, there was no evidence of their involvement and staff acknowledged this. Staff were unable to explain why people were not involved in their care assessment where they were deemed to have capacity. This placed people at risk of not receiving a service the way they liked. Staff informed us that people's relatives assisted with the care assessment and this was confirmed by the relatives we spoke with. This helped staff to meet people's needs. After our inspection visit we spoke with the registered manager who assured us action would be taken so people were actively involved in their care assessment.

Staff talked and interacted with people in a way they could understand. For example, a staff member said, when some people first move into the home they are reluctant to eat. They had discovered this was because they didn't have any money to pay for the meal. The staff member said, "I tell them the meal is on me and they can pay for it another day." They said this often worked. A relative said they had observed a person with an ornament. They said, "The staff didn't take it off them but allowed them to feel and touch the ornament whilst they chatted to them about it."

People were offered a variety of social activities. A relative told us, "People are entertained at lot and the activities are suitable for the individual's capacity." We observed that information about forthcoming social events were displayed in the home. People were also supported by staff to access social facilities within their local community. For example, the local pub and to go out for coffee. A staff member told us in the warmer months some people enjoyed being in the garden. A relative told us how delighted they were to see people sitting outside in the summer eating their meal. A staff member told us that some people became distressed in noisy environments so they had to be mindful of suitable activities for these individuals. We observed people undertaking various pastimes. For example, reading, listening to music, watching the television and some people were having their finger nails painted. One person told us they preferred to stay in their bedroom and their choice was respected by staff.

We spoke with staff about how they promoted people's rights to equality, diversity and human rights. One staff member said, "We treat people as an individual. We would take the time to become familiar with people's religious and cultural needs. The way they wish to dress and the things they like to eat." Another staff member assured us that everyone would be treated with respect regardless.

People could be confident their complaints would be listened to and acted on. All the people we spoke with confirmed if they had any concerns they would tell the staff or the registered manager. The deputy manager said they had not received any recent complaints. However, complaints would be recorded. This would enable them to monitor the nature of complaints received. They told us that all complaints would be responded to and where necessary action would be taken to improve the service provided.

Requires Improvement

Is the service well-led?

Our findings

People may be at risk of harm because systems in place to review the quality of the service were ineffective. For example, prescribed medicines were not stored in an appropriate medicine cabinet and could be accessed when locked by people who used the service and visitors. The provider's quality monitoring system did not identify this. This meant people could potentially have access to medicines that had not been prescribed for them and place them at risk of harm. We shared this concern with the area manager who assured us that action would be taken to address this.

Quality audits were carried out on the environment. However, these did not identify the unsuitability of the environment for people living with dementia and the impact this had on them. Staff described people's behaviours with regards to the environment and the impact this had on people's mobility due to various colours on the floor which confused them. The environment was not conducive in promoting people's independence to help them find their way around the home. For example, we observed that one person was unable to find the toilet and staff informed us that people needed assistance to find their bedroom. We shared these concerns with the area manager and the registered manager. However, they were unable to tell us what action they would take to ensure the environment was suitable to reduce people's confusion and to promote their independence in finding their way around the home. A 'dementia friendly' environment with appropriate signage in a format people can understand would help people to find their way around the home. The absence of patterned furnishings and flooring would reduce people's confusion.

An inspection was carried out by a fire safety officer in January 2017, where the provider was asked to remove clutter that caused an obstruction by the fire escape route. By May 2017, the provider had taken action to address this. However, on the day of our inspection visit we observed this area was cluttered with wheelchairs, a weighing chair and a hoover. This could delay the evacuation of people in the event of an emergency. This meant the service was not consistently well-led to maintain safety standards.

The provider's quality audit did not identify people's lack of involvement in their care assessment and reviews. This placed people at risk of not receiving care and support the way they liked. Discussions with both the staff and the management identified they had not recognised the importance of people being actively involved in planning their care.

This is a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager said quality assurance questionnaires were given to people to complete. This gave people, relatives and stakeholders the opportunity to tell the provider about the quality of service provided. The deputy manager said information collated from these questionnaires were fed back to the staff team. This enabled them to review the service provided and identify where improvements may be needed. We found that shortfalls identified in these questionnaires related to the laundry service within the home. These concerns had been addressed with the staff team.

People were given the opportunity to tell the provider about their experience of using the service. The deputy manager said meetings were carried with people who used the service and their relatives were also invited and this was confirmed by a relative. Records of discussions held in meetings related to ideas about social activities, the review of the menu and to ensure people were aware of how to share any concerns they may have. A staff member said, "At a recent meeting people had asked for cheesy potatoes and bacon to be added to the menu and it was." This meant people's views were listened to and acted on.

The home was run by a registered manager who was not present during the inspection visit. However, both relatives and staff were complimentary about how the home was managed. A relative said, "I would 100% recommend this home." All the staff we spoke with told us they would be happy for their loved one to live at the home if they required care and support. One staff member said, "My relative used to live here. I wouldn't have them anywhere else."

Staff told us they felt supported by the registered manager to carry out their role. One staff member said, "The registered manager is very supportive. They would address any poor care practices immediately." A relative said, "The registered manager shares their skills with the staff team and also assists with caring for people." They continued to say "We are lucky that [person] is here. This is everything you would dream of for your relative."

After our visit we spoke with the registered manager by telephone on 26 September 2017. They confirmed they were supported in their role by the area manager. They told us they received one to one [supervision] sessions with the area manager. This enabled them to discuss operation issues and to explore the best way to support people. The registered manager had access to training to enhance their skills in managing the home.

We spoke with staff about the culture of the home. One staff member said, "This is a homely place and people are able to walk around without any restrictions." The registered manager said, "We try to make the home as non-clinical as possible. Not only do we care and support people who live here but offer the same for their families."

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain fire safety standards as identified by a fire safety officer in January 2017, and the fire escape route remained obstructed. The provider's quality and monitoring systems were ineffective to highlight the unsuitability of the environment for people living with dementia. Medicines were not stored appropriately to ensure the safe custody of medicines. People's lack of involvement in their care assessment and reviews placed them at risk of not receiving a service the way they liked.