M & C Care Limited

Rowan House Residential Home

Inspection report

4 Lower Port View
Saltash
Cornwall
PL12 4BY
Tel: 01752 843843

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 4, 5, and 27 November 2015 and 4 December 2015 and was unannounced to the care home and announced to the domiciliary care part of the service.

Rowan House Residential Home provides care and accommodation for up to 26 people who are living with dementia or who may have physical difficulties. On the day of the inspection 23 people were living at the care home. The home is on three floors, with access to floors via stairs, a stair lift or lift. Some bedrooms have en-suite facilities. There are shared bathrooms, shower facilities and toilets. Other areas include three lounges, a dining room, and garden.

The service also provides domiciliary care services to adults within East Cornwall. On the day of our inspection

Summary of findings

45 people were using the service. The home care service provides palliative care, as well as supporting people with physical disabilities, sensory impairments and mental health needs, including people living with dementia.

The service had a registered manager. 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.

At the time of our inspection the provider was managing the service in the absence of the registered manager. There was a separate manager in charge of the domiciliary care service. The provider was open and transparent about areas which required improvement and was responsive in taking action on the day of our inspection when we identified anything of concern. The provider was in the process of creating an action plan to address improvements and was keen to make changes quickly.

People received care and support from staff who were kind and caring, treated them with respect and promoted their privacy and dignity. Relatives told us they were happy with the care their loved ones received. People told us there could be more staff at busier times, such as lunch time and when people wanted to go to bed. At the time of our inspection the provider was taking action to make sure additional staff were available at such times. There were social activities available, but some people told us they would like more to do to occupy their time, such as trips out.

People did not live in an environment which promoted the principles of good dementia care because of poor signage and a lack of colour contrast. The environment was clean and free from malodours, but people were not always protected by effective infection control procedures because staff did not always display knowledge of infection control practices.

People told us they enjoyed the meals, and people were supported to eat and drink enough and maintain a balanced diet. People who were at risk of losing weight were not always effectively monitored to help ensure prompt action was taken, such as contacting the person's GP.

People felt safe. The provider and staff understood their safeguarding responsibilities and staff had undertaken training. People were protected by safe recruitment procedures as the registered manager ensured new employees were subject to necessary checks which determined they were suitable to work with vulnerable people. However, records did not demonstrate disclosure and barring service (DBS) checks had been risk assessed to help ensure staff were suitable to work at the service. There was a whistleblowing policy in place, however, some staff told us they had not felt confident about whistleblowing in the past, but explained they now felt confident, and would report any concerns to their line manager or to the provider. The provider told us he would be having further discussions about whistleblowing with the staff team to alleviate any worries they had.

People had risk assessments in place to help staff minimise risks associated with people's care. People had personal evacuation plans in place, which meant people could be effectively supported in an emergency. The environment was not regularly assessed and monitored to ensure it was safe at all times.

People's consent to care and treatment was obtained, and staff asked people for their consent prior to supporting them. People's care plans did not always provide guidance and direction to staff about how to meet people's individual needs. People were not always involved in the creation of their care plan. External health professionals told us communication was not always effective regarding people's changing care needs.

People's end of life care and resuscitation wishes had not always been recorded so staff would know what to do at the end of a person's life to ensure they received the care they wanted. People's medicines were not always stored securely and documentation was not always in place to help guide and direct staff about the correct administration of medicines. Systems were not in place to monitor the management of medicines and staff who were responsible for medicines had not received effective training. The provider took immediate action to arrange training for staff at the time of our inspection.

People who were deprived of their liberty had been assessed to ensure their human rights were protected. People's mental capacity was not always assessed which meant care being provided by staff was not always in line

Summary of findings

with people's wishes. For example, people who lived with memory loss or dementia did not have care plans in place to provide guidance and direction to staff about how to support the person effectively.

People and those who mattered to them were not always encouraged to provide feedback about the service they received. People told us if they had any concerns or complaints they felt confident to speak with the staff or registered manager. People received care from staff that had been given training and supervision to carry out their role. Staff felt supported. However external health professionals felt staff required further training to improve their competence, such as identifying health care concerns promptly and recording people's blood pressure.

The provider did not have effective systems and processes in place to ensure people received a high quality of care and people's needs were being met. The Commission was not always notified appropriately, for example in the event of someone passing away.

The provider had an ethos of honesty and transparency. 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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People were not protected from risks associated with the environment.

People were not always protected from cross infection, because infection control practices were not always followed.

People were at risk of not receiving their medicines safely and as prescribed, because documentation relating to medicines was not always in place.

People told us there were enough staff to meet their needs, but some people felt there could be more staff at busier times of the day, such as lunch time or when people wanted to go to bed.

Safe recruitment practices were in place. However, records did not demonstrate disclosure and barring service (DBS) checks had been risk assessed to help ensure staff were suitable to work at the service.

People had risk assessments in place to provide guidance and direction to staff about how to minimise risks associated with their care.

People told us they felt safe. Staff knew what action they would take if they suspected abuse was taking place.

Is the service effective?

Requires improvement

The service was not always effective.

People's mental capacity was not always assessed which meant care being provided by staff may not always be in line with people's wishes.

People who were at risk of losing weight were not always effectively monitored.

People's changing care needs were referred to relevant health services; however external health professional did not always feel communication was effective.

Staff received training and support to meet people's needs. However, external health professionals felt staff required further training to improve competence, such as identifying health care concerns promptly.

People's consent was obtained prior to being supported or assisted.

Is the service caring?

Requires improvement

The service was not always caring.

End of life care plans were not always in place for every person, which meant people's wishes at the end of their life, had not been recorded.

Summary of findings

People, their friends and family were not always encouraged to be involved in making decisions about their care.

People told us staff were kind.

People's privacy and dignity were respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans did not always give guidance and direction to staff about how to meet people's care needs.

People's independence and social life was not always promoted which meant people had little to occupy their time.

People could raise concerns and complaints. People felt confident action would be taken.

Is the service well-led?

Requires improvement

The service was not always well led.

People did not receive a high standard of quality care because the registered manager's systems and processes for quality monitoring were ineffective in ensuring people's needs were met and the environment was safe.

The provider had not always notified the Commission of significant events which had occurred, in line with their legal obligations.

Staff felt supported by the provider.

Rowan House Residential Home

Detailed findings

Background to this inspection

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

We visited the care home unannounced on 4 and 5 November 2015. The inspection team consisted of one inspector. We commenced our inspection from 5.45am, because we had received information that people were asked to get up early.

The inspection of the domiciliary care service took place on 27 November 2015 and 4 December 2015 and was announced. The provider was given 48 hours' notice because we needed to be sure the manager would be present. The inspection team consisted of one inspector and an expert by experience.

During our inspection of the care home we spoke with eight people who used the service as well as two relatives. We spoke with people in private and observed people's care and support in lounge and dining rooms. We observed how people spent their day, as well as people's lunch time experiences. We spoke with five members of care staff, two duty managers, the laundry assistant, the cleaner, the chef, and the provider. We also spoke with a community nurse.

We looked at nine records which related to people's individual care needs. We also looked at records that related to people's medicines as well as documentation relating to the management of the service. These included five staff recruitment files, policies and procedures, accident and incident reports, training records, and kitchen menus.

During our inspection of the domiciliary care service, we spoke with 22 people who used the service and six relatives. We also spoke with four members of care staff, and the manager. We looked at four records which related to people's individual care needs and records associated with the management of the service.

Before our inspection we reviewed the information we held about Rowan House Residential Home and domiciliary care service, and spoke with the local authority. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law. We contacted two GP practices, the local district nursing team, a community matron, Healthwatch Cornwall and the local authority service improvement team.

Requires improvement

Is the service safe?

Our findings

Rowan House Residential Home

People's medicines were not stored safely. On our arrival the medicine keys were not stored securely and the lock to one medicine cabinet was broken. The provider told us he was not aware the lock was broken, but took immediate action to address this. The provider explained staffing responsibilities for medicines had recently changed and he recognised staff required extra training. Training was arranged on the day of our inspection.

Documentation was not always in place to help guide and direct staff about the correct use and application of medicines. For example, when people had pain relief patches applied, there were no care plans in place to provide guidance and direction to staff about why the person had been prescribed patches, where to apply the patch and for how long. People were encouraged to look after their own medicines. However, there were no care plans or risk assessments in place to help guide and direct staff, and to help minimise any associated risks.

People whose medicine was covertly administered did not always have a care plan in place. People's records did not always show how this decision had been made, and whether it had been made in the person's best interests, in line with the mental capacity act. This meant people's human rights may not always be protected.

People's prescribed topical medicine (creams), were not always dated when opened which meant it was unclear if the cream could still be used. The temperature of the fridge was not always being checked to ensure medicines were being stored at the correct temperature in line with prescribing guidelines. The provider did not have a monitoring system in place to promptly highlight where improvements were required, to help ensure people's medicines were administered safely.

People's medicines were not always managed effectively. Documentation was not always in place to provide instructions to staff about how people should be supported with their medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by effective infection control procedures. Staff were not always aware of infection control practices which were specific to people's individual care needs. For example, one person had an infection; however, staff were not always aware of the infection control practices in place to help prevent the spread of infection. The person's care plan did not detail the support required from staff to help ensure the person, staff or visitors were protected from cross infection. Staff received training, alcohol hand gel was available and staff were provided with gloves and aprons.

Infection control risks were not being properly assessed to help ensure people, staff and visitors were protected from the spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in an environment which had not been assessed to ensure its safety, for example the laundry room did not have a lock fitted to the entrance, which meant hazards, such as equipment and disinfectant could be accessed by people. Some fire exits had been blocked with wheelchairs and a mattress, meaning people may not be able to access the nearest exits in the event of a fire. The provider took action to address this at the time of our inspection.

Risks had not always been assessed and monitored in respect of the environment. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by suitable staff. Recruitment practices were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe, such as disclosure and barring service (DBS) checks. However, records did not demonstrate disclosure and barring service (DBS) checks had been risk assessed to help ensure staff were suitable to work at the service.

People had risk assessments, which gave guidance to staff about how to minimise associated risks related to people's individual care needs. For example, when a person was at risk of falling risk assessments were place to help reduce the risk of this occurring. It described the specific equipment in place, and the number of staff required to support people. People had personal emergency evacuation plans (PEEPs) in place which meant, in an evacuation emergency services would know what level of care and support people may need.

Requires improvement

Is the service safe?

People were protected from abuse because staff knew what action to take if they suspected someone was being abused or mistreated. Staff felt confident if they reported any concerns to the duty manager or provider that they would be appropriately dealt with. Staff had completed safeguarding training and had access to a safeguarding policy and contact details for the local authority. The safeguarding policy was in the process of being updated at the time of our inspection. There was a system and protocol in place when people's money was held for safekeeping, to ensure people's money was kept securely.

People had a call bell they could use to ask for staff assistance. People told us there were sufficient numbers of staff to support them, but some people felt there could be more staff at certain times of the day, one person told us, "Sometimes you could do with another; tea time, getting people to bed. People look as though they are waiting". Another person told us, "Sometimes they are busy, I have to wait, but I don't mind that". The provider explained the staffing rota was being reviewed to help ensure staffing was effective to meet people's needs, particularly at busy periods, such as mornings.

Domiciliary Care Service

People were reminded to take their medicines by staff. Staff had received training and care plans were in place to provide guidance and direction to staff.

People were protected from the spread of infection because staff had received training and were provided with protective equipment, such as gloves and aprons.

People had risk assessments in place to help minimise any risks to the person or to the staff. For example, environmental risk assessments relating to the person's home, highlighted action expected of staff to help keep people safe. Staff explained how they minimised risks, for example making sure people had their walking stick in reach and the environment was free from clutter. If there were any changes, staff informed the manager so the risk assessment could be updated to help ensure it was reflective of the person's needs. A health professional was complimentary about how the staff and manager had been observant about a risk associated with the care of one person, and had taken the initiative to discuss their concerns with the person, and put into place solutions to reduce the person facing unnecessary harm.

People told us generally staff arrived on time and when there was going to be a delay they were informed of this, one person told, "This is perfectly understandable as we live in a rural setting". Staff felt there could be more staff to meet people's individual needs, but they had shared this with the manager and action to recruit more staff was being taken. Staff told us generally they had enough traveling time between each person, and when they had felt rushed they spoke with the manager, who had re-arranged the rota. The manager explained she tried to group staff to particular areas, to provide continuity of care for people and to help reduce traveling time for staff.

People felt comfortable with staff who entered their property, one person told us, "I am very comfortable with all the staff who visit my home". Staff wore a uniform and had an identification badge to help people know who they were prior to them entering their home. People were supported by suitable staff. Recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Staff had received safeguarding training and were confident about how to report any concerns they may have and had access to the provider's safeguarding policy so they knew what to do.

There were protocols in place to protect staff when they were working independently; the lone working policy protected staff when they may be in difficult situations. Staff were provided with a mobile phone to keep in touch with their colleagues. Records, such as MOT certificates, insurance documents and driving licences were requested of staff, and a system was in place to ensure these were reviewed annually. This helped to ensure staff had the required legal documents in place to protect them, should they have an accident.

Requires improvement

Is the service effective?

Our findings

Rowan House Residential Home

People who were at risk of losing weight were not always being effectively monitored. One person's care plan detailed they should be weighed weekly; however, their records showed they had been last weighed on 14 July 2015. Records were not always legible and information was not recorded in one place, which meant it was unclear when a person was losing weight. External health professionals raised concerns about the disorganisation of how people's weight was being monitored, and told us it was not always clear whether advice was being sought promptly.

The Malnutrition Universal Screening Tool (MUST), a tool used to measure a person's weight by a calculation of a person's body mass index (BMI), was not being used for people who were unable to stand or sit on scales. Staff were not aware of the existence of this tool, however, by the end of our inspection the provider had arranged training for staff.

People had food and fluid charts in place if staff were concerned about how much a person was eating and drinking. However, there was no guidance or direction for staff about how much the person should be eating or drinking, and when to seek professional support of a GP or district nurse.

Risks associated with people's nutrition were not effectively monitored. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The legislative framework of the Mental Capacity Act (MCA) and associated deprivation of

Liberty safeguarding was not always being followed. 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 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had an understanding of the MCA, but people's care plans did not always reflect the person's mental capacity to help ensure staff supported people in the least restrictive way, and in line with their wishes. For example if a person was living with dementia, information was not detailed about which decisions the person may or may not be able to make.

People's mental capacity and decisions being made by staff on their behalf were not always reflected in people's care plans. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who may be deprived of their liberty had been assessed to ensure their human rights were protected.

People's consent was obtained prior to staff providing support, and people had documentation in their care plans to demonstrate they had consented to care and treatment at the service.

People's changing care needs were referred to relevant health services. People's care records demonstrated a variety of health care professionals were contacted as necessary, for example, psychiatrists, opticians, chiropodists, and speech and language therapists. A GP visited weekly to help ensure people's health care needs were met with a consistent approach. However an external health professional told us communication between the service and the GP practice was not always effective.

People were able to choose where they had their meals, and the majority of people told us they liked the meals, comments included, "A good variety of food, we have got a good cook here", and "Usually several choices". Others told us, "They're quite tasty, not quite what I would like" and "On the whole pretty good". One person told us they would prefer if the meals were served on a warm plate. A relative told us there were no freely available snacks or fruit for people to help themselves to, and felt this could be improved. The provider explained changes were taking place regarding the staffing of the kitchen, which would hopefully improve people's experiences of the meals and choices available.

Requires improvement

Is the service effective?

People received care from staff that had the knowledge and skills to carry out their roles and responsibilities. New staff completed an induction programme. The new 'care certificate' was yet to be incorporated, because of a change in leadership at the service. The care certificate is a national induction tool which providers are required to implement, to help ensure staff work to the desired standards expected within the health and social care sector. Staff had to complete training applicable to their role, for example dementia training and manual handling. External health professionals told us some staff required further training, to help identify people's changing care needs and to take prompt action.

Staff told us they felt supported by the duty managers and the provider. Staff had received supervision which had included a topic for discussion, such as safeguarding or medicines; as well as an annual appraisal. Supervision and appraisal is a process by which a person reflects on their work performance and identifies training and development needs.

Domiciliary Care Service

People who lived with memory loss or dementia did not have care plans in place to provide guidance and direction to staff about how to support the person effectively. For example, one person's care plan stated they had "fluctuating capacity" and "memory problems". This meant decisions being made by staff may not be in the person's best interests.

People were supported by staff who understood the importance of gaining people's consent, one member of staff told us, "You ask them all the time, are they happy, are they comfortable with how you are supporting them". Staff explained they sought the person's permission prior to contacting their family or GP.

People were supported by staff trained to meet their needs. People told us they felt staff provided a good level of care and support. One person told us, "Some are better than others".

Staff received an induction. This introduced them to important policies and procedures, as well as shadowing experienced staff and meeting people who used the service. The care certificate was being incorporated into the induction. Staff were provided with essential training, such as moving and handling and infection control. However, some staff had not completed training about dementia care or the mental capacity act. The manager told us she would take action to address this. The manager told us when people required specialist care; specialist training was provided to help ensure staff had the correct knowledge and skills, for example training had been provided in respect of stoma care.

Staff confirmed they felt well supported and documentation showed staff received regular supervision of their work; either by observation of their practice or by a one to one discussion. Staff explained supervision was an opportunity to obtain feedback about their practice, and told us they found it "Useful".

People's care plans provided details to help staff know what people's nutritional likes and dislikes were. Care plans also described if people required help with preparing their meals, or support with eating and drinking, so staff were informed about what action they needed to take. Staff told us what action they would take if they were concerned someone wasn't eating and drinking enough, for example, they explained they would try to "tempt" the person with a favourite meal or drink, help the person contact their GP, or share their concerns with the person's family.

People were supported to access external services such as GPs and district nurses. An external health professional told us staff and the manager liaised well, about people's care needs, and were responsive in reporting concerns and implementing changes requested by community nursing staff.

Requires improvement

Is the service caring?

Our findings

Rowan House Residential Home

People's end of life care and resuscitation wishes had not always been recorded so staff would know what to do at the end of a person's life to ensure they received the care they wanted. An external health professional told us they had also been encouraging staff to ensure this information was in place.

People were supported by male and female care staff. Whilst people did not object to this, people's care plans did not demonstrate they had been consulted about this, and their preferences recorded.

People told us they were able to get up and go to bed when they chose to. However, one person who enjoyed a lie in told us they had been assisted that morning at 7am. They explained, "It is a little early. They (the staff) were told not to get us up before 7am". Staff told us people did have a choice; however when we arrived at 5:45am night staff were assisting people. For one person who had been assisted, their care plan detailed they liked a lie in. We spoke with the provider about this, who told us he would speak with staff immediately to ensure this did not occur again.

People had a section in their care plans to record their personal history, dreams and aspirations. However, this had not always been completed. This information is useful to help staff have meaningful conversations with people, and empower people to help them achieve any future goals that they may have.

People and their relatives were not always involved in the creation of their care plan or its ongoing review. So people's preferences and wishes were not always obtained and considered in line with their day to day care plan. One relative told is, they had not seen their relatives care plan and "Would like to be a little more involved".

Care plans were not always reflective of people's needs and preferences, including end of life care and resuscitation wishes. People or their representatives were not always involved in the design or review of their care plans. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care from staff who were kind and caring. People told us, "The girls are very nice", "It helps when you have got nice people around you" and "I am very well looked after here, to the degree, this is my home". Relatives told us, staff "Genuinely care" and "They really are, kind and caring". People's relatives and friends were welcome to visit at any time.

Staff spoke with people in a respectful manner and gave people time when they needed reassurance. For example, one person was anxious and walked up and down a corridor. Staff were observant of this and used techniques to try and engage the person in other things to reduce the person's anxiety.

One person told us they had not been feeling very well. Staff had recognised this and offered a bath. The person told us, "I had a nice long soak in the bath, it took away aches and pains". Another person was complimentary about how staff had supported them, when they had suffered from a sickness bug and told us "They were very kind".

People told us staff showed dignity and respect towards them, one person explained how staff shut their curtains and their bedroom door prior to supporting them with their personal care. Staff knocked on people's doors prior to entering.

Domiciliary Care Service

People were supported by kind and caring staff, who told us they were "Very satisfied with the service provided", and who described the staff as "Very good". One relative told us, "The staff went the extra mile and beyond it, and this was greatly appreciated by all the family".

Compliment cards had been received describing the gratitude from people and from their families, "Thank you very much for all the care and attention you gave to mum", and "Without the help of them (the staff), we could not have managed".

The manager kept a list of people's birthday, to ensure a birthday card was sent from the staff and provider. The manager told us, "Some people don't get a card from anyone, but they do get a card from us!"

The manager explained how staff took time to resolve difficulties for people, when they were worrying. For example, one person who lived with dementia was unable to access money from their usual bank machine because the bank had closed; this had resulted in the person not

Requires improvement

Is the service caring?

buying any food. Staff had recognised this, and action was taken to support the person to make alternative arrangements. The manager explained, "I felt quite chuffed that we sorted that for him".

People felt staff treated them with respect and their dignity was promoted. Staff explained how they were respectful of people's privacy and dignity by explaining they closed curtains and covered a person's body with a towel or dressing gown when they stepped in and out of the bath or shower. Staff told us how they promoted a person's independence, and encouraged them to do as much as they could for themselves, such as washing their own hands and face.

People's care plans detailed family and friends who were important to them. This helped staff to be knowledgeable about people's family dynamics and involve them as much as necessary. People were involved in the review of their care plans, and were able to provide feedback about the service they received. People were also able to feedback to the manager when staff were supervised during spot inspections.

People's resuscitation wishes had been recorded so staff would know what to do at the end of a person's life to ensure they received the care they wanted.

Requires improvement

Is the service responsive?

Our findings

Rowan House Residential Home

People's care plans were not effectively reviewed to ensure they gave guidance and direction to staff about how to meet people's individual care needs. For example, one person's care plan detailed they should be re-positioned in bed to prevent pressure damage every hour. However, the person's re-positioning charts had been completed two hourly. Another person had been prescribed cream for a rash; however, their care plan did not provide guidance to staff about where the cream was to be applied.

People and/or their families were not always involved in their care plan reviews, so were unable to be actively involved in decisions about their care and treatment. Information was recorded in several places which meant that it was difficult to establish what care and support each person was receiving and whether it was in line with their care plan. By the end of our inspection, the provider was reviewing the care planning and recording processes at the service.

Care plans did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records demonstrated when a change in health had triggered responsive action. For example, daily records showed GPs or district nurses had been contacted when staff were concerned about the deterioration of a person's health. One person told us, "If they think I need it, they call in a doctor". External health professionals told us communication was not always effective, for example when they had been called in staff did not always know the reason why, or they found the person no longer required a visit.

People and their relatives told us social activities were available but limited. One person told us about the craft sessions they had enjoyed, and another person told us about the up and coming bonfire night. However, others expressed they would like to go out more, and would like a library service with large print books. On the days of our inspection there were limited social activities for people to take part in, but photographs displayed social events which had taken place in the past. The provider explained there was a member of staff responsible for activities, but they were not working on the days of our inspection.

People could raise concerns and complaints. People told us they would speak with the registered manager or staff, and felt confident action would be taken. The service had a complaints policy in place which was available to people and their relatives, people received a copy of this when they moved into the service. However, the complaints policy was not displayed for people or visitors, and it was not in a suitable format for people living with a visual impairment or dementia.

Domiciliary Care Service

People felt their needs were met by the care staff who came to support them, one person told us the service was "Wonderful" and others described it as "Very good". People told us how staff supported them to wash and dress and prepare their meals.

The provider had a pre-assessment process which helped to ensure the staff were able to meet people's needs prior to the service being offered. The pre-information was shared with staff prior to them visiting a new person. The manager told us, "I try and give the girls (staff) as much information as possible before they go in".

People had care plans in place to provide guidance and direction for staff about how to meet a person's needs. However, people's care plans were not always detailed to provide instruction to staff about how to meet people's individual needs. For example, in one person's care plan it stated the person became "confused" and "aggressive at times". However, there was no guidance for staff about how to support the person when this occurred. Another person's care plan detailed they had dementia, but again, there was no information about what this meant for the person or for the staff.

Care plans did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

People's care plans recorded their personal history so staff were aware of what a person had achieved in life. A person's history helps to enable staff to have meaningful conversations with people.

Staff told us people's care plans were reflective of people's needs. When care plans required updating, staff told us this was carried out promptly, one commented included, "She (the manager) is very good at paperwork".

People's changing care needs were shared with the staff team by either telephone or mobile phone text message so staff were fully informed prior to arriving at someone's home. Staff told us communication was good amongst the team, and reiterated, "We work together as a team very well".

When there had been concerns regarding the deterioration of a person's health the staff and manager had been responsive to help ensure the person received appropriate support. For example, one person had been unwell and an ambulance had to be called. An external health professional was complimentary that the staff had stayed with the person and felt staff had gone "Above and beyond". They also told us they communicated well when they felt someone required the support of health professionals.

People told us if they had any complaints, they knew who to speak with. The service had not received any complaints and the manager felt this was because she liked to respond and find solutions quickly.

Requires improvement

Is the service well-led?

Our findings

Rowan House Residential Home

People did not receive a high standard of quality care because the provider did not have systems and processes in place to monitor and make improvements in respect of the planning of people's care, meeting people's individual needs, the management of medicines, the environment, infection control, the management of risks, and the legislative framework the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS).

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always notified the Commission of significant events which had occurred, in line with their legal obligations. For example, when someone had passed away.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the time of our inspection the provider was managing the service in the absence of the registered manager. The provider was open and transparent about areas which required improvement and was responsive to take action on the day of our inspection when we identified anything of concern, for example medicine practices. The provider was in the process of creating an action plan to address improvements and was keen to make changes quickly. Staff were complimentary of the provider and told us they felt supported and described how the atmosphere in the service had improved, comments included, "I love coming to work", "and "It feels better". External professionals told us communication was not always effective and varied each time they visited the service.

There was a whistleblowing policy in place which protected staff should they make a disclosure about poor practice. However, staff told us they had not always raised concerns in the past because of a worry that they may not be protected or that their concerns would not be listened to or taken seriously. We spoke with the provider about this, who told us he would be re-emphasizing the importance of whistleblowing and the duty staff have to share any concerns they may have.

The service was underpinned by a number of policies and procedures, made available to staff. Polices were not always reflective of current legislation and regulations. The provider was taking action to address this.

The provider promoted the ethos of honesty, learning 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.

People, their family and friends had been asked in the past to provide feedback about the service by completing a questionnaire. A questionnaire for 2015 was still to be arranged.

Domiciliary Care Service

The domiciliary care service was operated by a different manager who reported to the registered manager of the care home and provider. The manager told us she felt supported by the provider and told us she could "Always contact the provider, they are always available". Although, the manager, felt supported, she had not had any formal supervision meetings with the registered manager or provider for some time. The manager explained she kept her knowledge up to date by attending training courses and reading the CQC website pages.

People who used the service and their relatives were positive about how the service was managed and described the manager as "Very nice" and "Very approachable". Staff told us they felt the service was run well and described the manager as, "Very good, very approachable", "She is organised, you can rely on her, she's there to help".

The manager had some systems in place to assess the ongoing quality and monitoring of the service. For example, auditing recruitment records, and spot checking staff performance.

Although, these systems were in place, the manager also worked alongside staff to continually monitor, assess and make improvements as required. The provider had no additional systems in place to monitor the quality of the service being delivered by the manager and staff. However, at the time of our inspection the quality processes were being reviewed.

Requires improvement

Is the service well-led?

The manager worked in partnership with other agencies, such as community health teams and local taxi firms. The manager explained the importance of good working relationships to help ensure people received a good level of service, and a coordinated approach.

There was an annual survey which was used to obtain people's feedback; people's feedback was used to improve the service. Some people told us they had not been asked to complete a questionnaire, whilst others told us they had.

The manager had organisational policies and procedures which set out what was expected of staff when supporting people. Staff had access to these and were given key policies as part of their induction. The whistleblowing policy supported staff to question practice. It defined how staff that raised concerns would be protected. Staff told us they felt the manager would take responsive action if they did raise concerns. Staff also explained they had the providers contact number as well, and had been encouraged to contact him if they were concerned about anything.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (3) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans did not always meet people's needs and preferences. People or their representatives were not always involved in the design or review of their care plans. Care plans were not effectively reviewed and reflective of the care being delivered. People's end of life care and resuscitation wishes had not always been recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's mental capacity and decisions being made by staff on their behalf were not always reflected in people's care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's medicines were not always managed effectively. Documentation was not always in place to provide instructions to staff about how people should be supported with their medicines.

This section is primarily information for the provider

Action we have told the provider to take

Risks associated with people's nutrition were not effectively monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems in place to monitor the quality of service people received were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to notify us of all significant events in line with their legal obligations.