Mr John Michael Eaton

Lowenva Care

Inspection report

Lowenva
Rescorla
St Austell
Cornwall
PL26 8YT

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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

Lowenva Care is a registered care home for up to six adults. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection six people were living at the service. Lowenva Care is located in a rural area, approximately four miles from the town of St. Austell.

We inspected Lowenva Care on 31 October 2018, the inspection was announced 48 hrs in advance. This was because the service is small and people are often out. We needed to be sure someone would be available to talk with us. At our last inspection on 3 June 2016 and we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service was operating in line with the values that underpin the CQC 'Registering the Right Support', and other current best practice guidance. This guidance includes the promotion of the values of; choice, independence and inclusion. The service was working with people with learning disabilities that used the service, to support them to live as ordinary a life as any citizen. Staff supported people to access the community regularly. People's independence was respected and they were encouraged to develop and maintain skills. Although the registered manager shared these values they were unaware of the guidance. Lowenva Care is a small care home and there were limited opportunities for the management team to keep abreast of changes and developments in the care sector. We have made a recommendation about this in the report.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Applications for DoLS authorisations had been made and the registered manager updated the local DoLS team when further restrictive practices were introduced. There was no evidence to show these decisions had been taken in line with the best interest process and we have made a recommendation about this in the report.

At our last inspection in June 2016 we found supervisions were not being effectively recorded and we made a recommendation. At this inspection we found staff supervisions were taking place regularly and these were recorded and kept on file. Records showed the meetings were an opportunity to identify any gaps in training and discuss working practices. Staff told us they were well supported and received regular training updates.

People were protected from identified risk. Staff were aware of the support people needed to help keep them safe and were confident at all times. When concerns were raised with the registered manager they took immediate and effective action to mitigate any risks. People and relatives told us they believed

Lowenva Care provided care and support safely.

The premises were clean and well maintained. People's bedrooms were personalised and reflected their tastes and interests.

There were quality assurance systems in place to monitor the standards of the care provided. Audits were carried out regularly by the registered manager. Staff roles and responsibilities were clearly defined and understood.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Lowenva Care

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 comprehensive inspection took place on 31 October 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location was a small care home for people who are often out during the day. We needed to be sure that they would be in. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was brought forward due to concerns raised with CQC and the local authority about how a person was spoken to on one occasion when they were agitated. Because of this we paid particular attention to how the registered manager responded to safeguarding concerns.

We looked around the premises and observed staff interactions with people. We met with all of the people living at the service, the registered manager, and five members of staff. We looked at detailed care records for two individuals, staff training records, three staff files and other records relating to the running of the service. Following the inspection visit we spoke with another two members of staff, two external healthcare professionals and a relative.

Good

Is the service safe?

Our findings

The inspection had been brought forward following concerns regarding how one person had been spoken to when they became agitated. We discussed this with the registered manager who told us of the action that had been taken since the concern was raised. This had included discussions with the party involved, the introduction of new processes and systems and the development of a risk assessment to help ensure this persons safety and well-being. We spoke with the person concerned and observed how they interacted with staff. We saw they were relaxed and were confident to raise their voice when they felt they needed to. Staff responded to them kindly and with patience. We concluded action to mitigate risk had been taken and there had been no apparent adverse impact on the person concerned. Staff confirmed that, when any concerns were raised to the registered manager, they took action to ensure people received support in a safe and caring way.

People were comfortable and at ease when approaching and interacting with staff. People and a relative told us they had no concerns about people's safety. A relative told us; "Yes, she's safe, that's the most important thing."

A safeguarding policy and information on how to report any concerns was available to staff. New staff had safeguarding training as part of the induction process and this was regularly refreshed. Staff told us they would be confident raising any concerns both within the organisation and outside if they felt that was necessary. One commented; "I care a great deal about the people I look after and when they haven't got a voice or can be disregarded you have to do it for them."

Staff were aware of their responsibilities to protect people from discrimination and harassment There was a Diversity and Equality policy in place which they were required to read as part of the induction process.

Risk assessments were in place so staff were aware of any identified risk and had clear guidance on how to support people safely. Risk assessments were regularly reviewed and updated as necessary. They were individualised and specific to people's needs.

Some people, when anxious or distressed, could behave in a way which might put themselves or others at risk. Staff told us they were confident supporting people at these times and did not need to restrain people. Information in care plans clearly described how to recognise when people were becoming distressed and the actions to take to alleviate this.

The premises were clean. Cleaning equipment was available and any potentially hazardous products were securely stored. Staff had completed infection control and food hygiene training. They had access to aprons and gloves to use when helping people with personal care.

The boiler, gas appliances and portable electrical appliances had been tested to ensure they were safe to use. There were systems to minimise the risk of Legionnaires' bacteria developing. Water outlets had been fitted with thermostatic mixing valves (TMV's) to control the temperature of water from taps and minimise

the risk of scalding. The water temperatures were checked monthly by staff. Checks on fire safety equipment were completed regularly. Personal emergency evacuation plans had been developed outlining the support people would need to evacuate the building in an emergency. These were detailed and specific to the person.

At the time of the inspection there were enough staff available to keep people safe. The registered manager was not included on the rota but was on site throughout the week to support with care if necessary. We observed staff were unhurried in their approach and people's needs were met quickly.

New staff were required to complete a number of pre-employment checks before starting work. This included Disclosure and Barring Service (DBS) checks and supplying suitable references. This meant people were protected from the risk of being supported by staff who were not suitable to work in the care sector.

People's medicines were managed safely. Medicine Administration Records (MARs) were completed to record when people had received their medicines. We reviewed these and found they were clear with no missed signatures. One person was able to self-administer some of their medicines with staff supervision and this was respected. Another person had their medicines administered covertly, this means they were hidden in food or drinks. There were records in place to show this practice had been agreed by the GP. When the person required additional medicines such as antibiotics, the registered manager ensured this additional covert administration was authorised by the GP and pharmacist.

People's monies were secured securely and individually. Records of expenditure and accompanying receipts were kept and these were audited regularly. We checked the amount of money held for one person and found this tallied with the records.

There was a system of health and safety risk assessment. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. There was a record of regular fire drills. Accidents and incidents were recorded and reviewed regularly by the registered manager.

Good

Is the service effective?

Our findings

At our previous inspection in June 2016, we found there was no formal system in place for staff supervisions and appraisals and we made a recommendation. At this inspection we found staff received regular supervisions and these were recorded appropriately. Supervision meetings were an opportunity to raise any concerns, highlight any training gaps and discuss individuals support. The registered manager had completed staff appraisals for two members of staff and was planning to complete these for the full staff team in the near future.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. DoLS applications had been made and the registered manager had informed the local DoLS team when further restrictive practices had been introduced. We did not see evidence that people's capacity had been formally assessed before the applications were made to help ensure the applications were appropriate. We discussed this with the registered manager who said they would address the issue.

There was some use of technology. Staff all had walkie-talkies so they could communicate with each other quickly and effectively. CCTV had been installed in some areas. The registered manager told us, and we saw, that these did not cover areas where people received personal care. The registered manager told us people had been consulted about the installation of the cameras but we did not see any evidence to support this. There were no records to show the decision had been taken in line with the best interest process.

We recommend that the service seek advice and guidance from a reputable source, about ensuring decisions made on behalf of people who lack capacity are taken in line with the best interest process.

People were supported to access external healthcare services for regular check-ups. For example, they attended GP and optician appointments and had annual health check-ups. When people needed additional support because of their health needs the service had worked closely with the local district nurse team to ensure the person received the support and equipment they needed. An external healthcare professional commented; "They are right on the ball really."

Staff had the appropriate skills, knowledge and experience to deliver effective care and support. New employees had an induction when they started working for the organisation. For those new to care this

included completion of the Care Certificate. The Care Certificate is a national qualification designed to give those working in the care sector a broad knowledge of good working practices. There was also a period of shadowing more experienced staff. The management team then reviewed staff competency and confidence before they started working independently. Training identified as necessary for the service was updated regularly.

People were assisted to eat a healthy and varied diet. They told us the food was good and they had a choice of meals.

Living areas and bedrooms were personalised and reflected people's personal taste and interests. There were enough bathrooms to accommodate people's needs and ensure people were able to bathe when they preferred.

Good

Is the service caring?

Our findings

People were at ease with staff. We observed staff chatting with people while they relaxed in their room or the lounge area. The atmosphere was friendly, we saw one member of staff laughing with someone and repeating an interaction which the person clearly enjoyed. They were patient and seemed to share the person's pleasure in the simple activity. One person told us; "I'm happy, happy as anything!"

The registered manager and staff knew people well. They spoke of people fondly and with respect. Comments included; "[Person's name] is amazing" and "It feels like a home rather than a workplace." Staff were able to tell us what people enjoyed doing and how they helped ensure they were able to take part in these activities. For example, one person liked dogs so a member of staff invited them to go dog walking with them.

Care records did not contain information about people's histories. This information can help staff to engage meaningfully with people and give them an understanding of events which have shaped people. However, there had been efforts to gather this kind of information for some individuals. For example, a relative had provided a series of old photographs for one person and these had been laminated to protect them. Staff could use these to initiate conversation with the person. The registered manager told us the person used to work as a secretary and so they gave them simple paperwork to complete. They told us; "It makes her feel valued and important."

Staff knew people well and understood their communication needs and styles. One person did not use words to communicate. The registered manager told us the person had ways of vocalizing which staff were familiar with. The person chose to spend much of their time in bed and staff frequently spent time sitting with them. The registered manager told us; "They are quite disappointed if they go in and he's asleep." We saw one member of staff sitting with this person and they were clearly enjoying each other's company.

We saw various visual aids throughout the service to support people's understanding. One person had a sequence strip on the wall to indicate, using pictures, what their daily routines were. Information about fire evacuation procedures had been put into easy read format and everyone had a copy of this in their rooms.

People were supported to maintain and develop their independence. Care plans had information about what people could do for themselves and what they needed support with.

Good

Is the service responsive?

Our findings

The registered and deputy managers met with people before moving into the service to check they were able to meet their needs. The registered manager told us ideally, they would have a planned transition period where people visited the service for increasing lengths of time to assess if it would be a suitable setting for them where they would be happy. If this was not practicable they used other methods of introducing people to the service. They told us of one situation where they had made a book for the person containing photographs of the premises and the person's bedroom so they could familiarise themselves with the environment.

Care plans were developed using information from previous providers and relatives where possible. These were regularly reviewed and updated as staff developed their knowledge of the person. The registered manager told us; "It takes time to learn all the important things, like what they like to eat and what they like to do." People were encouraged to be involved in care plan reviews according to their interest and ability to engage with the process.

Care plans included detailed descriptions of people's routines where this was important to them. This included information about what people could do for themselves and what they needed support with. The care plans covered a range of areas including physical and mental health, nutrition and hydration and medicines.

End of life care plans had been developed with some people and their families. These included information about funeral plans and where and how people would be preferred to be cared for at this period of their lives. The registered manager told us this subject could be difficult for people to consider and so they were alert to any occasions when the subject came up naturally. For example, one person had mentioned in passing they definitely did not want to be buried. The staff member had reported this back to the registered manager who had recorded it in their end of life plan.

Daily logs were used to describe the support people had received during the day, these were mainly records of completed tasks such as bathing. There was very little information on people's moods or what had worked well for them during the day. This meant opportunities to learn how to support people in line with their preferences were lost. We discussed this with the registered manager who told us they had already identified this area for improvement and would be working with staff to improve the quality of the records.

Monitoring records were in place for some people who had specific health care needs. These were consistently completed. This allowed staff to quickly identify if there was a change in this aspect of the person's health.

People were supported to take part in activities which reflected their interests and preferences. One person had recently been interested in horror films. A member of staff had come in on their day off to take them to see a film they particularly wanted to see. Another person had expressed an interest in yoga. The registered manager had bought them a yoga mat and DVD for their birthday. We met the person and they showed us a

yoga position they had learned. They told us; "I'm going to keep it up, I want to keep fit."

All adult social care providers are legally required to provide people with information they can access and understand in line with the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss. There was information on whether people required reading glasses and any support they might need to understand information. For example, it was recorded that one person needed any letters provided in large print. Hospital passports had been developed to share with other healthcare professionals if people needed to access services. These included an overview of people's health needs and information about people's preferred styles of communication.

There were systems in place to manage and investigate any complaints. A complaints policy outlined the time periods within which complaints would be addressed and responded to. There were no on-going complaints at the time of the inspection. People told us they would raise any concerns with the registered manager or other staff and were confident they would be listened to.

Good

Is the service well-led?

Our findings

The service requires a registered manager and there was one in post at the time 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.

The registered manager demonstrated a sound understanding of each individual's needs in their conversations with us. It was clear they were committed to helping to ensure people had a good quality of life. As the service was small they had limited opportunities to meet with other providers and keep up with any developments in the care sector. For example, they were not aware of the good practice guidelines Registering the Right Support.

We recommend that the service seek support for the management team, to ensure they are able to keep up to date with developments in the care sector.

There was a system of clear roles and responsibilities within the staff team. The registered manager was supported by a deputy manager and they worked closely together. For example, they shared responsibility for providing supervisions to the staff team. There were plans to introduce a key worker system. Key workers have oversight of named people's care plans and appointments.

Staff told us there were sometimes differences between the day staff and night staff teams. We discussed this with the registered manager who told us that, because of the difficulties getting all staff together for full staff meetings, the teams had separate meetings. They said they would start to invite a representative from each team to attend the other team meeting. They hoped this would improve communication between the two groups.

People were frequently asked for their ideas and opinions although these systems were not formalised. For example, when two people had swapped bedrooms the registered manager had spoken with both people to make sure they agreed with the change in arrangements.

Regular audits and checks were carried out. We saw evidence of regular audits of medicine records, personal monies and maintenance checks. The monitoring system generated graphs to show any changes to specific elements of people's well-being. This enabled the registered manager to be quickly aware of any emerging patterns or changes in people's health.

Staff rights under the Equality Act were protected. If any staff needed additional support to complete training this was provided. No-one reported any incidents where they felt discriminated against.

Action was taken to learn from any events. For example, it had been identified that one person's moods were affected cyclically in line with their medicine regime. As this pattern had been identified staff were able

to take account of this and develop a better understanding of the person's needs at these times.

Records were stored securely to help ensure confidential information was kept private. The records were up to date, accurate and complete. All care staff had access to care records so they could be aware of people's needs. The service informed CQC of any significant events. CQC ratings from the last inspection report were displayed at the service.