Loyal Care Centre Limited

Rowlandson House

Inspection report

1-2 Rowlandson Terrace
Sunderland
Tyne And Wear
SR2 7SU

Date of inspection visit:
19 June 2018
21 June 2018

Date of publication:
14 August 2018

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**

Summary of findings

Overall summary

This inspection took place on 19 June 2018 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 21 June 2018 and was announced.

Rowlandson House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Rowlandson House provides residential care and support for up to 27 people, some of whom are living with dementia. At the time of our inspection 18 people were living at the home. This is Rowlandson House's first inspection.

A registered manager was in place. A registered manager is a person who has registered with the CQC 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.

Following this inspection, we met with the provider to confirm what they would do and by when to improve the key questions of safe, effective, safe, responsive and well led to at least good. We found the service had breached a number of regulations.

Fire exits were obstructed, staff did not know how to use the evacuation equipment and the home did not carry out fire drills.

The provider failed to identify, assess and manage risks to the health and safety of people of using the service. Care plans lacked detail and were not written from the perspective of the person.

The home did not follow protocols when administering medicines covertly to people and best interests decisions had not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

The provider offered limited activities for people living with dementia. Outside areas were inaccessible to people and the risks had not been assessed. We recommended the provider reviews current guidance on meaningful activities for people living with a dementia.

Quality assurance systems were not effective as we identified a number of issues which the processes failed to recognise. For example, lack of best interest decisions, inaccurate information in care plans and the failings in monitoring training.

A robust recruitment process was in place, with staff being fully checked before starting working with people. The home had systems to monitor people's DoLS ensuring people were not being deprived of their liberty without the appropriate authorisation.

People had maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Processes were in place to investigate safeguarding concerns and accident and incidents but no analysis was carried out to determine trends and patterns. People told us they knew how to make a complaint.

Staff told us they enjoyed working at the home. People were happy with the care and support they received and spoke positively about the staff. Staff and people told us the registered manager was approachable.

The home worked in partnership with external health care professionals ensuring people received care in a timely manner.

The provider had failed to advise us of a change to their statement of purpose which is a regulatory requirement.

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.

Risks to people's health and safety were not always identified or managed.

Fire exits were obstructed and no fire drills had taken place. The provider did not have effective systems in place to support people in a safe evacuation in the event of a fire.

The provider's calculation for staffing levels was incorrect.

Is the service effective?

Requires Improvement

The service was not always effective

The provider did not ensure staff training was monitored effectively.

Best interests decisions had not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

People did not have access to a safe outside area.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidential information was not always protected.

The provider's assessment did not capture information to assist the service to protect people from discrimination.

People and relatives told us staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not personalised and some contained

inaccurate information.

People had limited access to activities.

The provider had a complaints procedure in place

Is the service well-led?

Requires Improvement

The service was not always well-led.

The home's quality assurance processes were not reliable and effective.

The registered manager worked in partnership with agencies to support care provision and ensured people received joined-up care.

The registered manager cascaded important information to staff.

Rowlandson House

Detailed findings

Background to this inspection

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

This inspection took place on 19 June 2018 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 21 June 2018 and was announced. One adult social care inspector conducted the inspection.

We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, local authority safeguarding, clinical commissioning group (CCG) and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived at Rowlandson House. As part of the inspection we conducted a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people who lived at Rowlandson House, Three relatives, the registered manager, the operations manager, two senior care members, four care staff members, one domestic support, two cooks and one maintenance support.

We undertook general observations of how staff interacted with people as they went about their work. We looked around the home and visited people's bedrooms with their permission.

We examined four staff files relating to recruitment and supervision, training records for all staff and various records about how the service was managed. We looked at care records for five people who used the

service.

Requires Improvement

Is the service safe?

Our findings

On our initial walk around the building we found the route to an internal fire exit was obstructed by ladders and staff member's belongings and posed a risk of falls to people. This area was accessible by people living at the home. Routes from two external fire doors to the rear exit were obstructed by rubbish and broken furniture. We asked the registered manager to address the matter. On our second day we found obstructions remained near one of the external fire exits.'

The home had no records of fire drills that had taken place. Staff we spoke with could not recall the last fire drill they took part in. One staff member said it was over a year ago. Staff were not able to describe the home's emergency procedure and how to use the evacuation equipment available. We advised the registered manager of our findings who immediately organised a session to show staff how to use the evacuation equipment.

Risks to people were not consistently assessed and identified. We noted within the maintenance book a nurse call system in an occupied room was reported as a fault in April 2018. The maintenance man advised us the registered manager was aware and the home was awaiting the services of an electrician.The provider informed us the nurse call had been repaired by the end of the inspection.

The registered manager told us the person who occupied the room was unable to use the nurse call system so it wasn't an issue. We reviewed the person's care records it stated '[Person] is also aware he can use the nurses call cord in his room should they require assistance day or night.' It also reported that the person remained in their room '24/7.' The registered manager told us that was incorrect and the person could not use the nurse call but the person received two hours observations during the night. The room was situated on the third floor and the nurse call system was the only method to alert staff to the person's needs. No risk assessment was in place to reduce the risks posed.

Pushed into a corner of the lounge area we found a high lounge chair with a missing leg, which made it unstable. This hazard was still accessible to people living at the home. We alerted the registered manager who had it removed.

The home was a period building with a large staircase separating the two sides of the building. Downstairs had three lounge areas, a dining room and a further room which was utilised by staff. People's rooms were located across the three floors. Areas of the home were tired in its appearance, stair carpets were worn, door handles were missing and a fire alarm box was hanging off the wall. The operations manager told us the provider was considering installing a stairlift so replacement carpets had been put on hold until a decision was made. We noted one lounge had recently been decorated. The provider informed us the fire alarm box had been repaired by the end of the inspection.

We discussed the availability of bathing facilities for people. One bath with a bath chair and one shower room were available for 18 people living at the home. The registered manager advised that the provider had taken the decision not to fix the other bath due to the cost and people had not suggested it was a problem.

The home had previously utilised the use of two hoists within the home. We were advised that one hoist had broken and the home had no plans to have it repaired.

Medicines were stored in a locked medicine cabinet within a small room. Medicines records were up to date and accurate. This included records for the receipt, return and administration of medicines. Senior staff had completed training in the safe handling of medicines. Senior staff conducted a daily audit to ensure any errors were identified quickly.

PRN (as required medicines) protocols were not in place. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines such as pain relief medicines.

Protocols for the administering of medicines covertly were not followed. Best interest assessments and a discussion with the pharmacist to ensure the person could take the medicine safely in the method described had not taken place.

People's care plans did not have information to support staff to administer medicines as the person preferred.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager advised that the home used a dependency tool to calculate staffing levels. They said they completed a calculation for each person and the operations manager then calculated the overall figure. On examining the individual forms we saw errors had been made in the scoring system on each form for the past three months. The operations manager confirmed that they had not identified this issue. This meant the service did not have an accurate calculation to ensure the appropriate staffing levels were in place.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager, one senior and three care staff were deployed during the day, with one senior and two care staff at night. We observed one person call for assistance, we went to aid the person as no staff were present. We had to call out three times raising our voice each time before a staff member came. The staff member told us other staff were supporting people in their rooms. We discussed our findings with the registered manager who advised that staffing levels were calculated taking into account people's needs and enough staff were available.

Health and safety risk assessments were completed these covered areas such as first aid, fire safety and medication. A business continuity plan was in place to ensure people would continue to receive care following an emergency. People had personal emergency evacuation plans (PEEPs) in place. We noted these lacked detail and were held on a computer system which meant they were not readily available to staff and fire service in the event of an emergency.

Records relating to the maintenance of the building were up to date and monitored. Monthly health and safety checks were conducted. The home had infection control systems in place. These included regular cleaning of premises and equipment. Protective Personal Equipment (PPE) was seen to be available for staff to use when supporting people with personal care.

Staff had recently completed safeguarding eLearning. The registered manager was proactive in investigating

any concerns raised and involved all relevant authorities. All safeguarding concerns were recorded on the home's electronic records system. The operations manager assured us that the home had systems in place for the safe storing of the information so it cannot be lost. Accident and incidents were recorded and collated. As with safeguarding concerns, accidents and incidents information was reviewed in regard to the individual involved. The provider did not carry out analysis for trends or patterns.

The provider completed full employment checks on new employees prior to them starting work. These included obtaining references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. The home also carried out three year renewal DBS checks on all staff members.

Requires Improvement

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 registered manager had systems in place to ensure people were not being deprived of their liberty without the appropriate authorisation in place. A matrix was in place to monitor people's DoLS status and applications to the local authority were made in a timely manner. We found the provider had not completed a mental capacity assessment prior to the application for a DoLS and no best interest decisions were in place when required. For example, the use of door alarms, sensor mats and covert medicines.

Staff we spoke with did not have a clear understanding of MCA and DoLS. However, they recognised the importance of gaining consent when providing care and support. Throughout our inspection we observed staff supporting people with day to day decisions.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective systems in place to monitor training to ensure staff had up to date training. On the first day of inspection the registered manager advised that the training matrix which was stored on a computer had been lost. The registered manager had not rectified the matter and was not able to show us previous records of staff training.

Following the inspection we were supplied with a training matrix which we were advised reflected the current training. We were unable to establish previous training as after repeated requests it was not made available to us. The matrix showed staff had completed eLearning training in the following subjects moving and handling, fire safety, health and safety and infection control on 22 and 26 June 2018. One staff member told us they were new to care and had not completed any training.
People and relatives we spoke with did not raise concerns about staff training. One person said, "I think they are all well trained."

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they received supervisions and records confirmed. One staff member told us, "We have them all the time every four – six weeks." We saw supervisions were conducted following an investigation into an accident.

People were supported to access healthcare professionals. Care records demonstrated the involvement of external healthcare professionals including dentists, speech and language therapists (SALT), opticians, GP and community nurses. One relative told us, "They get the doctor straight away if [family member] is poorly."

We observed a mealtime during our inspection. One person told us they enjoyed their meals. They said, "I told them I like duck so they always get it for me once a week." Pictorial menus were not available to support people living with dementia. A small print menu was displayed on the wall of the dining room. However, this was not easily accessible for people to view. People were asked for their daily choices. Staff members told us if people changed their choice of meal an alternative was always available.

Staff members were attentive to people's needs and repeatedly offered assistance to people or enquired if they would like more to eat or drink. The registered manager actively encouraged staff to sit and take their meals with people. Kitchen staff had completed dysphagia training and were aware of people's nutritional needs.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with told us staff were kind and caring. One relative said, "[Person] gets great care, the staff are so caring." Another relative told us, "The level of care is amazing, they can't do enough." One person said, "They always ask if I am ok. Nothing is a bother to them."

We were not able to speak to all of the people using the service because some of them had complex needs. This meant they were not able to tell us their experiences. We observed interactions between staff and people. People appeared comfortable with staff. When people were tactile staff responded appropriately. We saw one person reach out for a cuddle and the staff member returned the hug.

Staff we spoke with had good knowledge of people's likes and dislikes. One staff member told us, "[Person] likes to sit away from everyone. They can get anxious if too many people are about." Another staff member said, "[Person] likes to have a lay in on a morning."

People and relatives told us the home was quick to respond to their needs. One person told us, "They know before me if I'm a little off colour. A relative said, "They pick up on things, if [person] is quiet they know something isn't right." Another relative told us, "They get the doctor straight away if [person] is poorly."

Staff encouraged people to be as independent as possible. Care plans contained little information to support staff when supporting with personal care. It did not outline what people could manage and achieve for themselves and what actions they needed support for. One staff member told us, "I let people do as much as they can." Another staff member said, "I get to know what people can do or can't and I would do it for them."

We asked staff to describe how to support people with dignity and respect. One staff member told us, "I knock on the door, close the door, and ask if they would like help." Another staff member told us, "I am always respectful I think it's just like looking after my nana."

Cooks, domestic staff, maintenance team all engaged with people as they went about their duties. They enquired how people were and if they needed anything. When care staff were not supporting people, we saw they sat and chatted with people as they updated records.

Relatives told us they could visit anytime and they were always made welcome. One relative told us, "We just pop in and are always made welcome." We saw the home had sought the support of an independent mental capacity advocate (IMCA) when a person needed support with a specific decision.

The provider had an equality and diversity policy. However, this only made reference to employees of the home. We asked the registered manager how they would support people from the lesbian, gay, bisexual, transgender (LGBT) community. They said that is not a question they would ask at assessment as it is private to the person. We asked the registered manager how they home would support people if they did not ask questions about diversity. The registered manager then enquired if they needed to ask such questions. We

noted people's personal information referred to a person's marital status. This meant the provider did not gather appropriate information to ensure all the equality act characteristics were not discriminated against. We saw people were supported with their religious needs.

On the first day of inspection we found information about the running of the home and people's confidential information left unprotected in the reception area of the home. We discussed this with the registered manager and the matter was resolved on the second day. The electronic records system was password protected. Each staff had their own password to access the system this also recorded each time the staff member recorded information.

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us a full assessment was conducted prior to people moving to the home. The home had an electronic care records system in place. The system asks a series of questions and guides the staff member through all the sections and builds a profile of the person. Once the assessment is completed it then generates a care plan which the staff member can edit. We found these were not written in a personalised way and contained generic information. For example, we noted two people had word for word the same description of a fear of mirrors. No reference was made about people's choices and preferences as to how they wished to be supported.

We reviewed five people's care records and all we viewed contained inaccurate information. Some sections had missing information. For example, '[Person] is able to communicate verbally however has the following impairments(s) to their speech:' It did not give the impairment. Whilst other sections contained information that did not make sense. For example, 'English is [Person]'s preferred language and this does not hinder communication with staff.'

Care plans covered areas such as mobility, personal hygiene, continence, medication, night care and last wishes. These plans lacked detail and did not outline the support required. For example, one person's care plan reported '[Person] requires the following support and supervisions to meet their religious/ spiritual needs' however no other information was present. In another person's care plans it reported, 'May become agitated and can be affected by loud noises.' No guidance was available to support staff on the best way to support the person safely.

One person's care plan reported, 'Enjoys a pint on a teatime…' We noted the person also was prescribed a medicine that stated, 'do not drink alcohol.' Although the person had capacity no risk assessment was in place to ensure this risk had been considered. In another person's care records it reported the person had epilepsy. No risk assessment was in place to support staff in the event the person had a seizure. The registered manager told us they had not had a seizure whilst at Rowlandson House.

We observed one person naked in a corridor. We discussed this with staff and the registered manager who advised that it was normal for that person to leave their room and go to the communal toilet and bathroom naked. We were informed that the information to support the person maintain their dignity was in the person's care records. On examining the person's care records we found that was not the case and no information was found in the support plans and no risk assessment was in place to support staff in managing the situation for the person and other people.

Guidance from external health care professionals was not adopted into people's care plans. Information within the care plans referred staff to a separate blue file where the information was held. We also found people's DNACPR and Emergency health care plans (EHCP) were held in the blue files which were stored at the front of the building. EHCP contain information to help communication in an emergency for the individual, to ensure timely access to the right treatment and specialists.

We found inaccuracies which we identified had not been recognised in the provider's care plan audit. The audit reported, 'Support plans – currently being updated in a person centred format and complete.' For resident risk assessments it recorded 'yes and as and when required.'

We asked people if they were involved in the planning of their care. One person told us, "No I don't recall discussing anything. They write it." Two other people we asked did not comment.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our two day inspection we did not see any group activities taking place. The home did not have a dedicated activities co -ordinator and the only activity we observed during our inspection was staff talking with people and giving hand massages and painting people's nails.

Activities did not form part of the provider's quality audit. The provider did not offer a planned programme of activities and no community links had been established. The registered manager advised that no group activities took place as people preferred individual activities. Staff told us people were supported individually on shopping trips and visits to the pub. One person was taken to the local football club.

Outside areas consisted of a rear yard and a patio at the front of the building which was located on a main road. The rear yard was unkempt and had many hazards to people including rubbish, old broken furniture and a washing line drying clothing. People who wished to smoke were supported outside and left directly next to the door. When asked if people used the outside areas, one person told us, "It's dirty out in the yard and I won't sit on the front street." A staff member told us, "No one goes outside, we don't use it." This meant people did not have access to a safe outside area.

We recommend the provider reviews current guidance on meaningful activities for people living with a dementia.

The home had a complaints procedure in place. This was available at reception at the entrance of the home. People and relatives, we spoke with told us they did not have any concerns. One person said, "I would speak to the manager, she is lovely." Complaints were collated and recorded on the home's electronic record system. The home actively sought feedback from relatives and visitors. Feedback sheets were deposited near the sign in book and all were encouraged to complete the forms.

No one was receiving end of life care. We noted within care plans the home had made attempts to discuss people's wishes. However, people had chosen not to put plans in place at this point.

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of processes to monitor the quality of the home. This included such areas as reviews of medicines, customer money and property, health and safety, safeguarding and care records. However, we noted the issues we found during our inspections were not identified using the providers systems. For example, inaccuracies in care records, lack of mental capacity assessments and failure to address hazards within the premises.

Other areas such as the dependency tool, activities, daily walk around, mealtime experience and best interest decisions did not form part of the quality review completed by the operations manager and therefore these issues would never be captured. This meant the provider did not have effective systems in place for monitoring and assessing the quality and safety of the home.

The registered manager advised us that the local authority commissioning team had visited in March 2018 and had devised an action plan was received the end of April 2018. The action plan outlined a number of actions identified to be address within a month. We found these actions had not been completed.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home did not have any established links with the surrounding community. This had been recognised in the quality audit in February 2018 with actions to address the matter.

Staff were regularly kept up to date via staff meetings and supervisions. Monthly staff meetings for seniors, care staff and kitchen staff were conducted. The registered manager promoted an open culture within the home. They ensured all staff attended meetings, holding them twice a day when necessary. Items discussed included training, recording matters, staffing, accountability and safeguarding.

Staff we spoke with told us they could discuss issues with the registered manager and were encouraged to suggest ideas to improve the home. They told us the registered manager was approachable.

People and relatives were regularly asked to give feedback on the service they received. Feedback sheet were readily available by the signing in sheet as a reminder. The registered manager said it was an area they would be working on as response was limited.

Staff we spoke with told us they were happy working at Rowlandson House. One staff member told us, "I enjoy working here, I love helping the residents." Another said, "We all support each other it's a good team."

People and relatives we spoke with were complimentary about the registered manager. One person said, "[Registered manager] is lovely." A staff member said, "[Registered manager] gets things done."

The provider had failed to advise the Care Quality Commission of a change to their statement of which is a

regulatory requirement. We have asked the provider to address this matter.

The home had worked in partnership with a number of agencies, including the local authority, safeguarding teams and multidisciplinary teams.

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 11 HSCA RA Regulations 2014 Need for consent The home did not follow protocols when administering medicines covertly to people and best interests decisions had not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to identify, assess and manage risks to the health and safety of people of using the service. The provider failed to ensure the premises were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes to assess, monitor and improve the quality and safety of the service. Care plans lacked detail and contained inaccurate information.