Titleworth Neuro Limited

Rowland House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 1 March 2016 and was unannounced.

Rowland House Care Home is registered to provide care, support and accommodation for up to seven people who have an acquired brain injury. At the time of our visit there were seven people living at the home.

At the time of our visit a registered manager was in post. 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 visit the registered manager was on annual leave, however a senior member of staff assisted us with our inspection. We had a telephone conversation with the registered manager following the inspection.

Not all records at the home had been accurately maintained. We found there were gaps in the recordings of medication people had received and the daily recording of the temperatures where medicines were stored. However, these issues had been identified in the quality assurance monitoring as were being addressed by the registered manager.

People told us they felt safe living at the service. Staff had received training in relation to safeguarding and were able to describe the types of abuse and processes to be followed when reporting suspected or actual abuse.

Staff had received training and regular supervisions that helped them to perform their duties. New staff received a full induction to the service which included training.

Where there were restrictions in place, staff had followed the legal requirements to make sure this was done in the person's best interests. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure decisions were made for people in the least restrictive way.

People and relatives we spoke with were positive about the care provided and their consent was sought. People were positive about the caring nature of the home and all the people we spoke to consistently said that they liked the home. People told us that staff treated them with respect and attended to their personal care needs in private.

People's care and health needs were assessed and they were able to access all healthcare professionals as and when they required.

People's nutritional needs had been assessed and people were supported by staff to eat and drink as and when required. The menus provided a choice of meals and people were able to choose a meal that was

different to the menu choices. People and their relatives were complimentary about the food provided.

Documentation that enabled staff to support people and to record the care and treatment they had received was up to date and regularly reviewed. People had signed their care plans and were involved in writing and reviewing their plans of care. People's preferences, likes and dislikes were recorded and staff were knowledgeable about the care needs of people.

Relatives, partners and friends were encouraged to visit and people were supported to go out with their visitors.

Staff showed kindness and compassion and people's privacy and dignity were upheld. People were able to spend time on their own in their bedrooms and their personal care needs were attended to in private.

There were enough staff to ensure that people could undertake their activities and to meet the assessed needs of people. Staff encouraged people to be independent and to do things for themselves, such as cooking and doing their own laundry.

People and relatives told us they thought the home was well run and they were able to have open discussions with staff. People told us they were able to raise concerns and make complaints if they needed to.

Staff were knowledgeable about the values and visions of the service and worked in line with these. Staff were also aware of the whistle blowing procedures and would not hesitate to report bad practice.

Quality assurance processes were in place to help drive improvement at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of what abuse was and the processes to be followed when abuse or suspected abuse had been identified.

There were enough staff to meet people's needs.

People's medicines were managed safely.

The provider employed staff to work in the home who had been appropriately checked to ensure staff were safe to work at the home.

Is the service effective?

Good

The service was effective.

People were involved in decisions about their care.

Staff received appropriate training and were given the opportunity to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People had involvement from external healthcare professionals as well as staff to support them to remain healthy.

Is the service caring?

Good

The service was caring.

People told us they felt they were looked after by caring staff.

People's care, treatment and support was planned and delivered in line with their care plan.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

Is the service responsive?

Good

The service was responsive.

Where people's needs changed staff ensured that people received the correct level of support.

People were able to go out and take part in activities that interested them.

People and their relatives knew how to make a complaint and a complaints procedure was available at the home.

Is the service well-led?

Good

There was a registered manager in place who was registered with the Care Quality Commission.

Staff felt supported by the registered manager as well as the provider.

The provider and staff carried out quality assurance checks to ensure the home was meeting the needs of people.

Rowland House Care 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.

This inspection took place on 1 March 2016 and was unannounced. The inspection was undertaken by two inspectors

Before the inspection we gathered information about the home by contacting the local and placing authorities. In addition, we reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required to send us by law. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we had discussions with four people who used the service, three relatives, three staff, the administrator and a senior member of staff from the provider. We observed how staff cared for people and worked together. We read care plans for two people, medicine administration records, mental capacity assessments for people, three staff recruitment files, supervision and training records, audits undertaken by the provider, minutes of resident meetings and staff meetings, and a selection of policies and procedures.

At our previous inspection of the 1 October 2013 we did not identify any concerns at the home.

Good

Is the service safe?

Our findings

People said they felt safe at the home and with the staff providing their care. One person told us, "I would tell the manager if I was not happy." A family member told us, "Staff keep my relative safe and they discuss any changes with me. They are all very good, especially the manager." Another family member told us, "Yes the home is safe."

Information was displayed throughout the home about what to do if people or visitors to the home had any concerns. For example, a poster was displayed stating "If you see something, say something" and provided the contact details and a confidential telephone helpline to enable people to do this. Policies and procedures were in place so staff knew what to do if they suspected abuse or harm. Staff records confirmed they had received training. Staff knew the different types of abuse and what to do if they suspected or witnessed abuse. Staff told us they would not hesitate to follow the procedures and they were aware of the local authority safeguarding team and their role.

People were protected from the risk of financial abuse. The service held money for people and also received their bank statements. Each person had their own tin which was kept in a locked cupboard in a locked office. We checked the monies, receipts, records and bank statements for three people. They were all accurately maintained and monies in the tins balanced with the records kept.

Staff were reactive to incidents that occurred and took action to reduce the risks to people. The risk to people from repeating accidents or incidents was minimised because records of these had been recorded and discussed with staff during meetings. Staff told us that they made arrangements to try to prevent repeated occurrences of accidents and incidents. For example, one person left the building by the rear door without the knowledge of staff. An alarm was put on this door which activated when the door was opened to alert staff.

People were kept safe because assessments of the potential risks of injury to people had been completed. Risk assessments were based on daily living activities and accessing the local community. For example, moving and handling, medicines, falls, skin care, and choking. Risk assessments were reviewed on a regular basis. Guidance about the action staff needed to take to ensure people were supported to take risks were clearly recorded. Risk assessments were written in a person centred way.

The interruption to people's care would be minimised in the event of an emergency. The service had a business contingency plan that detailed the action to be taken to minimise the effects on people and the business in the event of an emergency, for example, if the lift broke down, fire or flooding. The home also had fire evacuation procedures that were displayed throughout the home. There was a grab bag which contained fire evacuation instructions, blankets and individual personal emergency evacuation plans (PEEPS). These were individual plans to ensure each person was evacuated from the home in cases of emergencies in a safe and effective way.

People and staff know what to do when the fire alarms sounded. We saw records of fire evacuation

practices had been undertaken and fire evacuation procedures were displayed throughout the home. Fire exits were clearly marked and free from obstructions.

There were detailed instructions given to staff to protect people from harm when people displayed behaviours that challenged. Staff told us that if a person was challenging, staff had written guidance on how to deal with it. For example, they had to take precautions when providing personal care to one person as they would 'lash' out. Staff told us they would place their arm over the person's arm and talk to them. Staff told us they managed to calm people through talking to them and they would give people space so they could calm themselves. We saw that staff had received training in relation to challenging behaviours. Staff stated that restraint was not used at the home.

People felt there were always enough staff on duty to support them. This was confirmed during discussions with relatives. People told us that there were always staff available to help them. One person told us, "Staff are always available when I need them." There was a good level of staff deployed to meet the needs of people. During our inspection we saw sufficient staff on duty throughout the day. People who required one to one support received this. Physiotherapy and occupational therapy sessions were taking place with individual people during our visit. People told us, and we saw that when the call alarms sounded, that they did not have to wait for staff to attend to them, the call alarms were responded to immediately.

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. The provider checked that prospective staff were of good character, which included check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People's medicines were managed safely. People told us they received their medicines on time and when they needed them. One relative told us, "There have never been any issues with the medication, the staff are sticklers about medicines." Only staff who had received the appropriate training administered medicines. Medicines were stored securely in a locked metal cabinet that was secured to a wall so they could not be accessed by unauthorised people. We identified some gaps in the recordings of medicines, but this had been identified by the manager's quality assurance check and action was being taken to rectify this.

Medicine Administration Record (MAR) sheets had a coloured photograph of the person that would help staff to identify the person medicines were being administered. This would help to minimise the risk of medicine being administered to the wrong person. Other information on the MAR files included the contact details for the person's GP and next of kin, any medicine allergies known and the route each medication has to be administered. For example, oral. The MAR sheets recorded the quantities of medicines and the times each medicine was to be administered. We observed a member of staff administering medicines. They checked the medicine against the MAR sheet to make sure it was the correct dose. They gave the medicines to individual people and waited until they had swallowed their medicines before they left them. This showed us that people could be assured they received their medicines as prescribed by their doctor.

PRN medicine protocols were in place for those people who required them. This is medicines that were to be given only 'when required.' They provided information on the type of medicine, what it was for and the maximum dose to be administered in a twenty-four hour period.

The home had a medicines return book for when medicines were required to be returned and destroyed by the dispensing pharmacist.

Good

Is the service effective?

Our findings

People received support from staff who had the necessary skills to meet individual's needs. Relatives told us that they believed staff were trained. One relative told us, "Staff always know what they are doing and are very confident in what they do."

All staff had been trained in areas relevant to their role which was in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It covers the learning outcomes, competences and standards of behaviour that must be expected of support workers in the health and care sectors and replaces previous common induction standards. Staff received training in medicines, safeguarding, moving and handling, fire awareness, first aid, food hygiene, acquired brain injury, health and safety, infection control, nutrition and hydration, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This showed us that staff received specific guidance and training related to the people they cared for which helped them to develop effective and particular skills.

Staff were provided with the opportunity to review and discuss their performance as they had regular supervisions and annual appraisals. Staff told us they were able to ask for extra supervision sessions with the manager if they felt they needed to discuss matters relating to their roles or extra training.

Decisions were made in people's best interest and staff had a good understanding of Mental Capacity Act and the Deprivation of Liberty Safeguards. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA). It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place are intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

Important decisions for people were made in their best interest and were taken in consultation with others and authorised by the local authority. MCA assessments had been carried out for people. DoLS applications had been requested and authorised with the local authority and dates for reviews had been recorded. For example, use of bedrails.

People told us they made decisions every day. One person told us, "I can bake cakes when I want." Another person told us, "I can choose what I want for my meals." We observed people making decisions throughout out visit. For example, one person told us they could go out of the home with their friends at any time. Other people told us they chose what food they wanted to eat and whether to spend time in their bedrooms on their own.

Family members told us that their relatives always made decisions for themselves, "My X always chooses the clothes they want to wear and the food they want to eat."

We observed staff asking people for consent prior to undertaking activities with them. For example, one member of staff asked a person if they were ready to go to their occupational therapy session. It was not until the person stated they were ready that the member of staff supported them to attend the session.

People's nutritional needs had been assessed and people were supported by staff to eat and drink as and when required. The menus provided a choice of meals and people were able to choose a meal that was different to the menu choices. People and their relatives were complimentary about the food provided.

People had enough to eat and drink. One relative told us, "Staff are very good with X, they help X to eat and drink, as they are introducing small amounts of food to X as he no longer has a PEG feed." They also told us, "Residents take different roles in preparing the food, some help with preparing the food, whilst others will lay the table and wash up. Everyone has a role to play."

People were involved in making decisions about what they wanted to eat and drink. One person told us, "We have menu planning meetings every week." We looked at the menus maintained by staff. Menus included meat, fish, pasta and fresh vegetables and fresh fruit. We saw staff supporting people in the kitchen to make meals and snacks. People's religious and cultures needs were considered when food was bought and prepared. People had a menu plan of the foods they wanted to eat. We also saw a very large variety of halal foods kept at the home. Another person was a vegetarian. We saw meals for these people were cooked separately from other meals. People who required a soft or pureed diet with eating would have lunch 12 noon, others would eat at 1.00pm. This was to ensure that people received the support they required.

Staff identified risks to people. People had up to date risk assessments in their care plans relating to nutrition. Specialist cutlery and mugs were provided for people who required it to help them eat their meals. People told us they liked the food and they could have a drink and a snack when they wanted to.

People could be assured that their individual healthcare needs would be met by the required healthcare professionals when they needed them. People told us they saw the GP, dentist and attended hospital appointments when they needed to. Other specialist advice was available, for example, speech and language therapist (SALT) and dieticians. Staff told us that the GP visited the home, if required, otherwise people would visit the GP surgery. A domiciliary dentist who and a hygienist visited the home. If people were anxious about seeing the dentist then appointments would be rescheduled or a gradual transition period for the treatment would be made.

People had access to equipment that supported their needs. There was a mini gym at the home where physiotherapists undertook one to one sessions with people. This was because some people, due to their diagnosis, required help and support to regain use of parts of their body that may have been affected by their acquired brain injury. During our visit one person was receiving this therapy. Other equipment provided included raised sofas, specialist transport that accommodated a variety of different wheelchairs, and turning boards. There was information available about how to use the electric scooters and wheelchairs.

Good

Is the service caring?

Our findings

People told us that the staff were caring and helpful. One person told us, "They are kind and always available when I need them." Another person told us, "I like my key worker, she is very good with me." Relatives told us that staff at the home were very caring. One relative told us, "The atmosphere is excellent, staff are friendly and they make you feel welcome all the time. I can visit whenever I want, there are no restrictions." Another relative told us, "Staff are very kind and compassionate."

We observed positive interactions between people and staff during our inspection. People looked relaxed and comfortable. Staff engaged in conversations with people and waited for them to respond to their questions. People had access to all communal parts of the home including the kitchen. We saw people in the kitchen either eating or making a snack. Staff supported people as and when they required support.

People's individuality was recognised by staff. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them. They were aware of their life histories, likes and dislikes and how to attend to each person's needs. They were aware of the communication needs of people and how to communicate with them. Staff told us they regularly looked at care plans to ensure they kept up to date with any changes to peoples' needs.

People were supported by staff who knew them and had knowledge of their past histories and their assessed needs. For example, one member of staff was able to give a clear description of how to meet the identified needs of one person that included their special dietary requirements and one to one support. People were provided with information about their care and support. People and staff told us that they had monthly key worker meetings whereby they discussed their progress. This provided people with the opportunity to have their say about their care and how they preferred to be looked after and the choices they liked to make. Relatives confirmed these arrangements and told us that they worked well.

People were supported to be independent as they were able. People and staff told us that people were mainly independent with their own personal care needs. Staff provided support to people who required it or asked for it. Staff told us they encouraged people to do as much for themselves as possible.

People's privacy and dignity was promoted. People told us that staff respected their privacy and they were able to spend time in their bedrooms, either on their own or with their visitors. People were able to continue their personal relationships.

Staff told us they always knocked on people's bedroom doors and waited for a response before entering and that personal care needs were attended to in the privacy of bedrooms and bathrooms. Each bedroom door displayed a notice when personal care needs were be attending to so other people and staff did not disturbed them. We saw people in their bedrooms with either the door opened or closed, this was their choice.

Good

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the home, to make sure their needs could be met. Care plans had been written from the information in the pre-admission assessment. People and relatives told us they had been included in the development of their care plans. Care plans were person centred and recorded people's likes, dislikes and how they preferred their care needs to be attended to. People told us that staff helped them in the way they wanted to be helped. A family member told us, "Yes I am involved in X care, if there is anything staff are concerned about, they will let me know."

Care plans reflected what care people needed. Care plans included information about people's history, healthcare needs, cultural and religious needs, medicines and communication needs. Where people's needs changed staff ensured that people received the correct level of support and care plans were reviewed and updated.

Staff wrote up daily notes for each person that recorded the care given during the day. This showed that staff had provided care and support as per the care plan. Care plans were reviewed on a monthly basis with the involvement of people. People were involved in making decisions about their care, treatment and support. Staff told us, and this confirmed during discussions with people and relative, that they reviewed the care plans with people during their monthly key worker meetings.

People were encouraged to go out in the local community. Activities were organised on an individualised basis. Each person had their own individual activity list of daily living activities that were led by the person. For example, one person's recorded activity was "Teach staff how to play dominoes." One person told us they like taking part in activities such as skittles, art and craft and exercises. Other people told us they enjoyed the activities. One family member told us," X has physio 3 days a week, he gets the newspaper, X goes to the cinema and swimming." Other activities included going out for walks, exercises, visits to the local library, games and free time for themselves. People were also included in preparing and cooking meals and doing their laundry.

People and relatives knew how to raise a concern or make a complaint. People told us they would talk to staff or the registered manager if they needed to raise a concern. Relatives told us they had not needed to make a complaint but felt they could talk to the registered manager at any time. They told us that the registered manager always listened to what they and their relative had to say and would action any requests made.

Information was provided to people and relatives about how to make a complaint and who to contact. It also included the contact details of the local ombudsman. Complaint forms were available at the home. Records of complaints showed that when a complaint had been made the registered manager had taken the appropriate action to resolve the complaint. There was also information available about advocacy services for people and relatives should they need to access these services. An advocate is an independent person who will support a person with making decisions.

Compliments about the home had been written in the people and relatives surveys undertaken in August 2015. Compliments included, "The atmosphere is very good in my experience." In relation to food, "Well-chosen and very well prepared." About the care, "I am confident that my X is being well looked after by pleasant and caring staff members," "I can't imagine a better place for my relative to be living in," and, "The Manager and staff are all really good at their job and deserve to be recognised for all their hard work. Keep it up. Shame there's not more like them."

Good

Is the service well-led?

Our findings

People and relatives told us the home was good because it was small, staff were welcoming and kind and it was like being cared for in your own home. Family members told us staff were approachable and always talked to them about their relative. One person told us, "I like the feel here, I don't think you could improve it much."

Relatives told us that the registered manager was approachable and does a very job. One relative told us, "The manager deserves an award for the way she manages the home and staff."

There was an open culture at the home. Staff told us that they had monthly meetings and supervisions where they could discuss ideas about the home. We saw minutes of these meetings that included discussions about the home, for example, staffing, people living at the home and staff training.

Staff told us they felt supported by the registered manager. Staff stated they had daily handover meetings and multi-disciplinary meetings. They said the registered manager listened to what they had to say. For example, extra occupation therapy sessions were requested for one person to help them become more independent. This was accommodated at the home.

People's views about the home were listened to and acted on. We saw records of meetings that had been held with residents and staff at the home. Staff told us that people were asked if they would like to attend the meetings. If refused then this was respected by staff, however, the meetings would take place with people who wanted them. Examples of things discussed included food, activities and the accommodation.

The provider undertook an annual survey to ascertain the views of people and their relatives about the service provided at Rowland House. Areas covered included bedrooms, food, privacy, staff support, activities and the support they received. Comments received in the surveys were positive about the home. Where an issue had been raised the manager had discussed them at staff meetings and addressed them. For example, one survey informed that there were no photographs of staff displayed at the home so people and relatives could know who was who. This had been addressed and staff photographs were clearly displayed at the home.

The provider had a set of values and vision for the home and these were on display at the home. Staff were knowledgeable about the values and vision of the service and we observed staff putting these into practice. For example, compassion. We observed staff interacting with people in a quiet and respectful manner, asking them for their views and attending to the requests made by people.

On the day of our inspection the registered manager was on annual leave. A senior person on duty was able to provide the inspection team with all the information requested, and was knowledgeable about people, staff and the home. This showed us that the home was well managed in the absence of the registered manager.

The registered manager was aware of and kept under review the day to day culture of the home. Staff told us, and we saw on the duty rota, that the registered manager worked on duty with staff. We saw a written hand over document from the registered manager that was forwarded to the senior members of the staff team and the provider that provided clear guidance and information in relation events and duties to be undertaken during her absence. For example, healthcare appointments for people, review meetings, audits due and people's birthdays.

Policies and procedures were in place to support staff. We saw a number of policies and procedures that were available to staff. These include medication, safeguarding, Mental Capacity Act 2005, deprivation of liberty and nutrition and hydration. Staff told us they had read the policies and procedures that provided guidance to them. For example, procedures to be followed when they identified a person was not eating or drinking properly.

The home was quality assured to check that a good quality of care was being provided. We saw regular audits had been undertaken by both the registered manager and a senior member representative for the provider. These included weekly and monthly audits that monitored care plans, risk assessments, food, medicines, staffing and training. Weekly audits also included checking the equipment used at the service, for example, fire extinguishers, hoists, gas and electric. We noted that when an issue had been raised it was attended to, for example, one emergency lighting had been identified as not working. This was repaired by a professional person. The service had regular checks on equipment used at the home. For example, fire protection service. This showed us that the provider and manager were aware of their responsibilities to ensure people received good safe care. Staff told us that they discussed the findings of audits during staff meetings.