Loyal Care Centre Limited

Rowlandson House

Inspection report

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

Date of inspection visit:
15 January 2019

Date of publication:
12 February 2019

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Rowlandson house is a residential care home that was providing personal and nursing care to 17 people, two of whom were in hospital at the time of our inspection.

People's experience of using this service

At the time of our inspection, people were experiencing significant change as the provider had decided to close the home.

Staff were supporting the reassessments of people to enable them to move to other homes which could meet their needs.

Nutrition plans were provided to Care Quality Commission (CQC) to meet the requirements imposed on the service following the last inspection. The plans indicated people were at risk of health conditions due to having a low body mass index (BMI). The operations manager told us this information was being passed as a priority to staff in other care homes and the advice of dieticians had been sought.

Since the last inspection improvements had been made in the administration of people's medicines. The local clinical commissioning group and a pharmacy had worked with staff at the home to improve oversight of the medicines. This had assisted staff to more closely monitor people's stock of medicine.

The home required cleaning to reduce the risks of cross infection.

Additional hoists had been provided to negate the need for staff transporting a hoist between floors.

Fire evacuation equipment was in place.

We passed on our concerns to local authority representatives to ensure people's needs could be met in their new care homes.

Rating at last inspection: At the last inspection carried out in September and November 2018 we rated this service as inadequate. (Report published 11 December 2018).

Why we inspected: This inspection was planned to check improvements to the service were underway. However, we learned on 11 January 2019 of the impending closure of the home and we carried out this inspection to check people were safe.

Follow up: The service was due to close on 18 January 2019. We will speak to the local authority to confirm everyone who used the service has moved out.

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.

Details are in our Safe findings below.

Rowlandson House

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: Two inspectors carried out the inspection

Service and service type Rowlandson House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in the service. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This was an unannounced inspection. We did not give the provider notice of our intended arrival

What we did:
Before the inspection: We reviewed the information, we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. Notifications enable us to monitor the service.

Following our last inspection in October 2018. The service was rated as inadequate and we imposed conditions on the provider. We requested information to show compliance with the conditions. Not all information was supplied within the required timescales. Further information was supplied to the CQC on 2 January 2018. We reviewed this information prior to our inspection.

On 11 January local authority commissioners advised us that the home was due to close and they were acting to ensure people could be transferred safely to other care homes. We decided to carry out this

inspection on 15 January 2019 to check to see if people were safe.

During our inspection: We looked at four people's care records. We spoke with one person who used the service and carried out observations of people who were unable to tell us about their experiences. We checked seven people's medicines records.
following the inspection we continued to work closely with the local authority.
We were advised by local authority representatives who were in the home at the time of our inspection that all people who were using the service would have moved out no later than Friday 18 January 2019.

Following our inspection: We continued to work closely with the local authority.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At the last inspection in September and October 2018 the provider had failed to ensure they met the requirements of Regulation 12 - Safe Care and Treatment, Regulation 13 – Safeguarding service users from abuse and improper treatment, and Regulation 19 – Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found improvements had been made in the administration of people's medicines.

Assessing risk, safety monitoring and management
• The provided submitted 15 nutrition and hydration care plans to us on 2 January 2019. On reviewing the nutrition plans we found six people with a BMI of less than 18 and two people with a borderline BMI score.
• People's care plans and risk assessments failed to include information regarding such low weights including re-feeding syndrome or the increased risk of cardiac failure or liver and kidney damage. Re-feeding syndrome is a potentially fatal condition and can occur when food and fluids are introduced into a malnourished person's body. No risk assessments and care plans were in place to deal with these potential issues.
• Care plans contained the required actions in line with the Malnutrition Universal Screening Tool (MUST) where a person was at high risk of malnutrition. However, daily records did not demonstrate these actions had been carried out and reviewed.

These findings evidenced a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We passed this information to local authority representatives who were visiting the home to enable them to ensure staff in people's new homes could provide people with the right support.

• Kitchen staff provided us with information which failed to describe people's needs. Following the inspection, we spoke with the operations manager who advised us there was a further file in the kitchen which contained all the required information about people's dietary needs. They told us this information was being passed to people's new care homes as a matter of priority.
• Advice had been sought by the service from dieticians. Supplements to meet people's dietary needs had been prescribed and their use was described in care plans.
• Staff confirmed they now had a hoist lift on each of the floors which avoided them having to transport a hoist between three floors to safely transfer people.

Using medicines safely
• Improvements were found in the administration of medicines. Protocols were in place with personalised information for oral medicines which were required on an 'as and when' basis.

• Stock counts were now in place for medicines. However, these were not in place for all medicines and some did not record exactly how much medicine had been received, instead records stated 'rest in cupboard.' We passed this onto local authority representatives for their information.
• Staff still did not always record how much medicine was received so when count sheets were not available it was difficult to determine what was in the building.
• When staff administered creams they did not record this on the MARs and this record just stated, 'kept in bedroom.'

Systems and processes
• The operations manager was cooperating with other agencies to ensure a safe transfer to other care homes. They were providing information to enable other professionals to make decisions about providing care for people.
• The operations manager told us people who were in hospital would be transferring to their new homes once they were discharged.

Staffing levels
• Despite staff being told the previous day of the impending closure of the home and potential difficulties with their pay, day and night staff had turned up for work to support people. The operations manager told us they hoped to keep three staff on duty at all times during the period of closure. Staff continued to treat people with dignity and respect.

Preventing and controlling infection
• If people were to continue to live in the home, the building needed care and attention to enable them to live in an environment where the risks of cross infection were mitigated.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of service users of receiving the care or treatment due to having a low BMI. Regulation 12 (2)(1)