Hollybank Trust

Rowan Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Rowan Court on 17 and 21 August 2017. Both days of inspection were unannounced; this meant the service did not know we were coming.

Rowan Court is provided by Hollybank Trust, an organisation specialising in education, care and support for young people and adults with complex needs. Staff at the home refer to people who use the service as 'adults.' The premises were purpose built and located in the grounds of Holme Valley Memorial Hospital, in Thongsbridge. The home provides care and accommodation for up to 15 people; at the time of this inspection 15 people were using the service. The building has three floors and five people live on each floor; all rooms are ensuite.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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.

At the last inspection in June 2016 we identified a breach of regulation relating to good governance, as risk assessments were not always reviewed by the stated review date, and the manager at the time lacked oversight of safety and quality at the home. A second breach of regulation we identified related to staffing and was the result of issues with training. The home had been rated as Requires Improvement in the key questions of Safe, Effective and Well-led, and Good in Caring and Responsive.

On the first day of inspection we identified concerns with the way medicines were managed and administered. We fed this back to the registered manager the same day. On the second day of inspection, four days later, we found no improvements had been made.

Accidents and incidents at the home were not always recorded on the provider's electronic system. Those which were on the electronic system did not always contain information about how they had been investigated and what measures (if any) had been put in place to prevent reoccurrences.

The provider and registered manager lacked oversight of safety and quality at the home; this was a concern at the last inspection in June 2016. The system of audit at Rowan Court was not fit for purpose.

The registered manager did not fully record how complaints had been investigated and resolved.

People's care files contained a range of person-centred risk assessments. All but one we saw had been updated according to the stated review date. This was an improvement from the last inspection. Risks to people posed by the building, equipment and utilities had been managed.

People's relatives, staff at the home, and other healthcare professionals told us sufficient staff were

deployed to meet people's needs. Our observations supported this.

People were supported to have 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. However, there was no consistent approach to mental capacity assessment at the home.

Staff had access to the training, supervision and support they needed to provide people with effective care. This was an improvement from the last inspection.

People liked the meals cooked by staff at the home; risk assessments and guidance was in place to ensure people were supported to eat and drink safely. We found one person's food and fluids charts had not been completed fully.

The building had been purpose-built for people with complex physical needs. People had specialist equipment which they had been assessed for and staff had the guidance they needed to support people with this equipment safely.

Records showed people had access to a range of healthcare professionals to help them maintain their holistic health. Feedback we received from healthcare professionals about the home was positive.

People indicated staff were caring and treated them with respect. Relatives and healthcare professionals who visited the service were also complimentary about the support workers.

Support workers helped people retain and build their independence; they also respected people's privacy and dignity. Our observations showed staff knew people very well as individuals.

People's records did not evidence how they had been involved in designing and reviewing their care plans, although support workers could describe to us how they did this. The registered manager said conversations with people about their care and support would be captured in future.

People's care plans were detailed and person-centred. Support workers could describe people's care needs in detail, although we did observe one intervention when support workers did not follow a person's plans.

People had access to a range of activities and were supported to go on holiday with support workers they chose, if they wanted to.

Feedback about the registered manager was positive. He had taken action to try and improve staff culture and morale.

Senior support workers had regular meetings with the registered manager; those held for other support workers were sporadic. The registered manager had created a newsletter to help keep staff up to date.

Forum meetings were held for people who lived at Rowan Court, and the provider organised relatives' meetings on a regular basis. A regular newsletter was sent to people's relatives to let them know about activities and events at the home.

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

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.

Medicines were not always managed or administered safely.

Accidents and incidents, and action taken as a result of them, were not always recorded.

Sufficient staff were deployed to meet people's needs. Recruitment procedures at the service were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The extent to which staff assessed people for their capacity to consent to various aspects of their care varied.

Staff received the training and supervision they needed to provide effective care and support.

People had access to a range of healthcare professionals to meet their wider health needs.

Is the service caring?

Good

The service was caring.

People told us, and our observations confirmed, staff were kind and caring. They were also respectful of people's privacy and dignity.

Support workers promoted people's independence by encouraging them to do as much as they could for themselves.

Staff knew people well as individuals and could describe each person's likes, dislikes and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The registered manager had not always recorded how complaints had been investigated and resolved.

People's care files contained detailed and person-centred care plans and information about them to guide staff.

People had access to a wide range of meaningful activities. They were supported to go on holiday if they wanted to and could choose which support workers came with them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Both the provider and registered manager lacked oversight of safety and quality of the home. The system of audit had not improved since the last inspection.

The registered manager had put plans in place to try and improve staff culture and morale.

Support workers could describe the values of the service. Our observations showed the support they provided to people was underpinned by these values.

Rowan Court

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 17 and 21 August 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience on the first day and one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider was asked 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. We used this to help plan the inspection.

Prior to the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. After the inspection we also received feedback from two healthcare professionals involved with people using the service and spoke with a representative of the local fire service.

During the inspection we spoke with three people who used the service. Each person had their own unique style of communication which staff helped us to understand. We also spoke with six support workers, the registered manager, the administrator, a learning and development officer for the provider, and a speech and language therapist for the provider. After the inspection we spoke with three people's relatives by telephone.

As part of the inspection we looked at three people's care files. We also inspected two staff recruitment documents, staff supervision and training records, two people's medicines administration records, accident and incident records, and various records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People indicated to us they felt safe at Rowan Court and their relatives agreed. One relative told us, "[My relative] is safe, definitely. We are heavily involved in [their] care and we have no worries about [their] safety there." A second relative said, "I feel [my relative] is safe living at Rowan Court."

The provider had identified issues with medicines management and responded by changing the way medicines were stored at the home. This has happened the week before this inspection. Medicines which had been stored in one place for the whole home were now stored in designated medicines rooms on each floor. When we checked the medicines room on the ground floor we identified concerns. For example, we found a bottle of liquid Paracetamol which had not been dated on opening and had no expiry date on the bottle; it had been dispensed in June 2016 so we could not tell whether it was still safe to use. Another person's bottle of Senokot liquid had expired on 1 August 2017, 16 days before this inspection. A third person's bottle of Baclofen liquid had no instructions for administration; because of this it should have been returned to the pharmacy when received and not booked in. We also found no temperature checks had been made on the fridge used to store people's refrigerated medicines. This meant medicines were not always checked or stored properly.

We checked the stock levels of three medicines prescribed either 'when required' or in boxes, and three controlled drugs, to determine whether they tallied with recorded amounts. 'When required' drugs, such as pain-killers and laxatives, are to be taken when people feel they need them. Controlled drugs are strictly regulated and include strong pain-killers such as morphine. Levels of controlled drugs tallied with stock levels in the controlled drugs register. One of the 'when required' medicines tallied with recorded stock levels. A second boxed medicine did not tally, and it was not possible to be certain stock levels for a third 'when required' medicine were correct because the number of tablets administered each time had not been recorded. This meant recorded stock levels of medicines were not always accurate.

Various medicines prescribed 'when required' for people lacked medicines protocols. Medicines protocols are person-centred care plans which inform staff when, how, and how often the medicine should be administered; they are especially important when people are unable to verbalise a need for their medicines. We found topical creams lacked body maps to show staff where, how, and how often and they should be applied. Some creams had been prescribed with vague instructions such as 'Apply when required' or 'Spread thinly to affected areas', so without further instructions it would not be possible for staff unfamiliar with the person's needs, for example agency workers, to apply people's creams correctly. This meant staff lacked the instructions they needed to administer some of people's medicines.

We found multiple gaps in both MARs we examined for different medicines. Some MARs had been amended by staff at the home and we could find no instruction from a GP or other prescriber to support these changes. For example, one person was prescribed Laxido 'when directed'; their medicine protocol stated it was to be given if the person had not opened their bowels for two days. We saw their MAR had been altered, so there was a cross in the signature box every other day at 4.30pm; staff signatures showed the medicine had been given on alternate days at 4.30pm for the 13 days prior to this inspection. This meant medicines

records were not always complete or accurate.

Concerns with medicines were a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our findings about medicines to the registered manager on the first day of this inspection. On the second day of inspection, four days later, we checked the same two MARs again; we found 13 gaps in one MAR since the first day of inspection, and gaps in the other MAR, which suggested medicines had not been administered. MARs which had been altered remained the same and medicines protocols had not been put in place or updated. This meant the registered manager failed to take action to make improvements to medicines management at the home.

This was a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the record of accidents and incidents to see how they had been investigated and what action (if any) had been taken. Any accidents and incidents at the home were recorded on an electronic system and submitted to the provider. We found most incidents between June and August 2017 had involved issues with medicines administration, such as gaps in people's MARs. Most contained details of investigations and action taken but some did not. For example, the wrong medicine was administered to a person in June 2017; it was still listed as 'under investigation' on the system and the registered manager could not tell us what action had been taken. On 2 July 2017 it was reported a person's topical cream was out of stock and had been listed as such on the last audit on 6 June 2017. The registered manager had recorded he had spoken to the medicines lead and needed to investigate further, but there was no further information as to how the incident had been resolved. This meant the registered manager could not fully evidence how accidents and incidents were investigated and whether appropriate action was taken in response.

This was a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in June 2016 we found not all risk assessments were updated within their stated review period. This was a breach of the regulation relating to good governance. At this inspection we found people had a range of risk assessments in place, and all except two we saw had been reviewed by the specified review date. We fed this back to the registered manager and he said they would be updated immediately. Risk assessments we saw were individualised and included aspects such as use of the home's vehicles, use of moving and handling equipment, participation in various activities, skin integrity, and aspects of personal care such as shaving. This meant the breach of regulation had been resolved as detailed and up to date risk assessments were now in place.

Staff we spoke with could describe the different forms of abuse people could be vulnerable to and said they would report any concerns immediately, even if they involved other members of staff. One support worker said, "I'd report abuse to CQC (the Care Quality Commission) and safeguarding (the local authority)", and a second told us, "I would speak to [the registered manager] and call safeguarding (the local authority). If it was a colleague I'd treat it the same." This meant staff knew how to recognise and report abuse.

As part of this inspection we looked around the home, in people's rooms and ensuite bathrooms, in communal areas and kitchens. We found the home to be clean and tidy; any odours we noted dissipated within a short period of time. One relative told us, "It's a very clean and hygienic environment that [my relative] lives in off what I have seen on visits", and a second relative said, "It's always clean when we call,

which is very regularly." Where people were known to be carriers of a potentially communicable infection, support workers we spoke with could identify these people and list the precautions they took to minimise the possible spread of infection. We saw information and control measures were listed in each person's care plans. This meant the home took action to help prevent the spread of infections.

Relatives told us sufficient numbers of staff were deployed at the home to meet people's needs. One relative said, "There have always been plenty of staff around on my times there", and a second relative commented, "There are enough staff on." A healthcare professional commented, "There's loads of staff." Staff we spoke with agreed but said there could be shortages of staff at times. One support worker told us, "Staffing levels are high. We're having a staff turnover at the moment so we're using agency", and a second said, "Sometimes (enough staff), yes. Summer and Christmas can be difficult with holidays and sickness. We are safe on nine to 10 staff." A third staff member told us, "There are enough staff to meet care needs. Sometimes activities are cancelled because there aren't enough staff."

Five people lived on each of the three floors at the home. All people at the home required two support workers to help them to move with specialist equipment; other support, such as help to eat and drink, could be provided by one member of staff. Day time staffing levels were four support workers per floor including one senior support worker; night time levels were one staff member per floor. In addition, on weekday mornings, an extra senior support worker was on shift to provide support and co-ordination. One so-called 'hands off senior' told us their role included ensuring people got to their activities or appointments on time, providing supervision to other support workers, and liaising with other healthcare professionals. Rotas showed most day shifts were staffed with between 10 and 12 support workers, although in the weeks preceding this inspection several people had been on holiday or gone to music festivals so staffing levels at the home did not need to be 12 at those times. The registered manager told us the home tried to source agency workers when staffing levels dropped below 12 in order to make sure people were not affected.

During the inspection we observed mornings were busy times as people got up and ready for their activities or appointments. A buzzer system was in place which staff providing support used to signal to other staff they needed help with a care intervention or to use equipment; we heard buzzers were answered promptly. Throughout the day we saw staff were present in communal areas and provided support when people needed it. Feedback from people's relatives, staff and our observations showed sufficient staff were deployed to meet people's needs.

The home was in the process of recruiting new support workers. We checked the recruitment records of two support workers employed by the service and found all the required documentation was in place to evidence robust recruitment procedures had been followed.

Records showed the appropriate checks had been made on the building, its utilities, facilities and equipment. Fire drills were undertaken regularly and people each had a personal emergency evacuation plan, which included instructions for those supporting people to follow in an emergency situation. Two fire enforcement notices had been served on the home in 2017 by the local fire service after they conducted an inspection. An action plan was in place and appropriate action was being taken in line with the agreed deadlines.

Requires Improvement

Is the service effective?

Our findings

One person we spoke with indicated they felt support workers were well trained. A relative told us, "I think that the staff are well trained." One healthcare professional we consulted as part of this inspection said, "They (the home) do engage in regular staff training there."

At the last inspection in June 2016 we identified a breach of the regulation relating to staffing, as some staff had not completed the provider's mandatory training courses and other staff training was overdue. At this inspection we found a comprehensive training matrix was in place which showed the courses staff had attended, which had been booked, and which were due. The home's administrator managed the training matrix and booked all the training courses; we saw they then placed information on the staff training noticeboard.

The training matrix showed which courses the provider considered to be 'core skills' which required an annual update, and which needed updating either two or three yearly. Annual updates included courses on safeguarding, the Mental Capacity Act 2005, health and safety, fire safety, medicines administration, moving and handling, and record keeping. Two-yearly courses included gastrostomy care, supporting people with behaviours that may challenge others, and the administration of special anti-seizure medicines. A gastrostomy is an opening made in a person's abdomen which allows them to receive liquid food and fluids via a percutaneous endoscopic gastrostomy tube, or PEG tube.

The training matrix showed most staff were either up to date with their training or had training booked for them. Gaps in training we saw were for staff members who were on long-term sickness or maternity leave. Records showed support workers received regular competency checks for the administration of medicines, moving and handling, and the administration of food/fluids via people's PEG tubes. Support workers told us they could request additional training if they wanted to.

Newly recruited support workers received an induction when they started work at the home. This involved a combination of training and on-the-job learning via shadowing other more experienced staff. A training and development officer for the provider explained how the Care Certificate had been incorporated into the home's induction process. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care.

Support workers told us, and records showed, they had access to regular supervision and an annual appraisal with more senior staff or management. Comments from staff about supervision included, "It's useful because we can bring up issues. You can speak about stuff", "It's very good to keep in touch with everything that's going on", and, "They're useful if I have any problems or issues." This meant staff received the training, supervision and support they needed to provide effective care.

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.

People who required DoLS because they lacked capacity to consent to living at the home and were being deprived of their liberty, had DoLS authorisations in place.

We found people's care files contained person-centred information on the best ways to support them to make decisions. However, care files varied in terms of the range of MCA assessments and best interest decisions they contained. One person had been assessed for their capacity to make various decisions, such as buying expensive equipment with their own money, having an online account to access TV and films, taking their medicines, and having their room decorated. A second person's care file contained two MCA assessments, one for receipt of flu vaccine and another for their capacity to make decisions around end of life care. A third person's care file contained capacity assessments for holidays, receipt of the flu vaccine, the use of a postural management system, and body hair removal. Best interest decisions involving people's families and other healthcare professionals, where relevant, had been made when people had been deemed to lack capacity.

This meant people's files were different even though they received similar types of support, did similar activities and all had their medicines managed for them. The registered manager could not explain why there was such variability across people's care files in terms of MCA assessments. This meant there was no consistent approach to the assessment of people's mental capacity to make specific decisions.

People indicated to us they enjoyed the food at Rowan Court. One relative said, "The food is good there." A healthcare professional involved with people using the service told us, "They provide a good selection of foods with good hygiene."

Mealtimes were coordinated on a floor by floor basis and cooked by the support workers on duty. Four-weekly menus had been devised which were based on foods support workers knew from experience people liked. One support worker told us, "We do seasonal changes, so in winter there's more roasts and stews. We observe people in pubs and restaurants to see if they want to try food we haven't thought of (cooking at the home). We speak to parents to find out what meals they prepared at home." Some people had special dietary needs which were catered for; one person ate a gluten-free diet and another person had dairy-free food and drinks.

During the inspection we observed people received the support they needed to eat and drink. Equipment, such as cups with handles, specially shaped glasses and cutlery, was used, and people were encouraged to manage independently if they were able. We saw people were also provided with choices; support workers communicated with people using their own unique style to find out what they wanted to eat and drink. On the second day of inspection we noted appetising cooking smells coming from the kitchen on one floor; the support worker told us they were preparing a special sausage casserole as a treat for three people who had been at a music festival all weekend. They told us, "I thought I'd make them something lovely to welcome them back. I can't imagine they'd get nice food at a festival – they've probably had burgers!"

The registered provider employed speech and language therapists (SALTs). They were responsible for updating people's swallowing risk assessments and providing staff with guidance around safe eating and drinking for each person, and the equipment they needed to eat and drink as independently as possible. A SALT we spoke with told us, "Support workers ring us to say if people are struggling to eat or having other problems." They also told us they checked each person's up to date eating and drinking guidelines were available in the kitchens on each floor when they visited weekly. This meant people were supported to eat and drink the things they liked in a safe way.

We reviewed three people's daily records to find out how their food and fluid intake had been recorded. Two people's records were fully up to date and evidenced they received the food and fluids they needed. A third person's records had gaps for some mealtimes and their fluid records were very sparse at times. This was a concern because their nutrition care plan stated that, whilst the person had a good appetite, at times they refused food and fluids and should be offered an extra food supplement on such days at supper time. When food charts were not completed properly the need for this supplement could not be determined. The person's records showed their weight was relatively stable, so this appeared to be a recording issue. We fed this back to the registered manager who said they would update staff knowledge around the importance of record-keeping.

People had access to a range of healthcare professionals to support their wider health needs. The provider employed SALTs, occupational therapists and physiotherapists, and records showed they were involved in people's care and support. One relative told us, "They (the home) were on the ball in getting [my relative] [their] new wheelchair. We had lengthy consultations with the physio (physiotherapist)." A second relative said, "[My relative's] key worker, [name of support worker], will go out of [their] way to rearrange [their] shifts so that [they] can support [my relative] to doctors' and other healthcare appointments. [The support worker] is marvellous with [my relative] at things like that."

A SALT visited the home on a weekly basis and reviewed people's speech and swallowing needs when it was required, or on an annual basis, whichever was sooner. Healthcare professionals we spoke with about the home gave us positive feedback about the care and support people received. One told us, "If they do have any concerns they always ring", and a second said, "They're quick to highlight issues, which is a big plus." This meant the service worked with other healthcare professionals to ensure people's wider health needs were met.

Rowan Court was purpose-built to meet the needs of people with complex physical needs. Rooms and corridors were large and airy; equipment such as tracking hoists, was fitted in some bedrooms so people could be transferred from their bed to their ensuite bathroom. Tracking hoists were fitted in communal lounge areas so people could get out of their chairs if they wanted to. People were also supported with a range of other equipment, such as specialised wheelchairs, walking frames, specialist sleeping support, shower trolleys and toilet chairs; risk assessments were in place with detailed guidance for their use by staff. This meant people's needs were supported by adaption and design at the home.

Good

Is the service caring?

Our findings

People we spoke with indicated staff at Rowan Court were caring. A relative told us, "When I've visited, the staff seem kind and caring and they do look after [my relative]", and comments from healthcare professionals included, "They're very friendly and welcoming", and, "They're very passionate."

We found the home to be friendly and welcoming, with a homely atmosphere. A healthcare professional we spoke with said, "I think it's inclusive. It's warm. Whenever I go it seems a happy place", and a second told us, "It's quite warm and welcoming. It operates like a family." Relatives' comments about the atmosphere included, "There has always been a good atmosphere there", and, "I find the atmosphere at Rowan Court really good. People chat and say hello. [My relative] couldn't be in better hands in my opinion." Relatives also told us they were made welcome at any time. One said, "Visits have never been an issue, we can go anytime", and a second relative commented, "There've never been any restrictions put on the times that I can visit. I can just turn up any time that I want to." We observed staff laughing and joking with people, and with each other for people's benefit and amusement, and support workers included people in conversations.

People indicated staff respected their privacy and dignity. One relative commented, "The Staff have always been very careful to give [my relative] [their] privacy and to treat [them] with dignity and respect." Support workers described how they did this. One support worker said, "We close windows, doors and blinds (when providing personal care). We communicate discreetly with colleagues to say what we're going to do"; a second support worker told us, "We cover them during washing and dressing. I knock before entering rooms." We observed staff knocking on doors before entering people's rooms during the inspection and noted support workers did not discuss people's personal information in front of others. This meant staff respected people's privacy and dignity.

We saw staff promoted people's independence and gave them choices so they could make their own decisions. People's care plans contained information about the things they could do for themselves, such as pushing their arms through sleeves or lifting their bottoms to help when getting dressed. Staff used people's unique styles of communication to help people make decisions. We observed staff taking food to a person to smell before they decided if they wanted to eat it, and a support worker spent several minutes with a person going through drinks options to find out which one they wanted. We heard one person asking about the daily phone call they made to relatives. The support worker asked which member of staff the person wanted to help them make the call; they told us the person made this choice each day. The home had two large red buttons which could be connected wirelessly to various pieces of equipment. The registered manager described a cooking session where one person got great amusement from surprising staff by using the red button to turn the food mixer on and off. One relative said, "They do help [my relative] to stay independent", and a second commented, "They help [my relative] to stay independent by doing things that [my relative] likes to do."

Staff we spoke with knew people really well as individuals; they could list people's likes and dislikes, and describe their personalities. We noted people's bedrooms were personalised and contained pictures and

items which showed their individuality. Throughout the inspection we saw people were supported according to the preferences recorded in their care plans. For example, one person liked music from two bands in particular. We saw when they came to the kitchen/dining area for breakfast a support worker changed the music for them. We observed another person enjoying classical music; a support worker spoke with the person and offered to lend them a music CD, saying, "It's very relaxing; I think you'll like it." The person indicated they would like to borrow the CD. Conversation focused on topics people were interested in, such as activities, people's families and the local football team. This meant staff had developed strong relationships with the people they supported.

It was not clear from people's care plans how they had been involved in designing and reviewing their plans. Support workers told us the information in people's care plans came from their experience of supporting people over many years and from day-to-day conversations and observations. One support worker said of updating the care plans of a person they were keyworker for, "It's mostly from working alongside [them]. [Name] struggles to engage in meetings and formal settings", adding, "We keep tweaking [the person's] eating and drinking care plans and discussing it with [them]." The person had also recently decided to change from having a shower in the evening to a shower in the morning; the support worker had updated their care plan with their preference. The registered manager agreed this type of consultation with people regarding the content of their care plans was not documented. He said they would ensure such discussions were recorded in future.

None of the people supported at Rowan Court had specific religious or spiritual needs. Each person had a spiritual care plan in place which noted they liked to celebrate occasions such as Christmas, Easter and birthdays. The staff training matrix showed support workers attended equality and diversity training on an annual basis. The registered manager gave examples of when he had supported people with equality and diversity needs in the past and said he would do so again if the need arose.

People had access to advocates if they needed them; the registered manager had referred people to advocacy services in the past. Most people had relatives who were closely involved with their care and support and so they acted as advocates for them. Records showed one person's advocate was actively involved in their care and had provided feedback about their documentation. The registered manager could describe the referral process and told us, "It's an extremely useful tool." This meant people could receive independent support with decision-making if they needed it.

None of the people using the service was receiving end of life care at the time of this inspection. Records showed dialogue with people's families about people's end of life preferences had started. The registered manager said some relatives were not ready to talk about this aspect of their family member's future care arrangements and this had led to a display about end of life care being moved from near the front entrance to the home to a noticeboard by a side entrance. The registered manager told us, "We almost need to get a foot in", and said they would continue to try and start these conversations with families when appropriate opportunities presented.

Requires Improvement

Is the service responsive?

Our findings

We asked people's relatives if they had ever made a complaint about the service. One relative told us, "I haven't had to complain", and a second said, "There have only ever really been one or two problems and that was with bank staff. We took it higher and it was sorted out to our satisfaction. We've no other complaints."

Each floor of the home had information in an easy to read format on how to complain prominently displayed outside the kitchen/dining area. Easy to read means it contained simplified wording and pictures to help people voice any complaints they had about the service. Records showed no complaints had been made by people using the service since the last inspection in June 2016.

The registered manager told us he had an open dialogue with families, particularly those who were closely involved with their family member who used the service. He said, "Most families are our most ardent fans and vociferous critics. We all want the same thing."

We reviewed the log of complaints received by the service to see how they had been investigated and responded to; we also read the provider's complaints policy. According to the complaints policy, all complainants must receive a reply to their complaint, including details of any investigation, within 10 days. We saw this did not always happen. A complaint received in July 2017 about a person's medicines had no response. Another complaint received in November 2016 about staffing and activities also had no response. The registered manager described other concerns raised in 2017 as 'informal' and said complainants had asked him not to consider them as official complaints, although one email we saw stated the complainant was 'angry' and had asked for an investigation into their concerns. The registered manager could explain what action had been taken to investigate all complaints and concerns logged and told us he had an open dialogue with people's relatives. However, he acknowledged he had not always fully documented how complaints had been investigated and responded to.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed support workers were responsive to people's needs throughout this inspection. For example, one person's salvia dampened the tops they wore. Shortly after we noted the person's t-shirt had become damp a member of staff supported the person to their room to change it. We saw they did this twice more in the next four hours. The need for regular clothing changes was recorded in the person's care plan. This meant staff were responsive to the person's needs.

We found people's care plans were detailed and person-centred. They contained information about people's likes and dislikes, their preferred daily routines, their families and social contacts, and detailed guidance about their unique styles of communication. This was in addition to care plans which guided staff on how to support people with their nutrition, personal care, mobility, medicines and any medical conditions. The registered manager told us the provider was in the process of introducing new

documentation with the aim of slimming down people's care files, as they were rather large.

A healthcare professional we spoke with said of people's care files, "They're very efficient for what I need to see." Senior care workers were allocated one or two people to act as keyworker. This meant they were responsible for reviewing and updating the person's care plans and risk assessments on a monthly basis. People's care files were also reviewed at an annual review meeting led by their social worker.

Most care plans we saw had been updated within the stated review timescales, although two in one care file relating to personal care and a person's moving and handling, had a review date of May 2017. We also noted one person's DisDAT tool was dated November 2013 and a second person's was over a year old, suggesting they were not updated on a regular basis. DisDAT tools are used to evaluate triggers for distress in people with limited verbal communication. We observed people were supported according to their care plans, apart from one instance when support workers hoisted a person onto a special cushion on the floor. We saw they did not apply the person's hoisting sling according to their moving and handling care plan and did not support the person whilst on the floor with cushions according to their care plan for this. We fed this back to the registered manager who told us the support workers would receive supervision and training. We checked other support workers' knowledge of the three people whose files we reviewed and found they could describe people's needs in terms of nutrition, moving and handling, personal care, and their unique communication styles. This meant most staff knew how to provide people with person-centred care as described in their care plans.

People communicated to us that they enjoyed the activities they had access to and had plenty to do. They also confirmed they could choose the members of staff who accompanied them to their activities. Relatives told us their family members who used the service were busy. One relative said, "[My relative] is always doing something when I phone up." A second relative commented, "[My relative] does hydro (swimming exercises) at the pool. One member of staff is a keen walker and takes [my relative] all over Holmfirth and surrounding areas and they both love it. They call in at the cafe and the charity shop." A healthcare professional involved with people using the service said, "Sometimes I can't access the patients because they're always out – which is great!"

On the first day of this inspection one person went out to a flower arranging class and another went wheelchair dancing. One person indicated to us they enjoyed swimming and exercise sessions in the pool. Support workers told us people engaged in a whole range of other activities such as going for walks, going out to pubs, restaurants and cafes, trampolining, and the cinema. Each person had an activities care plan which described their preferences and things they had tried; risk assessments were in place when required. Activities were also available inside the Rowan Court building. There was a sensory room for people to enjoy lights and music. Specialised matting had been fitted to a ground floor area so people could spend time out of their wheelchairs, if they wished. A support worker said one person particularly liked this activity, telling us, "[Name] likes to be out of [their] chair a lot too so [they] will have at least an hour a day in the 'soft play' area." This meant people had access to meaningful activities they chose, both in the home and out in the community.

Support workers told us each person could go on holiday if they wished. Staff used people's preferred method of communication and pictures or objects of reference to find out where people wanted to go on holiday. One support worker told us, "Two adults here like two sunny holidays a year. They often go together." On the first day of inspection two people were on an activity holiday in the Lake District. Another person had attended a weekend music festival in June 2017 and was attending another shortly after this inspection. A support worker explained, "The service user (person) picks which members of staff that [they] want to go to festivals or on holiday [them], thus allowing [the person] to keep [their] independence in that

instance." This meant people were supported to go on holidays and attend events if they chose.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with indicated they knew who the registered manager was, and one person communicated the registered manager came to chat with them. A support worker commented, "[Name] enjoys it when [the registered manager] comes and talks with [them]." Feedback from relatives and staff about the registered manager was positive. One relative said, "I can talk to the manager. He is approachable", and a second told us, "We have a good relationship with the manager, [name]. He goes out of his way if he isn't on duty to ring us back as soon as he gets the message."

Support workers also gave us positive feedback about the registered manager. Comments included, "He listens and I've gone to him with my issues. He's definitely approachable", and, "I think he's a brilliant guy. He's very staff focused so we can be adult-focused. I think it's a good way of doing it", although one support worker said, "He knows what's happening in the building but I think he could know more about the adults – their medicines and care plans."

At the last inspection in June 2016 we identified a breach of the regulation relating to good governance because the manager at the time lacked oversight of the safety and quality of the service. The area manager told us the provider was in the process of centralising audit across the service and was going to make them monthly. At this inspection we found improvements had not been made.

Rowan Court's manager had registered with the Care Quality Commission (CQC) in October 2016 and was not in post at the last inspection in June 2016. When we asked about audit at the home he told us, "I don't have a central system of audits at all." Lack of audit and oversight by the registered manager at the home was evidenced by the issues we found with medicines management and administration, the poor recording of complaints, and differences in the extent to which people were assessed for their mental capacity to make specific decisions. The registered manager told us people's keyworkers audited their care files once a month. However, these were the same staff responsible for writing and updating the care plans and it is not good practice to audit your own work. The registered manager said the medicines lead audited the medicines weekly; the medicines lead told us they checked medicines had not expired and there was enough of each medicine in stock to last until the next delivery. This was not a full medicines audit; it had failed to address the issues we found at this inspection and those reported on the provider's accident and incident system. Minutes from a staff meeting held in April 2017 stated a monthly audit of medicines records would be completed to identify trends; this had not happened. This meant the quality assurance tools used by the home were not effective.

The provider's electronic system used for logging accidents and incidents could not be used by the registered manager to look for trends or patterns; he told us only the provider could do this. We compared the accidents and incidents listed in one person's care file to the electronic system and found not all had been recorded there. This meant there was no evidence that investigations or any action had been taken in some cases and the registered manager could not recall details when we asked. Accidents and incidents at the home were therefore not routinely reported or investigated which meant the registered manager lacked oversight of safety and quality at Rowan Court.

Since his registration in October 2016 the registered manager had put in place an audit of people's behaviours that may challenge others in order to better understand their triggers. This was an example of good practice.

The registered manager told us the provider was implementing a new system of audit at the home. The documentation had not been put in place yet but what we saw consisted of brief tick-lists of checks a registered manager should make each day. There was no prompt to look at previous findings or consider trends in information. Representatives of the provider came to the home to meet with the registered manager on a bimonthly basis; the registered manager said, "We go through everything." He explained managers from the human resources and finances departments checked records of supervision, training and accounts, and discussed issues such as staffing levels. However, the registered manager told us these visits were often not recorded and there were no action plans produced as a result to evidence any quality improvement.

The lack of audit and oversight by both the registered manager and provider of safety and quality at the home demonstrated a continuous breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Support workers we spoke with said there was a positive staff culture at the home and a good atmosphere. One said of the culture, "It's good. It's all about the adults and led by them." There had been problems with the staff team culture and morale after the change in management in 2016. To try and better understand these issues the registered manager had asked for a manager from another of the provider's homes to observe staff at Rowan Court and provide feedback. He told us their conclusion was, "[They] found people (support workers) working independently but not part of a team." To address the problem the registered manager had arranged some shadowing for staff at another of the provider's homes and developed a task list for support workers to follow each day. The aim was to ensure workload was shared fairly and staff worked as a team. The registered manager was also considering the skill-mix of the team of support workers and senior support workers, to make sure staff worked across the three floors and knew each person's needs. This meant the registered manager was trying to improve staff culture and morale at the home.

Regular meetings were held for senior support workers; these were attended by the registered manager. Minutes showed meetings had involved a discussion of the health of people using the service, any complaints received, the importance of record-keeping, and training. At the last meeting in July 2017 it had been agreed the senior care workers would take responsibility for organising and chairing these meeting going forward. Meetings for other support workers were irregular and held on a floor by floor basis. By the time of this inspection, in 2017 there had been no support worker meetings on the ground floor, two on the first floor, and one on the top floor. Support workers we spoke with said they valued staff meetings and could share any concerns or issues. The registered manager did not attend the floor meetings, he told us it was the responsibility of senior care workers to arrange them. The registered manager said the meetings were often difficult to arrange around people's activities and staff not on duty that day were often reluctant to attend. To address this, the registered manager had created a staff newsletter to keep staff up to date and had received positive feedback about it. This meant not all staff had access to regular staff meetings, although other means of keeping them up to date had been put in place.

Forum meetings were held at the home for people to share their views about activities and to make decisions around parties and events. Meetings for relatives were organised by the provider. One relative said, "We are on the [name of committee]. We meet at main site (the provider's location) around three times a year." Since starting at the home, the registered manager had begun producing a regular newsletter for people's families to keep them informed of goings on at the home. This meant people and their relatives

were kept up to date and given opportunities to feed back about the service.

When we asked, the registered manager could not remember the provider's vision and values for the service. Support workers we spoke with could. One support worker told us, "'Quality of life, for life' is their (the provider's) mission statement", and a second support worker answered, "Independence, choice, dignity, rights, fulfilment, safety. There's two more I can't remember (they laughed). It's person-centred care basically." Staff told us they loved working with the people at Rowan Court. Comments included, "It has its stressful moments but the adults we work with are absolutely wonderful. The more I can do, the better", "I love working with the adults and seeing their smiles, I like helping them with everyday stuff. I just love it", and, "I care about the adults. I want to make a difference. They've been given this life, I want to help them live it." Our observations showed staff supported people according to the vision and values of the provider.

Registered providers have a responsibility to report certain incidents and information to CQC. We found reporting by Rowan Court was in accordance with regulation. Registered providers also have a legal duty under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 to display the ratings of CQC inspections prominently in both their care home and on their websites. We saw ratings from the last inspection were clearly displayed in the reception of the home and on the registered provider's website.

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 Medicines were not always managed or administered safely. Regulation 12 (1) and (2) (g) Records could not always evidence how accidents and incidents had been investigated and managed. Regulation 12 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Records relating to the investigation and management of complaints were incomplete. Regulation 16 (2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager failed to address concerns with medicines management and administration. Regulation 17 (1) and (2) (a) (b) (f) Records could not evidence how all complaints had been investigated and resolved. Regulation 17 (1) and (2) (a) (b) (f) The provider and registered manager lacked oversight of the safety and quality of the service. This was a breach of regulation at the last inspection. Regulation 17 (1) and (2) (a) (b) (f)

The enforcement action we took:

We served a warning notice on the Provider and the Registered Manager. They were told they must become compliant with the regulation by 3 November 2017.