Towans Care Limited

The Towans Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 was unannounced and took place on 16 and 18 August 2017.

The Towans Care Home is registered to provide care and accommodation for up to 28 older people. At this inspection there were 27 people living at the home. The home has a number of people who wish to live a more independent lifestyle within the safety and security of the care home. The provider offers respite (short stay) care.

The home is an older building; it has two floors with communal spaces such as lounges, conservatory and a dining room on the ground floor. There was a garden which people were able to freely move to. At this inspection two people were sharing a bedroom which was their choice because they were married. Everyone else had their own individual bedroom. People were able to personalise their bedrooms.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good.

Why the service is rated Good

The home now requires improvement to ensure people were safe. There were enough suitable staff to meet people's needs and to spend some time socialising with them. Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. The provider, registered manager and staff continued to encourage people to remain independent. People received their medicines safely and, where possible, were supported to administer their own medicines. People were protected from abuse because staff understood how to keep them safe and senior staff understood the processes they should followwith regard to reporting concerns. All staff informed us concerns would be followed up if they were raised.

People continued to receive effective care. People who lacked capacity had decisions made in line with current legislation. Staff received training to ensure they had the skills and knowledge required to effectively support people. However, some staff required further training and competency checks to observe medicines being administered. People told us and we saw their healthcare needs were met. People received support to eat and drink sufficient amounts.

The home continued to provide a caring service to people. People and their relatives told us, and we observed that staff were kind and patient. People's privacy and dignity was respected by staff and their cultural or religious needs were valued. People were involved in decisions about the care and support they received. People's choices were always respected and staff encouraged choice for those who struggled to communicate with them. People were supported to have a dignified death because their needs and wishes were respected by staff.

The home remained responsive to people's individual needs. Care and support was personalised to each

person which ensured they were able to make choices about their day to day lives. There were individual and group activities daily to provide a range of opportunities. These considered people's hobbies and interests and reflected people's preferences. People knew how to complain and there were always a range of opportunities for them to raise concerns with the manager and designated staff.

The home continued to be well led. People, relatives and staff spoke highly about the management. The manager continually monitored the quality of the service and made improvements in accordance with people's changing needs. When concerns were raised during the inspection the management were proactive in responding to them. The manager was proud of the links they had developed including the use of social media.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service now requires improvement.	**Requires Improvement**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

The Towans 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 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.

This inspection took place on 16 and 18 August 2017 and was an unannounced inspection. It was carried out by one inspector and an expert by experience. 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, we looked at information we held about the provider and home. This included their 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 took this into account during the inspection.

We spoke in depth with eleven people that lived at the home and had more informal conversations with others. We spoke with the manager who was the provider, deputy manager and eight staff members, including a chef, senior care staff, activities coordinator and care staff. We spoke with three visitors who regularly visited the home including a health professional and two family members.

We looked at seven people's care records and observed care and support in communal areas. We looked at three staff files, previous inspection reports, rotas, audits, staff training and supervision records, health and safety paperwork, accident and incident records, statement of purpose, complement records, minutes from resident and staff meetings and a selection of the provider's policies.

Following the inspection we asked for some information from the manager including some actions taken for things we identified during the inspection. The manager returned all information within the required time frame.

Requires Improvement

Is the service safe?

Our findings

The home now requires improvement to provide a safe service to people. Most medicines were managed safely. People could choose if they wanted to manage their own medicine and this was respected by staff. One person told us, "I have medicines twice a day" and confirmed they were always given on time. Another person said, "My medicines are given at the right time, they stay until they are taken". However, one person who was administering their own medicines did not have a secure place to store them. This meant there was a risk someone else could come and take their medicines. During the inspection the manager organised a new lockable drawer for their medicines to be stored in. The person told us the manager had been "Marvellous about the medicine" when they resolved it.

On one occasion we saw a member of care staff observe and sign for medicines being signed out because a person was ending their respite. They had not been trained to do this or had their competency checked. We spoke with the manager who immediately looked into staff training and competency checks for care staff who observed medicine administration. Following the inspection the manager told us all care staff who counter sign medicines now complete a competency check to demonstrate they understand about the medicines being administered or signed out.

People were supported by sufficient staff to meet their care needs. All staff we spoke with thought there were enough. One health care professional told us, "There is always somebody [meaning staff] around. I think it is very good". Staff had been through a recruitment procedure. This included checks on staff suitability to work with vulnerable people and references from previous employers. However, we found three members of staff did not have a full employment history in line with current legislation. This was because the current application form only requested ten years employment history. We spoke with the manager who realised the error and immediately told us they would change their application form. Following the inspection the manager told us they were seeking full employment histories for all staff and showed us their new form.

When people had specialist equipment for their care, staff would provide support when it was required. For example, one person had an oxygen machine to help them breathe. At night they were unable to reach the machine to turn it on. They told us staff were always there to help them. By helping people with their specialist equipment staff were keeping them safe and meeting their health needs. Three people required catheters. The district nurses oversaw this aspect of their care. Some staff had been shown how to manage catheter care for specific individuals. Following the inspection, the provider told us they had successfully prevented some infections for people using catheters. However, most staff told us they completed this task without suitable training. This meant there was a risk of infections spreading. We spoke with a senior care worker and deputy manager about our concerns. They immediately made phone calls to the district nurses and training providers to arrange adequate training for staff to ensure people were safe. Following the inspection the provider told us they had recently successfully resolved an issue with some of this equipment by sourcing a new provider and liaising with the district nurses.

People and visitors told us they were kept safe at the home. Two people told us they trust the staff. They

said, "No reason not to" and "Yes, I do" when we asked them. Other people confirmed they felt safe when we asked them.

The PIR told us and we saw people were kept safe because they were supported by staff who understood and recognised signs of abuse. All people could name a member of staff they could speak to if they felt they needed to. One member of staff said, "I would speak with a senior" if they were concerned. A more senior member of care staff was able to talk through the process they would take to keep people safe if there was an allegation of abuse. All staff confirmed action would be taken by the management and knew who to report concerns to externally.

People were kept safe because there were environmental checks regularly completed at the home. This included for fire safety, both by internal and external providers. The manager told us they were striving to make the home even safer by installing a new fire alarm system. During the inspection there was a routine fire alarm test to ensure the current system was all working. All specialist equipment for helping people with mobility issues had been visually checked every month by staff. In addition, every six months an external company had completed maintenance checks.

People were kept safe because accidents and incidents were managed well. Overviews of these were then analysed by senior members of staff to identify patterns. When any were found action was taken. For example, one person had an increased number of falls so a number of alert systems were explored so staff would be able to check the person was alright if they got up at night.

Risk assessments were carried out to ensure people's health and well-being and to promote independence. For example, one person had previously tried to get up whilst wearing a special cap attached to a drier when they were with the hairdresser. This meant they were at risk of hurting themselves. Their risk assessment identified actions to be taken by staff and the hairdresser to reduce this risk. Other people had risk assessments in place to administer some of their medicines themselves. Those at high risk of pressure related injuries had risk assessments in place. There were proactive measures in place such as special cushions on their chairs to reduce the risk of injury.

Good

Is the service effective?

Our findings

The home continued to be effective. People told us and we saw they enjoyed the food which was served. Mealtimes were treated as a social occasion for those who wanted to eat in the dining room. Tables were laid nicely and people were laughing and joking with each other. People told us "The food is very good. I usually get a choice which is nice. I can get a biscuit if I ask" and "I do like the food. No problem at all. I get a choice. I can get food and drink outside of meal times".

If people were not happy with the meal options they could ask for something different and this was provided. For example, one person was read out the choices of the meal on the first day of inspection. They asked if they could have a salad instead. The chef was happy to do this and then gave an option of which salads they could have. The person later told us their lunch was good. Another person in their bedroom told us they had a "Nice lunch" and staff "Always bring lunch" to them which was always hot. When people required special diets to meet their health needs these were catered for. There was a whiteboard in the kitchen which highlighted those needs and acted as a reminder for the kitchen staff.

People were supported by staff who had a range of skills to meet their needs and had completed a thorough induction. For example, one member of staff who worked in the kitchen told us they had recently been on training for people who required specialist diets. They told us "I found the course really interesting". Other members of staff told us they had recent training in fire safety and first aid. Some staff told us they had completed special training in health and social care.

People were asked for their consent before staff supported them with a task. Some people lacked capacity to make all decisions about their life. 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.

The PIR told us and we saw staff were aware of the need to assess people's capacity and make day to day decisions in their best interest when they were unable to. For example, one member of staff spoke about giving people a choice of what to wear from the wardrobe. They told us if the person remained confused they would consider what clothes the person usually wore. One senior member of staff talked us through the process if there were more important decisions. They were clear it should always be in the person's best interest and the least restrictive option. Documentation usually reflected the decisions staff had spoken about.

Regular reviews were completed of people's capacity to ensure it was still relevant. For example, one person's capacity was thought to have decreased due to dementia. As a result, appropriate decisions were taken to ensure their rights were being respected. Throughout this process the staff also considered the person's cultural and religious influences.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There were five people at the location who currently had a DoLS in place. There was a system in place to remind staff when these required renewing.

People were able to see other health and social care professionals when it was required to meet their needs. One health care professional explained staff always contacted them in a timely manner when it was required. They told us, "Staff always ask if they don't know" to make sure the correct care and treatment was being delivered. There were strong links with other health and social care professionals. For example, every Friday a named doctor would visit the home to see named people. Staff would communicate a couple of days prior to the visit which people needed seeing so the doctor could be prepared. The manager told us, "We are proud of the relationship".

Good

Is the service caring?

Our findings

The home continued to be caring. The PIR told us the home was "Offering an exceptional level of care" to the people and we saw people were supported by kind and caring staff. People told us, "Yes, I like them all [meaning the staff]. Everyone's friendly, very likeable", "They are very kind and caring" and "I am very happy". One person explained, "They look after you well" and told us staff encouraged them to do things themselves to keep their independence. Relatives said, "Staff are always kind and helpful, they always contact me if necessary" and "Staff are wonderful". One health care professional told us, "They [meaning the people] all seem really happy". Staff told us, "I love this home. This is a friendly home" and "They [meaning the people] become our family. We treat them how I want to be treated".

Compliments received in cards and emails reflected the positive, caring nature we were told about and saw. For example, one card from a relative read, "Many, many thanks for your wonderful caring care of my mother [name of person] with much appreciation". Others read, "We write this to say a huge thank you for the care and compassion that you all gave to mum whilst she was in your care" and "Just to say thank you for making my respite stay so uplifting and positive. Everyone was so helpful and kind".

People were supported to make choices and these were respected by staff. For example, one person was brought into the lounge in a wheelchair during the morning and asked by staff what they would like to drink. They responded asking for a glass of wine; another member of staff went to get them a glass of wine. The person was then asked whether they wanted to go into the garden to help set up for the party; they said "Yes" and the member of staff helped them go to the garden.

People's communication differences were respected by staff and ways were found for people to express their choices and opinions. For example, one person struggled to hear some of what staff were saying to them. So the staff used a whiteboard in their bedroom to write messages to them. By doing this they were preventing the person becoming frustrated and allowed them to communicate their choice and wishes.

People were supported by staff who knew how to protect their privacy and dignity. One member of staff said, "We knock on the door. Say who it is" before entering a person's bedroom. All staff agreed during intimate care they would close curtains and doors then put a towel over any intimate areas of a person's body. The annual quality assurance completed by people reflected the positive approach to privacy and dignity we found.

People had their end of life wishes respected so they could have a dignified death. One member of staff told us they discussed these with people in advance. When a person was unable to express their wishes and had no relatives they had arranged for an advocate to ensure their likely views were respected. The member of staff said it was important to "Make every end of life special". Another member of staff told us they made people comfortable and played soft music if they would like it.

When people had specific cultural or religious beliefs these were respected. For example, a member of staff told us a person who had recently passed away was know to have had a very strong religious faith. They

were unable to verbally communicate their wishes so members of staff sat and read the Bible to them.

Good

Is the service responsive?

Our findings

The home continued to be responsive. People were able to participate in a range of activities. These were tailored to people's interests. During the morning the activity coordinator completed one to one activities with some people such as a manicure and painting of their finger nails. The afternoon was when larger group activities were held. On the first day of inspection this was a church service. Other afternoon activities included reminiscing, pub games including a "Tipple", skittles, darts and a pub quiz.

Recently the activities coordinator had been organising a party to invite the people, those important to them and to say thank you to those who helped the home such as the vicar. Live entertainers attended on the second day of inspection and people became excited when they saw them. The activity coordinator explained they liked to organise other events for the people such as a summer holiday event. There was going to be a 'Punch and Judy' show, ice cream van, sticks of rock and other things to remind people living at the home of their past. The activities coordinator told us it was a way to "Stimulate conversation" and for people to reminisce.

People's care plans reflected their needs and wishes. They provided guidance for staff on how to support each person. For example, one person's care plan identified they enjoyed socialising and sometimes joining in activities. Staff were informed to make the person aware whenever there was an event or activity occurring at the home. It also explained the person may need to take a rest after lunch so they were "Well rested to join in the activities she enjoys". Both these things were followed by staff during the inspection. When a person was unable to be involved in their care plan their relative was asked for input. One relative said, "We went through everything; I'm confident that her care plans are all fine".

Each person had a memory box in their bedroom. Information of this nature could guide and aid staff when communicating with people living with dementia or a cognitive impairment; it may trigger memories and encourage the person to communicate. For example, one person had all their Brownie badges. Other people had a copy of the order of service from their wedding and a pilot license. Each person also had life histories created. Families were involved as much as possible with these to make them personal. People and their families valued these personalised items. For example, one person's family read out their life history at their funeral to remember them.

The PIR told us and we saw detailed assessments were completed prior to people moving in so their care and health needs could be identified. One relative said, "They [meaning the staff] keyed in very quickly to her needs. She is happy with her treatment". When people were unable to visit the home prior to moving in staff found ways to make them feel welcome. For example, one person was in hospital and was ready to be discharged yet unable to visit. The manager made some videos on their mobile phone of the person's potential bedroom and the home. They showed them in hospital. The manager informed us this was appreciated by the person.

The PIR told us and we saw people were able to express their opinions and these were listened to. There were monthly resident meetings for people to attend. These were an opportunity for information to be

shared and people to feedback about activities or concerns. When people raised any issues actions were taken to rectify them. For example, in June 2017 there were some comments about the quality of food and lack of choice of salads. There had been a review of the menus recently including consulting people about their likes and dislikes. During the inspection we saw one person chose salad for their lunch.

People knew how to complain and told us action was taken by the staff when they raised a concern. The activity coordinator told us there was a suggestion box or people can speak in private to seniors, manager or activity coordinators. Periodically they also put suggestion slips in bedrooms. All people knew who they could speak to if they had a complaint. One health care professional said, "I have never heard anyone make complaints". They continued to explain all staff were very responsive to making changes when required. Since the last inspection there had been two formal complaints. Both were resolved in a timely manner by the provider.

Good

Is the service well-led?

Our findings

The home continued to be well led. There was not a registered manager in post as the previous registered manager had left earlier this year. One of the providers was completing the application process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager explained and we saw they had recently employed a deputy manager to support them to run the home.

People and staff spoke highly about the management of the home. One health professional said, "I think it is a very good home. They are very professional". One member of staff said the management were "Really supportive". They went on to describe their own health condition which the manager had supported them through and how they went above and beyond to help them. They told us the manager was "Looking out for my well-being". The deputy manager was described as "Firm but fair".

The manager was regularly monitoring the quality of care being delivered. When improvements required were identified action had been taken. For example, one person had been administered the incorrect medicine. In response, the member of staff had been retrained and had a supervision with the manager at the time to discuss lessons which could be learnt. On another occasion the fire and rescue service had visited the home and made some recommendations such as improving the fire doors and additional carbon monoxide alerts. These had all been followed up and put in place promptly.

The provider ensured high quality care for people by sending out annual quality assurance surveys. When concerns were raised through these actions had been taken to rectify them. For example, the provider had identified better communication and links could be built with one health care professional following the responses. Another comment was raised about the number of trips out for people. During the inspection the activities coordinator demonstrated ways they were completing trips out for small groups of people at different times. For example, one person recalled with enthusiasm a tea party and they went in a taxi to it.

The manager was proud of the links they had with other people. One of the methods they used was a social media site They shared photos of recent activities and news from the home. Prior to doing this they sought people's consent and they ensured photos were dignified. Families commented on how much they found it useful. They had relatives as far as New Zealand keeping in touch this way.

The provider and manager had informed external agencies such as the local authority and CQC of specific events in line with current legislation. By doing this they were sharing information so others could monitor the care and safety of people living in the home. However, on one occasion they had not informed CQC about an incident where the police had been called to keep people safe. Following the inspection this notification was sent to CQC.