MacIntyre Care

Rowan Close

Inspection report

10 – 11 Rowan Close
Bursledon
Hampshire
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection was carried out by an inspector on 5 and 6 October 2015.

Rowan Close provides accommodation for up to six people who require personal care. They provide support for people who may have a severe learning disability, complex physical needs, sensory impairments and epilepsy. The home has its own adapted vehicle. The service can offer a variety of activities in the local community and can also support holidays and trips away.

The home had a 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 and associated Regulations about how the service is run.

Staff showed a good understanding of the needs of the people they supported. People were offered a choice of food and drinks which were sufficient for their needs and that met their dietary requirements. People's hobbies and

Summary of findings

interests were documented and staff accurately described people's preferred routines. Staff supported people to take part in activities both within the home and in the community.

There was a strong, visible person centred culture within the home. Staff identified creative and innovative solutions to delivering care that supported people to maintain their independence and to provide re-assurance when needed.

People, their families and their advocates were involved in planning and review of their care. Care plans were personalised and support was tailored to their individual needs. People's risk assessments and care plans had been reviewed regularly to take account of their changing needs. Staff were knowledgeable about people's health conditions and made referrals to health care professionals quickly when people became unwell or if they had concerns.

Relatives told us they were happy with the care people received. Staff treated people with kindness and compassion and respected people's privacy and dignity. People's end of life wishes were discussed, recorded and enabled and relatives told us their feelings were acknowledged and respected at these difficult times.

There were sufficient numbers of staff on duty to support people safely and meet their assessed needs. The provider had appropriate systems in place to recruit staff and appropriate checks were carried out before they commenced employment to ensure they were suitable for the role. Staff received an induction before they started work and were appropriately trained and skilled to deliver safe care. Staff undertook reflective practice which helped them improve the way they supported and interacted with people.

Safeguarding people was understood by staff who knew about their responsibilities to report any concerns of possible abuse. Individual and environmental risk assessments had been carried out and measures put in place to mitigate risks to people. There were robust systems in place to effectively manage the ordering, storage and administration of medicines.

Staff understood the requirements of the Mental Capacity Act 2005 and best interest decisions were made, where appropriate, and recorded in line with the Act.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We observed people's freedoms were not unlawfully restricted and staff were knowledgeable about DoLS. Applications for DoLS had been made to the local authority when appropriate.

There were systems in place to monitor the effectiveness and quality of the service provided. Incidents and accidents were recorded and analysed, and lessons learnt were communicated to staff to reduce the risk of these happening again. Complaints procedures were in place although the home had not received any complaints.

There was an open and transparent culture within the home and staff and relatives said the manager was approachable. Staff understood the vision and values of the service and were actively involved in the development and improvement of the service. The provider understood their responsibility to inform the commission of important events and incidents that occurred within the service, such as safeguarding concerns and DoLS authorisations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood the different signs of abuse and knew what to do if they had concerns. Risk assessments were carried out and plans were in place to minimise the risks.

The home had sufficient numbers of suitably skilled and competent staff to keep people safe. Staff were subject to appropriate checks before they began working in the service.

There were procedures in place to manage and administer medicines. Staff had received training in how to administer medications safely.

Is the service effective?

Good

The service was effective. Staff were knowledgeable about the requirements of the Mental Capacity Act 2005 (MCA). The provider ensured people's liberty was not restricted without authorisation from the local authority.

Referrals to health care professionals happened quickly when people became unwell or staff had concerns. People were offered a variety of food and drinks which were sufficient for their needs.

Staff had received effective induction, training and on-going development to support them in their role, and undertook reflective practice to enable continuous improvement in their care practice.

Is the service caring?

Outstanding

The service was caring. Staff were kind and treated people with dignity and respect. Staff were passionate about the support and equality of opportunity people received. The service had an enabling culture that promoted choice and independence.

People, their families and their advocates were fully involved in planning their care. Innovative and creative ideas were put in place when people needed reassurance.

Relatives told us that staff really cared and went the extra mile. Staff were sensitive to people's wishes and feelings and showed compassion and understanding when supporting people at the end of their lives.

Is the service responsive?

Good

The service was responsive. People were supported to maintain relationships that were important to them.

People's care plans were detailed and person centred and written with the involvement of families. People, families and advocates were involved in regular reviews and records were updated to provide accurate guidance for staff.

An environment had been created which enabled people to maintain their physical independence, life skills and sensory stimulation.

Summary of findings

Is the service well-led?

Good

The service was well led.

The culture within the home was open and transparent. The manager was approachable and listened to and acted on feedback.

Staff were supported and knew what was expected of them in their role. Staff understood and worked to the visions and values of the home.

The provider had quality assurance systems in place to assess and monitor the quality of the service. People, families and staff and were involved in improvements within the home.

Rowan Close

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 5 and 6 October 2015 and was unannounced.

The inspection was carried out by one inspector.

Before the inspection the provider completed 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 reviewed the information included in the PIR along with information we held about the service such as previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During our visit we spoke with the deputy manager, three care staff, the registered manager, two relatives and a healthcare professional. Following the inspection we received verbal and written feedback from four health professionals of their views of how the provider delivered care to people. People were not able to tell us verbally about their experiences of living at Rowan Close so we also conducted a Short Observational Framework for Inspection (SOFI). A SOFI is a structured observational tool which enables us to observe and analyse the way staff interact with people they support.

We pathway tracked three people's care who lived in the home. This is when we follow a person's experience through the service. This enables us to capture information about a sample of people receiving care. We looked at staff duty rosters, four staff training and recruitment records, and other records relating to the management of the home such as internal quality assurance audits.

We last inspected the home on 15 May 2013 where no concerns were identified.

Good

Is the service safe?

Our findings

Relatives told us the service provided safe care. One relative said their family member used a lap belt in their wheelchair and cot sides on their bed because without it they could be harmed. Comments from health professionals included "I have no concerns at all" and "I think people are safe here."

Staff were knowledgeable about their responsibilities to protect people from abuse and knew who to contact if abuse was suspected. Staff had received training in safeguarding people and could describe the different types of abuse to look out for. They knew about the whistleblowing policy and said they would not hesitate to use it if they had to. Whistleblowing is when staff can raise concerns about staff practice within the home either internally or externally. For example, to CQC or to the local authority.

The service had deployed sufficient and suitably skilled staff to meet people's needs. Staffing levels were assessed and reviewed to ensure the service had staff with the correct mix of skills and competency on duty during the day and night to be able to meet people's individual needs. The number of staff on duty was dictated by the care and support needs of people, and shifts were always covered by the staff team if people called in sick or were on annual leave. The staff roster for the day of our inspection showed the number of staff on duty matched that which we had been told.

Risks to people had been identified and actions taken to mitigate those risks. Individual risk assessments, for example relating to the use of the hoist and bed rails had been completed and staff understood how these should be used safely. Risk assessments relating to people's health conditions, such as epilepsy, had also been completed and the guidance followed by care staff. Risk assessments were reviewed regularly and staff were aware of how to reduce the risks to people.

There were robust recruitment systems in place. These included assessing the suitability and character of staff before they commenced employment. Applicants' previous employment and experience was reviewed at interview and references were taken up as part of the pre-employment checks. Staff were required to complete a Disclosure and Barring Service (DBS) check. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work in care.

Arrangements were in place for the safe ordering, storage and management of medicines, including controlled drugs (CD). CDs are medicines which may be misused and there are specific ways in which they must be stored and recorded. There was an effective system in place for the ordering of medicines and stock levels were not excessive. Medicines were stored in a locked cabinet and keys were accounted for at all times. Regular checks of medicines were carried out to ensure they were all accounted for. Staff received training before administering medicines and competencies were checked regularly. We observed two staff administering people's medicines and each checked the details of every person, their medicine and dosage before it was given. Staff signed the medicine administration charts to confirm each medicine had been given correctly.

Procedures were in place to protect people if there was an emergency. People had individual emergency evacuation plans which guided staff in what support each person required in the event of an evacuation from the building. The emergency plans included important information to guide staff in what action to take in different emergencies, such as the failure of the gas supply. Contact details of senior staff as well as staff who were on call and utilities companies were included in the plan.

Environmental risk assessments had been completed and actions taken to mitigate any risks identified. Maintenance checks and servicing were carried out regularly, such as on the hoist and people's wheelchairs and any action taken as necessary. For example, there was a problem with one person's wheelchair brackets which meant it could not safely be used in the home's vehicle as it could not be secured. All staff were aware this and that the wheelchair was awaiting repair.

Safety checks on the fire alarm system and home's vehicle were carried out weekly. Other equipment tests, such as emergency lighting and carbon monoxide levels were completed periodically and records were up to date. External contractors visited when required to check the gas boiler, water system and electrical wiring system which ensured the building was safe.

Good

Is the service effective?

Our findings

Relatives told us staff provided effective care and were well trained to meet people's needs. A relative said "The staff look after [my relative] brilliantly." They told us the staff knew about dietary requirements and how food needed to be prepared to meet their relative's needs. They also told us "They place her beaker so can she can feel it" which was important as the person had a sight impairment and could not see it.

Staff received an effective induction. Each member of staff had undertaken an induction when they started work which provided them with training, skills and knowledge which helped them to support people appropriately.

Staff had regular supervision and appraisal. Supervision and appraisal are processes which offer support, reflection and learning to help staff develop in their role. Staff told us they felt supported and could always access help, advice and information from their manager and senior staff. One staff member said "[The manager] is very good. I can go to her for anything. I have supervision every four to six weeks and an appraisal every twelve months."

Staff received a range of general training such as fire safety, first aid, moving and handling and training specific to people's needs. A health professional told us "I was asked to go and review someone for the continence team. I went back to do some training so that everyone was confident [in how to use the equipment]. Staff started to think about how they could transfer that knowledge to other residents and identified who else would benefit from [the equipment]." Other training included strategies for crisis intervention and prevention. This aimed to support staff to identify triggers and recognise early behavioural indicators, so that non-physical interventions could be used to prevent a crisis from occurring.

All staff completed bespoke three day training called "Great Interactions" which was a system devised by MacIntyre to enable staff to develop effective facilitation skills and provide good outcomes for people. Staff used a workbook called "My key to developing facilitation skills" which outlined examples of good practice and a self-assessment tool. This encouraged staff to reflect on what they had done, how they had done it and what they could have done differently. For example, had they thought about their positioning when carrying out an activity with a person to encourage independence and maintain eye contact where appropriate? Could they improve this for next time? These reflective self-assessments were discussed during supervision sessions so that staff and managers could review staff practice together.

People were referred to healthcare services quickly when needed. Staff regularly made contact with GP's and the speech and language therapist to discuss specific behaviours and health needs. People had access to healthcare professionals, such as the dentist, chiropractor and optician, to check on their health and wellbeing.

Staff were knowledgeable about people's dietary needs and accurately described people's requirements, including if they needed food to be prepared in a specific way such as pureed. Where food was pureed, this was done as separate items of food so that the individual tastes were identifiable and not all pureed together. We observed people enjoying their food at meal times and they were supported to eat safely. For example, one person needed to be offered an empty spoon in between each spoonful of food to encourage appropriate swallowing.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Staff were knowledgeable about restrictions to people's freedom of movement and why they were in place. DoLS applications had been made by the manager which had been authorised by the local authority and were kept under review to ensure they were re-applied for in a timely way. The home completed a "Restrictions checklist" for each person who lacked the capacity to consent to any restriction being placed on them. The checklist identified the type of restriction, the frequency and how the person responded to it. Each checklist was signed off by the area manager which ensured a second layer of checks were in place to reduce the risk of any restrictions being excessive and unlawful.

Staff sought people's consent before providing any care or support. They did this by showing objects of reference or by using signs and gestures. Staff were knowledgeable about the requirements of The Mental Capacity Act 2005 (MCA). The MCA contains five key principles that must be followed when assessing people's capacity to make decisions. These

Good

Is the service effective?

principles were applied. Decisions made in people's best interests were properly assessed. Staff told us people using the service did not have capacity to make some decisions so relatives, advocates and care professionals were involved in making decisions about some aspects of people's care. These decisions were appropriately recorded.

Outstanding ☆

Is the service caring?

Our findings

Relatives told us the staff were caring. One relative told us they valued their relationship with staff. They said "Staff go above and beyond. Nothing is too much trouble. They have a lot of patience. Their respect and compassion is genuine. All the staff deserve a pat on the back." They also told us the staff looked for creative ways to make life interesting for their relative who had lost their sight by stimulating the senses of touch and smell. They gave an example of arranging a trip to a lavender farm because of the lovely smells. Staff told us "I love working for MacIntyre Care because of their philosophy of care" and "These guys are the priority." Health professionals told us the staff were caring and seemed to know people well. One health professional told us they had always found people to be well dressed. Another health professional said "Staff respect people's dignity."

There was a strong, visible person centred culture within the home. People had personalised bedrooms with things that were important to them, such as photographs and momentos. One person had a photo of themselves on a special day out which had been blown up onto a canvass and fixed to their bedroom wall. Another person had been supported by staff to attend their sister's wedding and a large photo was on their bedroom wall as a reminder of the day. People had been involved in choosing colours and themes for their bedrooms, such as butterflies and African animals. The garden had recently been landscaped and staff had been fundraising to help to fund the purchase of garden furniture and ornaments. People had visited the garden centre with staff and chosen the ornaments they liked, such as lizards and windmills, to put in the garden.

Staff knew people well and were able to tell us about them in detail, such as their care needs, birthdays, preferences, life histories and what they liked to do. We consistently saw that staff engaged people in conversation and choices about what activities they wanted to do, or what they wanted to eat or drink. Staff spoke with people in a kind, friendly and courteous manner, depending on the method of communication the person responded to, which included communicating by using hand gestures, pictures and symbols. Staff spoke kindly with people, smiled, encouraged and promoted independence by enabling them to do as much for themselves as possible. For example, one person was encouraged and supported to make their own drink in the kitchen which had lowered worktops and sinks that made it possible for them to reach from their wheelchair. People also had access to advocates to support them to be involved in discussions and make decisions alongside their family members to maximise their independence.

Staff treated people with dignity and respected their privacy. We observed staff knocking on all doors throughout the home, not just their bedrooms. For example, when entering the dining room where people were taking part in activities. Staff excused themselves when they left a room and explained why they had to go and when they would be back. People were addressed by their preferred names and were acknowledged as individuals.

The atmosphere in the home was friendly and relaxed. Staff consistently supported people in a calm, positive and respectful manner and provided reassurance by using gentle touch. One staff member told us one person had lost their sight so it was important "To touch [the person] so she knows you're there." At lunchtime one member of staff showed genuine concern that a person was showing signs of having a seizure. They knew the signs to look for and sat with the person talking to them calmly and gently stroking their hand. They told us they would keep the person with them while they cleared up the lunch plates so they could "Keep an eye on them." The staff member was re-assuring and was mindful of the person's dignity.

Staff were highly motivated and inspired to provide excellent care. There were "Think bubbles" around the home with key works relating to the Great Interactions training staff had completed. For example; Listen; Eye contact; Warmth; Positioning and Communication. Staff talked to us about this throughout the inspection and referred to it regularly. It was clear from our observations that the philosophy was embedded in their day to day work. One staff member told us "The key when supporting with food is positioning. It's crucial. There is a problem with [a person's] wheelchair and I can't make eye contact. It feels wrong. This is a vocation, not just a job."

Staff used creative ways to develop tailored and inclusive communication. For example, they had made one person a "Happy face" with a recording inside of their relative's voice saying "Good morning" and "Goodnight." They had

Outstanding ☆

Is the service caring?

recorded another relative's voice and put the recording inside the person's teddy bear so it talked to them. For example "How are you?" They told us this helped to re-assure the person and offer comfort if they were upset.

People's end of life care was discussed, planned and enabled with relatives and other professionals, and their wishes were recorded. Staff cared for, and supported people and their relatives with empathy and understanding during the end stages of their life. One relative told us the staff were compassionate and "They [staff] listen to how I feel." They told us that when their relative was very ill the staff "Offered to make a bed up for me at 2am so I could stay with her."

Good

Is the service responsive?

Our findings

Relatives told us staff were responsive to people's needs. Comments included "These good homes are few and far between. They have known [my relative] a long time. They know if she is uncomfortable or in pain. They keep me in the loop." Most comments from health professionals were positive. One health professional told us they thought the staff had a good understanding of people's needs and would contact them if they had any concerns or needed advice. Another told us "I have found the carers to be accommodating. They have collected data to inform assessment, for example, by completing coughing charts to assist in the assessment process. They have appeared to take on the recommendations made to minimise risk of aspiration."

We received some comments that indicated not all recommendations were responded to. For example, one health professional told us the home did not always take up opportunities for hydrotherapy. We discussed this with the manager who told us this was a private therapy and whilst some people took part in this therapy, some people could not afford to participate due to the high cost. They told us that any other recommendations that were put in writing would always be acted upon or discussed with the health professional further. They told us this was to ensure all recommendations were being followed appropriately and were not being misunderstood or communicated inconsistently throughout the team.

Initial assessments were undertaken before people moved in to the home. These recorded people's needs, such as communication, medicines and getting around. Assessments included periods of time where staff visited people in their previous home and worked alongside staff there to get an in depth understanding of the person, their care needs and routines. People also had the opportunity for a short stay at Rowan Close before a final decision was taken for them to move in. Compatibility was taken into account when assessing people for a place at Rowan Close to ensure that people who already lived there did not get upset or distressed.

Care plans were personalised and contained detailed information about people's health and social care needs and included information about their likes and dislikes, preferences, hobbies and interests. Records gave clear guidance to staff on how best to support people, for example a person's daily routine was broken down and clearly described so staff were able to support people to complete their routine in the way that they wanted. Care plans recorded people's specific behaviours. For example, one person's care plan stated "I will take the glass to my mouth and take the drink. I will pass it back to you. If you do not take the glass within three to four seconds I will drop it." People, their relatives and their advocates were involved in regular reviews with staff and care plans were updated to ensure they reflected people's changing needs and any recommendations provided by healthcare professionals. These were signed by relatives to confirm they were satisfied, and agreed with the care plans and risk assessments. Annual reviews were held with the local authority to ensure people's care packages were still appropriate.

People were able to take part in a range of activities which suited their individual needs. On the day of the inspection all of the people who lived at Rowan Close were taking part in various individual activities such as Connect Four, sensory games or watching a film. Others attended community activities. Care records showed people had been supported to take part in or attend their chosen activities most of the time. Staff explained that if a person was unable to attend their planned activity in the community, for example due to not being well, they would offer something to do in the home, such as listening to music, games or crafts. Each person had a daily record which staff completed to record what they had been doing and any observations regarding their physical or emotional wellbeing.

People were protected from the risk of social isolation because the service supported them to have a presence in the local community and access local amenities. For example, people regularly went to the lunch clubs, visited the garden centre or to the hydrotherapy pool. People were encouraged to maintain relationships that were important to them. Relatives and friends could visit at any time and one relative told us they came at different times and were always made welcome. Staff told us they had facilitated Skype (a computerised communication system) to enable a person to see and hear their family members as they could not communicate verbally by telephone.

The organisation had a complaints procedure which provided information on how to make a complaint. There was a complaints box in the hallway with a picture of a sad

Good

Is the service responsive?

face on the front for people to leave comments or complaints. The home had not received any recent complaints but one visitor had left a comment requesting that a pen was left out with the signing in book. This had been addressed. A relative told us "I have never complained but I would speak to [the manager] if I had need to."

Good

Is the service well-led?

Our findings

Staff and relatives told us the service was well-led. A relative told us "[The manager] leads them well. The culture is right. She doesn't take any nonsense. You're only as good as your leader." They told us they felt involved and were kept up to date with important information at reviews or when they visited. Healthcare professionals told us the home appeared to be well run and staff were responsive. Relatives had been given an annual survey to complete and the results were positive. For example, "We are extremely satisfied with [our relatives] care under the superb management of [the registered manager]."

One staff member said "[The manager] is top dog. She is good. I can go to her for anything." Another staff member said "I'm proud of this house. We get a lot of input to be the best of the best. I need to know I'm getting it right." Staff told us they could access support when needed. One staff member said "The manager is very open and approachable".

The registered manager demonstrated a thorough understanding of people's individual needs and they knew their relatives well. They had volunteered to take part in a research study, with the permission of a person's relative, conducted by The University of Cambridge to provide data about a person's epilepsy. This was to help monitor seizure patterns and identify and develop more suitable medicines to manage the condition.

The registered manager understood their staff and knew the strengths and needs of the staff team. This enabled staff to be given responsibilities in line with their skills, knowledge, abilities and competencies. Staff understood the vision and values of the home, and this was evident from our observations throughout our inspection. Staff felt valued and said there was a good team ethos. The registered manager explained that MacIntyre Care had a companywide staff award every year and she had nominated a member of staff for the award in recognition of their work.

Staff were actively involved in improving the service and were clear about their responsibilities. One staff member said: "There is an open culture and we share ideas." They told us there were regular staff meetings and there was an open agenda where staff could discuss issues that were important to them. Minutes of the last meeting showed that staff discussed incident and accident forms, the complaints procedure and fire evacuation.

MacIntyre Care held regular meetings within the company to discuss and develop key areas, and staff from Rowan Close attended these. For example, there were staff council meetings to discuss staffing issues, and health and safety committee meetings. Minutes showed that staff had discussed issues specific to health and safety at Rowan Close. There was also an independently chaired safeguarding group which ensured up to date and consistent practice in relation to safeguarding people from harm.

The home had a system in place to manage and report accidents and incidents. All incidents were recorded by staff and reviewed by the manager. However, not all actions taken had been recorded. We spoke with the manager who explained what action they had taken and said they would ensure actions were recorded in future. Care records were amended following any incidents if they had an impact on the support provided to people using the service.

As part of the provider's drive to continuously improve standards, regular audits were conducted by the registered manager and area manager to identify areas of improvement. Audits included checking the management of medicines, risk assessments, care plans, DoLS, mental capacity assessments and health and safety. The home had received an annual service audit in August. Recommendations and actions had been written into a service development plan which the registered manager had just received and was about to start working through.

The provider understood their responsibility to inform the commission of important events and incidents that occurred within the service, such as safeguarding concerns and DoLS authorisations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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