Avery Homes (Nelson) Limited

Rowan Court

Inspection report

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Date of inspection visit:
16 May 2017

Date of publication:
16 June 2017

Ratings

Overall rating for this service

Is the service safe?

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?

Summary of findings

Overall summary

This unannounced inspection took place on 16 May 2017. At our previous inspection in October 2016 we had found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe, effective, caring, responsive and well led. The service had been rated as Inadequate and placed into special measures. At this inspection we found some improvement in all areas of care. The service was no longer inadequate and will be removed from special measures. However during this inspection we identified further improvements were required and the provider remained in breach of three regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rowan Court provides care and support, including nursing care, for up to 76 people, some of whom were living with dementia. At the time of the inspection there were 51 people living in the home.

There was a new manager in post who was in the process of registering with us. 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.

Risks of harm to people were not always assessed, managed and minimised. Staff did not always have the information they needed to be able to care for people safely.

People were not always safeguarded from harm or abuse as incidents of potential abuse were not always referred for further investigation. Some people were at risk of abuse as decisions were being made in isolation by staff at the service and the principles of The Mental Capacity Act 2005 were not always being followed.

People were not always receiving care that met their individual needs and preferences. Care records were regularly reviewed, however they were not always up dated promptly to ensure staff had the correct information to be able to care for people safely.

People's right to privacy was not always upheld. However, people told us they were cared for by staff who treated them with dignity and respect.

People received health care advice and support if their physical needs changed, however there was a delay in people receiving support for mental health care issues.

People were offered a choice of food and drink and if people lost weight or experienced difficulties in eating or drinking, referrals were made for advice.

People's medicines were stored and managed safely. People had their medicines at the required times.

There were sufficient numbers of suitably trained staff to meet the needs of people who used the service. New staff had been recruited through safe recruitment procedures to ensure they were of good character. Staff felt supported and received training to be effective in their roles.

The provider had a complaints procedure and action was taken when people raised concerns. There was a range of hobbies and activities available to people if they chose to join in.

The provider and manager had implemented new systems to drive improvement, however not all of the systems had proved effective in identifying the required improvements.   .

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 consistently safe.

Risks of harm to people were not always assessed, minimised and managed safely.

People were not always safeguarded from abuse.

There were sufficient numbers of suitably trained staff to meet people's needs safely.

People's medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of The MCA 2005 were not always being followed to ensure that people were being safeguarded from unlawful restrictions.

People did not always receive health care and advice in a timely manner.

People were supported to eat and drink sufficient amounts to remain healthy.

Staff received training and support to be effective in their roles.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy was not always upheld.

People were treated with kindness and respect.

People were able to make choices about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always receiving care that reflected their individual needs.

There was a range of hobbies and activities available to people based on their personal preferences.

The provider had a complaints procedure and were responsive to people's concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems the provider had in place to monitor and improve the quality of service had not been fully effective in making the necessary improvements.

There was a new manager in post who was in the process of registering with use.

People who used the service and staff felt that positive changes had been made.

Care Quality Commission

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 16 May 2017 and was unannounced. It was undertaken by three inspectors, a specialist nurse advisor 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.

We looked at a range of information we held about the service which included the action plan the provider had sent us following our last inspection. We also looked at notifications the manager had sent us about significant incidents. Statutory notifications include information about important events which the provider is required to send us by law. We had discussions with the local authority to gain their views on the quality of service. We used this information to help us plan the inspection.

We spoke with ten people who used the service and three visiting relatives. We spoke with seven members of staff, the manager and area manager and two visiting health professionals. We observed people's care throughout the service.

We looked at the care records for ten people. We observed medication administration and looked at medication records. We looked at staff recruitment files, rosters and the systems the provider had in place to monitor and improve the quality of service.

Requires Improvement

Is the service safe?

Our findings

At our previous two inspections we found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment being delivered was not always safe.

At our last inspection we found that some improvement had been made in the management of medicines and the deployment of staff. However we found further concerns and continuing risks to people as they were still not receiving care and treatment that was safe. At this inspection we found that further improvements had been made, however we still had concerns that people were not receiving care that was consistently safe as people's risks of harm were not always being assessed and managed safely. The provider remained in breach of this regulation.

We had previously found that some people who experienced periods of anxiety which resulted in behaviour that challenged were not being cared for safely. A person's behaviour can be defined as "challenging" if it puts them or those around them at risk, or leads to a poorer quality of life. At this inspection we found that although staff had received training in some areas of managing people's behaviours some people were still not receiving care that was safe when staff were supporting them during periods of anxiety. People's care plans lacked comprehensive information in how to support people at times of heightened anxiety. We saw records that confirmed that staff were adopting different approaches to supporting people. We looked at one person's care records and saw that one of the approaches staff told us they used meant holding the person. This was not safe for the person or staff as they had not been trained to use this approach. This put people at risk of harm as care being delivered was not safe.

We saw that staff did not always follow people's risk assessments. For example, one person had recently ingested some of their own toiletries. We saw a risk assessment had been put in place which stated that all toiletries should be removed from the person's room. We checked the person's room and found that their toiletries were in there and within easy reach of the person. This meant that this person was at risk of harm as their risk assessment was not being followed to ensure their safety.

We saw another person's risk assessment stated that they should be observed in communal areas as at times their behaviour became unpredictable and they could potentially cause harm to other people who used the service. We observed that this person was often unobserved in the corridors, coming and going to their bedroom. This person's risk assessment was not being followed to ensure the safety of other people who used the service.

Risks of harm were not always minimised following incidents that could have harmed people. For example, we saw one person had recently fallen forward out of their chair and the chair had toppled over on top of them. The person's risk assessment had not been reviewed to reduce the risk of this occurring again.

These issues constitute a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were not always being safeguarded from abuse. At this inspection we found that the provider was still in breach of this regulation.

We saw that staff recorded incidents of abuse they had witnessed such as when one person who used the service assaulted another. However, we found that not all of these incidents of abuse had been reported to the local authority for further investigation. This meant that people were not being protected from the risk of further abuse.

This was a continuing breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 18 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014. There had been insufficient numbers of suitably trained staff to meet the needs of people who used the service. At this inspection we found that improvements had been made and they were no longer in breach of this regulation.

One person told us: "There seems to be loads of them (staff) around. I don't think I have missed out on anything because no one is about." All the staff we spoke with told us there were sufficient staff to meet people's needs in a timely manner. One staff member said: "The new manager has made changes and it's much better. The new manager told us that staffing had been increased throughout the service and that the provider was reducing the number of nursing placements to ensure they could safely meet people's needs. We observed care in all three areas of the service and did not see that people had to wait to be supported with their care needs.

People were supported by staff that had been safely recruited. The provider was carrying out pre-employment checks to ensure staff were suitable to work with people. There was a staff recruitment procedure in place including carrying out relevant checks such as Disclosure and Barring Service (DBS) to ensure that staff were suitable to work with people who used the service. The provider obtained suitable references, employment history and DBS checks for each person before they were offered employment.

At our previous inspections we had concerns that people's medicines were not always being managed safely. We had found that staff did not have the correct instructions to be able to safely apply people's prescribed creams. At this inspection we found that new records had been put in place to support staff to be able to apply people's creams as prescribed. We saw that staff were signing the records when they had applied the creams. One person told us: "I always get my tablets when I need them". We observed a medication round and saw that they were administered safely by suitably trained staff. If people were prescribed 'as required' (PRN) medicines such as pain relief, this was offered to them. There was clear guidance in individual protocols for staff to be able to administer PRN medicines as prescribed. We observed that medicines were stored in a locked cabinet and in a locked clinical room. This meant that people's medicines were being stored and administered safely.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found that the provider was not consistently following the principles of the Mental Capacity Act 2005 (MCA) and that they were in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The 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.

At this inspection we found that some decisions were being made on behalf of people who lacked mental capacity without following the principles of The MCA 2005 Best interest decisions should involve all people who are involved in the person's life to ensuring that a multi-agency approaches adopted. This safeguards the person from unlawful decisions being made on their behalf. We saw that one person's care plan stated that if they refused personal care that this should be carried out 'anyway' in their best interests. This decision had not been discussed and agreed through the MCA 2005 procedures. This meant that this person was not being safeguarded from the risk of abuse through the use of unlawful restraint.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some people had been referred for a Deprivation of Liberty authorisation. We saw one person had been confined to their bed for three weeks as the staff had decided that this was in the person's best interests following an incident. This decision had not been discussed and agreed through the MCA 2005 procedures. This meant that this person was not being safeguarded from an unlawful deprivation of their liberty.

This was a continuing breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People generally received health care advice and support when their physical health needs changed or they became unwell. We saw and spoke with a visiting GP on the day of the inspection who attended the service on a regular prearranged basis. However, we identified a delay in gaining support and advice for people when their mental health deteriorated. Some people required professional support for heightened times of anxiety and would of benefitted from a community psychiatric nurse (CPN). Some people had a CPN however they were not actively working with the person or the staff to support them with their anxiety. We saw one person had recently been referred to a CPN however this was only identified by another professional involved in the person's care. This meant that not all people were receiving the health care support they required in a timely manner.

At our previous inspection we had found that people did not always have their assessed nutritional needs met as action was not always being taken to ensure people had their drinks as required to prevent the risk of choking. At this inspection we found no concerns in relation to thickened fluids however we saw that one person's care records stated that they had been assessed by a speech and language therapist (SALT) as needing a 'moist normal diet'. We spoke to staff who were unable to tell us what a 'moist normal diet'

consisted of and we saw records and staff told us the person ate a normal diet. This meant that this person was at risk of not having their individual nutritional needs met.

People we spoke with told us they liked the food and that they were offered choices. One person told us: "You get two choices for your meal. I've always liked one and you get plenty to drink". We saw people's weight was monitored if there were concerns about weight loss and referrals were made to the GP or SALT if necessary. We observed meal time and saw that people were offered a choice in way in which met their individual needs. For example, staff showed some people the plates of food so they could visualise the choices. When people required support with eating and drinking this was completed in a calm and patient manner. For example, we saw one person being supported with a pureed meal and the member of staff explained what each item of food was and asked if they were ready for the next forkful before taking the food to the person's mouth.

At our previous inspection we had concerns that staff were not always being supported to fulfil their role effectively. At this inspection staff told us and we saw that they were receiving training and the support they required. One staff member told us: "The new management are amazing, I feel really supported". Another staff member told us: "The induction process has changed over the last few months. Before we were just left to get on with things. Now we complete all the basic training we need. This included moving and handling and safeguarding. We then have shadow shifts where we work on shift with other staff members. We get to know the routine and the people we are supporting. Only when we feel confident are we then put on shift as a regular staff member." Since the last inspection a dementia specialist had been supporting staff to care for people with dementia and staff had begun to attend training in the proactive approach to behaviour that challenged. A member of staff told us: "We've had lots of support from the dementia specialist, she's great". There was a regular programme of training and staff told us they had one to one time with a manager and regular staff meetings. A member of staff told us: "We recently met with the manager as part of a group supervision. This was to discuss inconsistencies in the recording of people's individual food and fluid intakes. We discussed methods on how to best record amounts to ensure we were consistent." This meant that staff were being suitably trained and supported to fulfil their roles effectively.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found that people's right to privacy was not always maintained as people who were being cared for in bed had their privacy and dignity compromised. We had seen that several people required catheters and these were clearly on show to visitors passing people's open bedroom doors.

At this inspection we found that although we saw no catheters visible some people were still not having their right to privacy upheld. Most bedroom doors on the nursing unit were left open and we saw several people being cared for in bed who were in an undressed state. We saw several members of staff walk past the bedrooms and did not take any action to protect people's dignity. One member of staff did eventually see this was a concern and covered people up to protect their privacy. We discussed with the manager whether people had been asked if they wished their bedroom doors to be left open. Visitors could clearly see the individual needs of the person and some people were sleeping and it was unclear why their bedroom doors were open. Following the inspection the manager told us that they planned to ask people what their preferences were in relation to their bedroom door being open.

People and their relatives told us that staff treated them in a kind and caring way. One person told us: "The staff are great, you've only got to mention something and it's done. Another person told us: "They are good carers they are always tender". A visiting relative told us: "I saw another resident looking poorly the other day. The carer was on the floor holding their hand. That for me says it all".

We observed that staff interacted with people in a compassionate, patient manner. For example, we saw one person started to cough whilst at the dining table. A staff member went to them and sat with them whilst comforting them. The person was offered a drink of water and the staff member stayed with them until they felt comfortable. We saw the staff member comforting them by saying: "It can be a bit scary when you have a cough like that, can't it". We saw another person was refusing to go to the dining room for lunch. Several staff tried to encourage the person in a patient and kind manner to have lunch. One staff member offered the person their lunch in the corridor area where they were sitting. Eventually the person was calmly and kindly encouraged to have their lunch and they chose to do so in the dining room.

Staff we spoke with demonstrated a kind and caring value base. One staff member told us: "I look forward to coming into work, the residents are like family to me". One of the activity staff told us: "This is not a part time job, you think about it all the time. When you're doing your own shopping you're always looking at things for ideas". This meant that people were being supported by staff who cared about them.

People were as involved in the running of the service as they were able to be. There were regular resident and relative meetings to discuss ideas of how to improve the service. People were offered choices about their care such as 'what time to get up and go to bed' and whether they chose to join in with the planned activities and their choices were respected. Friends and relatives were free to visit at any time and we saw lots of visitors on the day of the inspection.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had found that people's care records did not always reflect people's current needs. At this inspection the manager told us that they were in process of reviewing everyone's care plans. We saw reviews were taking place on a monthly basis. However, staff were not always aware of people's current needs and this meant people were receiving inconsistent care. For example, we saw several examples of different staff approaches to people when they became anxious and aggressive. These people's care plans did not inform staff of the best way to care for them at these times.

We spoke to staff about one person's nutritional needs as their care plan stated they required a specific diet. Staff we spoke with told us they did not know the person was on a special diet and the person had been eating a normal diet. This meant that these people were at risk of receiving care that was not always safe as staff did not have the information they needed to respond to their individual needs.

At our previous inspection we found that some people had little or no individual time spent with them. On the Nursing unit a large proportion of people were being cared for in bed and staff told us they did not have time to spend with them and this meant they were at risk of isolation. At this inspection we saw evidence that people were being given some individual time from the activity coordinators. People told us and we saw that there was a regular programme of activity. We saw memory boxes were being put together with people who were living with dementia to help them reminisce and other activities were available throughout the service. One person told us: "There is always something going on here, there's an activity every afternoon. I can play the piano in the lounge when I want and I can enjoy playing music on the organ I brought from home in my room too". We observed that this person was playing the piano in the lounge in the afternoon.

People who were able to used the garden to sit outside and some people had recently enjoyed a day trip to Wales. We saw that the manager had implemented a new system that ensured that people were offered the opportunity to go outside at least once a month. We saw that several people regularly refused, however they were still always asked in case they changed their mind. This meant that people were offered opportunities to engage in hobbies and interests of their liking.

The provider had a complaints procedure and we saw that the manager investigated people's complaints as stated in the policy. One person told us: "I have recently moved rooms. This was in response to me telling a carer that I was being disturbed by a noisy neighbour. They had raised it with the management and within a short while I had been given a choice of three rooms on another section. I was given chance to discuss it with my family and I have now moved just a few days before your visit". This meant that the provider was responsive to people's complaints and concerns.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we had concerns that the provider's systems were not always effective in identifying and making improvements to the quality of the service. We had found the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that significant improvements had been made in several areas including the staffing levels throughout the service. However, we identified further improvements were required to ensure the service was consistently safe, effective, caring, responsive and well led.

The provider's checks to ensure the quality and consistency of the service remained ineffective at identifying the required improvements or required action. For example, we found that not all incident reports were being seen and actioned when necessary by a manager. There had been several incidents of potential abuse that had been recorded by staff but had not been escalated to the management for any necessary action. This left people at risk of abuse not being managed and the risk of further incidents occurring being reduced.

People's care records were being regularly audited and we saw that the audits were identifying that some care plans that required up dating. However, no action had been taken to update the care plans and staff were delivering care or at risk of delivering inconsistent care that did not meet people's individual needs.

These issues constitute a continuing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan which they had implemented following the previous inspection which had driven improvement throughout the service. We saw there had been improvements in the staffing levels and the deployment of staff within each unit. A dementia specialist had been working with staff to offer guidance and support for staff supporting people living with dementia. New recording charts had been implemented to record the details of where and when people's prescribed external creams should be applied.

The manager had implemented a weekly quality assurance check in each area of the service. The manager met with the team leaders and went through any identified weight loss or issues surrounding a person's care. Following the inspection the manager told us that the individual incident records would be added on to this weekly check to ensure that any necessary action arising from the records would be taken in a timely manner.

Since the last inspection the provider had recruited a new manager and implemented new systems and training for staff. Staff felt they were well supported and were happy with the changes being made. All the staff we spoke with told us they were informed about the changes the management team were making including changes to recording and staff deployment throughout the units. They told us they had the opportunity to question or make suggestions if they wanted and felt that they were listened too. One staff member told us: "The new manager is very accessible. We can question or seek clarity on any changes at all.

They meet with us every week and if we can't make it we can always make a time when we can meet with them and have a chat about anything we are unsure about or don't understand. They are so approachable".

The new manager was in the process of registering with us and notified us of significant events as they are required to do so by law. This meant that the manager was aware of her responsibilities in relation to being a registered manager.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care that was consistently safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always being safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to improve the service had not been fully effective.