Canterbury Care Homes Limited

Rowans Care Centre

Inspection report

Merriden Road
Macclesfield
Cheshire
SK10 3AN
Tel: 01625 422284
Website: www.canterbury-care.com

Date of inspection visit: 26 May and 23 June 2015
Date of publication: 29/09/2015

Ratings

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

Overall summary

The inspection was unannounced and took place on the 26 May and 23 June 2015.

The Rowans Care Centre is a care home providing nursing and personal care which is located in a residential area of Macclesfield. The premises provide purpose built accommodation for 36 people in single bedrooms. It is a two storey building and people live on both floors. Access between floors is via a passenger lift or the stairs. On the first day of our inspection there were 32 people living in the home.

Rowans Care Centre has 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 2008 and associated Regulations about how the service is run.

When we started our inspection we found that the registered manager was absent and management arrangements for the home were inadequate to ensure the wellbeing of the people. Staff told us that the

Summary of findings

registered manager had left the home and a replacement manager had been appointed to manage the home in April but they too had left on the 1 May 2015. We were not formally notified of these changes until 1 June 2015 when we received notification that the registered manager had left the home on the 8 May 2015 to take up a new position in the organisation. When we returned to complete our inspection on the 23 June 2015 we found that the registered manager had returned to manage the home until a suitable person could be deployed to replace them.

Whilst many of the people spoken with told us that they were well cared for we found that some of the more vulnerable people who lived at the home were at risk of their needs not being met because of a lack of management oversight and poor communication between staff. Some people were not getting the support they needed to take fluids until late in the day, risks were not being managed effectively and medicines were not always stored and administered safely. There were processes to monitor the quality of the service but these were not being used effectively so problems were not always identified or addressed in a timely manner.

People received visitors throughout the day and we saw they were welcomed and included. Visitors told us they could visit at any time and were always made to feel welcome.

We could see that staff ensured people's privacy and their dignity was respected. We saw that bedroom doors were always kept closed when people were being supported with personal care.

People told us that they enjoyed the food and could choose how to spend their day. The home employed an activity organiser and volunteers who supported people to take part in activities in small groups during the day evenings and on occasion weekends.

Staff received specific training to meet the needs of the people who lived at the home including safeguarding vulnerable people from abuse. All staff spoken with were confident that any allegations made would be fully investigated to ensure people who lived at the home were safe.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Following our inspection we were informed that a suitably qualified, experienced and competent person had been appointed and deployed to manage the home. This person told us that they were in the process of applying to the commission for registration as manager. This will help to ensure that the people who live at the home receive safe, responsive and effective nursing and personal care.

We identified breaches of the relevant regulations in respect of safe care and treatment, person-centred care, meeting nutritional needs and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was not always safe.

People told us that they felt safe and staff we spoke with were aware of how to recognise and report signs of abuse and were confident that action would be taken to make sure people were safeguarded from abuse. However, medicines were not always properly managed in the home nor were some other identified risks.

Recruitment records demonstrated there were systems in place to ensure staff employed at the home were suitable to work with vulnerable people.

Requires improvement

Is the service effective?
The service was not always effective.

Whilst there was a sufficient number of staff on duty they were not always being managed effectively which meant some of the more vulnerable people living at the home were put at risk of their needs not being met.

People told us that they were well cared for and those who were able to speak for themselves made many positive comments about the standard of care they received. They told us that the food was good and they enjoyed mealtimes.

The registered provider complied with the requirements of the Mental Capacity Act. The manager and staff had a good understanding of people's legal rights and the correct processes had been followed regarding Deprivation of Liberty Safeguards.

Requires improvement

Is the service caring?
The service was caring.

People were provided with care that was with kind and compassionate.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Good

Is the service responsive?
The service was responsive.

People told us that the staff responded to them as individuals. They praised the staff for the standard of care they provided told us that they had seen their care plans, were happy that their needs were met and felt involved in decision making about their care.

Good

Is the service well-led?
Management arrangements for the home were inadequate to ensure the wellbeing of the people who lived there.

Requires improvement

Summary of findings

Communication between staff was poor and quality processes to monitor and improve the quality of the service were not being used effectively so problems were not always identified or addressed in a timely manner.

Rowans Care Centre

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.

We carried out an unannounced inspection on the 26 May 2015 and 23 June 2015. The inspection was carried out by one adult social care inspection manager and two adult social care inspectors on the first day and two adult social care inspectors on the second day.

During the inspection we spoke with fifteen people who used the service together with three relatives. We talked with ten members of care staff, two nurses, the home's administrator, the registered manager and a manager from another home operated by the provider who was supporting the home in the registered managers absence. We looked at care records relating to 18 people who lived at the home. We looked around the building including communal areas of the home and bedrooms of the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Before our inspection we reviewed the information we held about the home and the service provider. We looked at any notifications received and reviewed any other information we hold prior to visiting. We also spoke with representatives of the local clinical commissioning group and invited the local authority to provide us with any information they held about Rowans Care Centre.

Requires improvement

Is the service safe?

Our findings

During our visit we observed relaxed and friendly relationships between the people living at Rowans Care Centre and the staff members working there. Staff were kind and caring in their approach and we could see that people were comfortable and at ease in the home's environment.

People told us they had good relationships with staff and felt safe living at the home. When asked, one person said "yes I feel safe, very safe indeed" and another said "oh yes very safe, if I had any concerns I would speak with the staff and they do listen". Relatives told us they had no concerns about the way their family members were treated and cared for. One relative said "I have no doubt they are safe" and another said "we had some problems at first but they (the staff) put things right I'm confident they are safe and well cared for".

People told us that their health care needs were met and that they received their medicines as prescribed by their doctor. Policies and procedures were in place to make sure medicines were stored and administered safely and staff training records showed that all staff involved in the administration of medicines had received appropriate levels of training.

We carried out a medicines check and found that medicines were stored in a locked medicines trolley which was kept in a locked medicines room when not in use. The home utilised a monitored dosage system (MDS) with medicines pre-packed by the dispensing pharmacy in bubble packs according to the prescription for each person. This helped to minimise the potential for human error in the administration of medicines. We saw medication administration records relating to the MDS system and noted that records tallied with the medicines administered from the bubble packs.

Some medicines were provided by the dispensing pharmacy in individual boxes or packets and we noted that all such medicines entering the home were recorded when received and when administered or refused. This gave a clear audit trail and enabled staff check that medicines were being stored and administered safely. However, when we checked the stock of some boxed medicines against the records we found discrepancies with some medicines missing or unaccounted for. This indicated that medicines may not have been stored safely or errors in administration and recording had occurred. We could see that similar errors had been identified when staff had completed a medicines audit a month before, but it was not clear what action had been taken to remedy this problem and the problem had not been resolved.

The home's medicines policies and procedures provided guidance for staff on the safe storage, administration, recording, and disposal of controlled drugs. The policy required that controlled drugs must be checked by a suitably trained second person prior to administration and that both the staff member administering the medication and the second person witnessing the administration sign the controlled drugs book. We checked the controlled drugs records against the stocks of controlled drugs and found that they tallied indicating people had received their medicines as prescribed. However, some of the signatures in the controlled drugs book were indecipherable and there was no corresponding signature in the home's records. The registered manager was unable to tell us who had witnessed the administration of the controlled drugs on a number of occasions and was therefore unable to demonstrate that controlled drugs had been administered in accordance with the home's policies and procedures and guidance provided by the National Institute of Clinical Excellence (NICE) for managing medicines in care homes.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment for people who lived at the home was not provided in a safe way because medicines were not managed safely.

Risk assessments were in place for each person for a range of areas such as nutrition, moving and handling, skin integrity and falls and in some instances we could see active problem solving to reduce the effect of hazards and improve the person's wellbeing. For example, we saw that one person had been assessed as at risk of falling but the use of bed rails had also been assessed as a risk. In this case a low level bed had been provided for the person and a crash mat placed at the side of the bed to cushion the impact if the person did fall out of bed. There was however, significant room for improvement in respect of risk assessment as we saw one risk assessment for skin integrity was inaccurate because it did not take into

account that the person had a pressure ulcer and another person's risk assessment had not been updated when it became known that they had a pressure sore on their sacrum and their heels had become swollen and red.

Poor communication between nurses and a lack of management oversight meant that this person's pressure area needs were not addressed satisfactorily for three days and therefore they were not protected from the risk of deterioration and developing further pressure sores, until we brought the matter to the registered manager's attention. This person had not been provided with appropriate pressure relieving equipment. At 11.37 am on the second day of our inspection we found that they were being nursed in bed; records showed that they had not had anything to eat or drink since the previous day when their recorded total fluid intake was less than 300mls, indicating they were at risk of dehydration. Their care plan on skin integrity indicated that they should be encouraged to change position when in bed because they were at risk of developing pressure sores but records showed they had not been repositioned since 8.43 that morning. Their bed was equipped with bedrails which had been pulled up into position but there was no evidence in their care records to show the risks of using such equipment had been assessed or justified. When asked, the registered manager told us that they did not know that bedrails were being used for this person and said the person did not need them. Using bedrails unnecessarily and without the benefit of a risk assessment put this person at risk of injury and is an unjustified restraint.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because risks were not managed safely and effectively.

We saw that the service had a safeguarding procedure in place. This was designed to ensure that any possible problems that arose were dealt with openly and people were protected from possible harm. The registered manager was aware of the relevant process to follow. They told us they would report any concerns to the local authority and to the Care Quality Commission [CQC]. Homes such as the Rowans Care Centre are required to notify the CQC and the local authority of any safeguarding incidents that arise. Records showed that managers and staff had responded appropriately when safeguarding concerns had been raised in the interests of safeguarding the people who lived at the home.

We spoke with three staff members about the home's adult safeguarding procedures. They told us that they had received training in protecting vulnerable adults and that this was updated on a regular basis. They told us that they understood the process they would follow if a safeguarding incident occurred and they were aware of their responsibilities when caring for vulnerable adults. They were all familiar with the term 'whistle blowing' and each said that they would report any concerns regarding poor practice they had to senior staff.

We found that the people living in the home had an individual Personal Emergency Evacuation Plan [PEEPS] in place. This was good practice and would be used if the home had to be evacuated in an emergency such as a fire.

We looked at the files for the two most recently appointed staff members to check that effective recruitment procedures had been completed. We found that the appropriate checks had been made to ensure that they were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw from these files that the home required potential employees to complete an application form from which their employment history could be checked. References had been taken up in order to help verify this. Each file held a photograph of the employee as well as suitable proof of identity. There was also confirmation within the recruitment files we looked at that the employees had completed a suitable induction programme when they had started work at the home. The administrator explained that she was carrying out an audit of all staff recruitment files to confirm that they were all up to date.

The staffing rotas we looked at and our observations during the visit demonstrated that there were sufficient numbers of staff on duty to meet the needs of the people living at the home. On the first day of our visit there was two nurses and six care staff members on duty between 7.30am and 2.30pm. From 2.30pm until 7.30pm there were two nurses and five care staff members on duty. During the night there was one nurse and three care staff members on

Requires improvement

Is the service safe?

duty. We looked at the rota and could see that this was the usual number of staff deployed each day. Agency staff members were being used to cover some shifts but these were generally the same people which meant that the people living in the home were being cared for by a consistent staff group.

In addition to the above there were separate ancillary staff including an activities co-ordinator, an administrator, two people working in the kitchen, two people cleaning the home, one person doing the laundry and a maintenance staff member.

There was an on call system in place in case of emergencies outside of office hours and at weekends. This meant that any issues that arose could be dealt with appropriately.

The kitchen within the home had been awarded a five star hygiene rating by representatives from the local council in August 2014. This is the highest rating possible.

Requires improvement

Is the service effective?

Our findings

People told us that they were well cared for and those who were able to speak for themselves made many positive comments about the standard of care they received. They told us that the food was good and they enjoyed mealtimes.

Some people raised concerns about staffing levels. They told us that they often had to wait long periods of time for staff to get around to attending to them in the morning or when they needed assistance to the toilet. One person told us that this meant they had "to sit in a wet pad whilst staff got around to attending to them in the mornings". We could see from this person's care plan that their preferred rising time was between 8am and 9am but on both days of the inspection staff did not get around to assisting them to get up until after 10am.

We could see that there was a sufficient number of staff on duty but in the absence of a manger there was a lack of management oversight and therefore staff were not deployed effectively. On the first day of the inspection we found several people still in bed late into the morning waiting for staff to attend to them.

We observed that staff who worked on the ground floor tended to meet the needs of people who were able to use their call bell first often leaving vulnerable highly dependent people without the care and support they needed to drink sufficient fluids to sustain their health and well-being. For example records showed that two people were at a greater risk of dehydration and would therefore require higher levels of care to ensure they had sufficient fluids. At 9.45 am we found that one of these people was still in bed, records showed that they had not had anything to drink since 00.25 that morning when they had taken 100mls and had not been offered anything else to drink since 04.37. There was a jug of juice in their room but this was placed out of their reach. We observed the care provided to this person throughout the morning and found that care staff did not go in to see this person again until 11am, when they got the person up and dressed. At 11.14 the care staff attending to this person told us that they had still not given this person anything to drink and had got them dressed first.

The staff told us that they were aware that this person needed encouragement to drink. They said they had offered them a drink at 9am but they refused it and had not gone back to them until 11am because they did not have the time.

At 10.52 we found that the other person identified as at risk of dehydration was also still in bed waiting for staff to attend to them. Records showed that they had not taken any fluids since 04.24 that morning. They had been offered a drink at 8.45 that morning but had refused and there was no record of them being offered anything else since.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The hydration needs of people were not being met.

At 10.25 on the first day of our inspection we found another person still in bed waiting to get up, they told us that they wanted to get up and were anxious that staying in bed for long period's weakened their legs. At 11.14 this person was still waiting for staff to attend to them.

On the second day of the inspection we found another vulnerable person who had complex needs in bed at 11.37am. Records showed that they had not taken any fluids or had anything to eat since the previous day. They had been offered breakfast and a drink at 8.43 but had refused and had not been offered anything to eat or drink since.

This person's care plan identified that they were diabetic and prone to hypoglycaemia. Instructions were provided as to how staff should manage this. Care staff were unaware of these requirements and the nurse in charge on the ground floor was unaware of the contents of the care plan and did not know this person's ordinary blood sugar range or the requirement to monitor blood sugars on a daily basis. This person had moved into the home four days prior to the date of our second visit but there was no record of their blood sugars being monitored since. The registered manager had drawn up an appropriate care plan on the day this person moved in but this had not been put into practice effectively. This meant that this person had been put at increased risk of hypoglycaemia, because staff were unfamiliar with their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care was not always carried out in accordance with people's care plans.

Requires improvement

Is the service effective?

This person's care records showed that they had been found to have a pressure sore on their sacrum and their heels were deteriorating and therefore required a certain type of pressure relieving mattress and treatment. This person's needs for specialised pressure relieving equipment had gone unnoticed for a period of more than 48 hours despite a deterioration in their condition and increased risk of dehydration, which in turn would have put this person at increased risk of developing pressure sores.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because risks were not managed safely and effectively.

There was a flexible menu in place which provided a good variety of food to the people using the service. The catering staff we spoke with explained that there was a four week menu and that this was discussed with the people living in the home all of the time and was based on what people wanted to eat. Choices were available and people could decide what they wanted at every mealtime. Special diets such as gluten free and diabetic meals were provided if needed. They explained that they met with anyone moving in to the home to discuss likes and dislikes and that the senior staff told them if someone had any specific dietary needs. They went on to explain that although there was a menu in place a variety of other alternatives were available and that they tried to be as flexible as possible. The people we spoke with confirmed that choices were available and that they could choose whether to eat their meals in their own room or the dining room. We observed lunch and saw that there was a calm and pleasant ambience. We observed staff members asking people what they wanted to eat.

We saw staff offer people drinks in the dining room and that they were aware of each person's preferences and choices in this respect.

The provider had their own induction training programme that was designed to ensure any new staff members had the skills they needed to do their jobs effectively and competently. We looked at the induction record that would be used for a newly appointed staff member and saw that it was based upon the Skills for Care Common Induction Standards, a nationally recognised and accredited system for inducting new care staff. In addition to the above new staff members completed an 'in house' induction that provided basic information such as the location of fire exits. Following this initial induction and when the person actually started to work they would shadow existing staff members and would not be allowed to work unsupervised for a period. Shadowing is where a new staff member works alongside either a senior or experienced staff member until they are confident enough to work on their own.

Healthcare Training Solutions are the providers own training company and they are responsible for delivering staff training. We discussed training with the registered manager and administrator who explained that they were currently working on how training was being recorded. They told us that company statistics were showing that percentages of staff who had completed a particular course could be quite low when in fact they weren't. This problem was being caused by all staff being scored against all training. For example, only the people dispensing medicines needed to complete a medicine training course. The current statistic was taking all staff working in the home into account, hence the low percentage of staff having completed this course. Given this problem they told us that at the time of our inspection they were unable to confirm if all staff training was up to date. Cheshire East council had also questioned this following one of their visits and it had been agreed that this anomaly would be addressed by the end of the year and all training would be up to date at that time. We were shown the planned training schedule that confirmed this.

We looked at the staff training records available and saw that staff had undertaken a range of training relevant to their role. This included fire safety, safeguarding and moving and handling. The provider used computer 'eLearning for some of the training and staff were expected to undertake this when required. These training packages had been produced by Healthcare Training Solutions. The staff members competency was assessed through the supervision system and through the auditing of records such as medication and care plans.

We checked the records which confirmed that supervision sessions for staff members were being held. We did see that during the previous year they were being held regularly until July but were then not as frequent until December. The records demonstrated that from January this year they were now taking place regularly The registered manager explained that the issue last year had been caused by an earlier change to the management of the home but this

Requires improvement

Is the service effective?

had now been addressed and staff members would receive supervision six times per year as per the providers guidance. Supervision is a regular meeting between an employee and their line manager to discuss any issues that may affect the staff member; this may include a discussion of the training undertaken, whether it had been effective and if the staff member had any on-going training needs.

During our visit we saw that staff members took time to ensure that they were fully engaged with the individual and checked that they had understood before carrying out any tasks with the people using the service. They explained what they needed or intended to do and asked if that was alright rather than assume consent. We observed staff members supporting people throughout the day and saw that they took their time and did not rush the person. All contact was carried out in a dignified and respectful way.

Policies and procedures had been developed by the provider to provide guidance for staff on how to safeguard the care and welfare of the people using the service. This included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This is a legal requirement that is set out in an Act of Parliament called The Mental Capacity Act 2005 [MCA]. This was introduced to help ensure that the rights of people who had difficulty in making their own decisions were protected. The aim of DoLS is to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Mental capacity assessments had been carried out where people lacked capacity to make specific decisions. For example we saw that a person's capacity had been assessed in relation to co-operating to maintain their safety and a best interest meeting had been held to determine the actions needed to minimise their risk of falls.

Records showed that DoLS applications were only completed if the person was deemed to be at risk and it was in their best interests to restrict an element of liberty. The application would be submitted to the local social services department who were responsible for arranging any best interest meetings or for agreeing to any DoLS imposed and for ensuring they were kept under review. The registered manager confirmed that at the time of the inspection there was one DoLS in place and they had applied for a further 12. Unfortunately there was a delay in them being looked at by the local authority. This is a national issue and relates to a High Court decision regarding the criteria for the issuing of a DoLS that has significantly increased the number needed.

Some people had representatives who had been appointed with Lasting Powers of Attorney (LPA). Details about LPA were provided in care files. This meant that staff had information about who could make decisions on behalf of the person if they lacked capacity to make decisions themselves.

The training records we looked at showed that some of the staff members had completed training in the MCA and DoLS. The registered manager was aware that all relevant staff would need to complete training in these areas.

A tour of the premises was undertaken; this included all communal areas including lounge and dining areas plus and with consent a number of bedrooms. The home was well maintained and provided an environment that could meet the needs of the people that were living there. The home provided adaptations for use by people who needed additional assistance. These included bath and toilet aids, hoists, grab rails and other aids to help maintain independence.

The laundry within the home was well equipped and there were systems in place for the care of people's clothes. We saw that the laundry was clean and tidy and appeared well organised.

Good

Is the service caring?

Our findings

The atmosphere in the home throughout the inspection was relaxed and sociable. We could see that people benefited from frequent and positive interactions with staff. We saw people laughing and joking with staff, and it was clear to us that there were trusting relationships between the staff and the people who used the service.

All the people who were up and about in the communal areas of the home were smartly dressed, clean and well presented. They had smiles on their faces and all had something positive to say about the staff and the way care was provided. One person said: "I am happy, they (the staff) are very good here, all clean and well looked after". Another person said: I am exceptionally well looked after, the staff are kind and caring".

We could see that staff were attentive and receptive to people's needs. For example we observed one member of staff overhearing someone saying they were still hungry after having their breakfast. The staff member immediately went and offered the person some extra toast and tea, which were served promptly.

We also saw staff treating people with dignity and respect. When staff provided personal care, they approached the person sensitively, discreetly asking them if they wanted to use the toilet or to have a bath or shower. Staff always knocked on bedroom doors before entering and ensured doors were shut when carrying out personal care.

We undertook a SOFI observation in the dining room over lunch and saw that people were being supported appropriately. We saw staff members responding to people's needs for assistance, offering choices and supporting them with timely prompts to encourage them to eat and enjoy their lunch. In all cases staff sat next to the person and chatted whilst they were helping them.

People's wishes for end of life were also recorded. For example, some people had a do not attempt resuscitation (DNAR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw that the person concerned and their family were involved in this decision.

Information including details of each person's life history was recorded in their care records, together with their interests and preferences in relation to daily living. Some staff spoken with were familiar with information recorded in people's files but others were not. One care worker, who lacked important knowledge about a person they were providing care for, told us that they did not have time to read care plans and an agency care worker told us that although they had worked in the home previously they did not know important information about the people being cared for, such as what support they needed with mobility, what sling to use or whether they had a DNAR order in place. They told us that they had not been asked to read care plans, and although they had attended a handover meeting at the beginning of the shift important information about each person's needs and personal preferences had not been shared with them. We were concerned that this lack of information could have negative consequences for people who lived at the home and shared our concerns with the registered manager, who was present in the home on the second day of the inspection. The registered manager told us that she had previously introduced a document which provided basic information about the needs of each person to ensure that all staff including agency staff had sufficient information to meet peoples' needs and would ensure that this document was reinstated.

The quality of decor, furnishings and fittings provided people with a homely and comfortable environment to live in. People's bedrooms were personalised and contained photographs, pictures, ornaments and the things each person wanted in their bedroom.

The provider had developed a range of information, including a service user guide for the people living in the home. This gave people detailed information on such topics as medicine arrangements, telephones, meals, complaints and the services provided.

We saw that people's care files were kept in a filing cabinet in a locked room. This meant that confidential information was stored securely.

Good

Is the service responsive?

Our findings

People told us that the staff responded to them as individuals. One person who praised the staff for the standard of care they provided told us that they had seen their care plans, were happy that their needs were met and felt involved in decision making about their care. Another person when asked about care plans said: Oh yes I know about the care plans, you can see them if you want to, they (the staff) are helping me with my knee, they are massaging it every day and doing a good job".

We looked at the care files for some people living in the home. Each file contained risk assessments and care plans to instruct staff on the care they needed to deliver. Generally care plans were detailed and advised staff of individual preferences and wishes. For example we saw that the care plans for one person stated that they had hearing aids, but didn't like using them, and that they often didn't finish their meals but liked a cup of tea when they sat down.

We observed some areas for improvement in the care planning and record keeping. For example, some care plans had not been dated or reviewed. Some care plans lacked specific detail to ensure that people got safe care. For example, none of the care plans relating to people's skin integrity detailed what setting their pressure mattresses should be set at. When we checked the settings of several mattresses, they were set incorrectly. This meant that the equipment may not be effective in preventing skin damage and may lead to a risk of actually causing pressure ulcers. We were given assurances at the time of the inspection that all care plans relating to pressure area care would be reviewed to ensure the correct settings for each person. We were given to understand that care plans were audited as part of the homes quality assurances systems.

Care files contained records of visits from other healthcare professionals and to hospital appointments. These showed that arrangements were in place to ensure people had support from appropriate specialists such as the Parkinson support nurse and tissue viability nurse and that routine checks and treatment from opticians and podiatrists for example, took place.

The home employed two activities co-ordinators. One person worked for 18 hours and the other worked for eight hours. Their job was to help plan and organise social and other events for people, either on an individual basis, in someone's bedroom if needed or in groups. The people using the service were asked what kinds of things they liked to do during the assessment and care planning processes. Information about any activities or events planned were on display around the home. Activities ranged from one to one work to group sessions where anyone could join in.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. We looked at the two most recent complaints made and could see that these had been dealt with appropriately.

A relative of one of the people who lived at the home told us that there had been some problems with communication when their relative had moved in but these issues had been addressed and overall they were satisfied with the standard of care provided. People were made aware of the process to follow when making a complaint as detailed in the service user guide.

Requires improvement

Is the service well-led?

Our findings

We carried out this inspection following our receipt of information from the local NHS Clinical Commissioning Group which indicated that the registered manager had left, interim management arrangements at the home were inadequate and vulnerable people were at risk of their health and social care needs not being met.

When we started our inspection we found that the registered manager had left the home on the 8 May 2015 to manage another care home over 200 hundred miles away from the Rowans Care Centre. Staff told us that a replacement manager had been recruited and appointed at the beginning of April 2015 but they too had left the home at the beginning of May 2015.

Failure to notify the commission of the absence of a registered manager no later than 28 days before the proposed absence and provide details of the name, address and qualification of the persons who will be responsible for the management of the home during the proposed absence is a breach of regulation 14 of The Care Quality Commission (Registration) Regulations 2009. The commission received such a notification from the provider but not until the 1 June 2015.

During the course of our inspection we found that a person living at the home had a necrotic pressure sore to their right heel identified on 27th February 2015. This would constitute a serious injury notifiable to the commission, without delay, under the requirements of the regulations. The home's records showed that the registered manager had sent a late notification about this serious injury to the commission on the 24 March 2015. There was no explanation as to why the notification was delayed until 25 days after the incident and the commission had no record of receiving such a notification.

This was a breach of regulation 18 of The Care Quality Commission (Registration) Regulations 2009. The provider and or the registered manager failed to notify the Commission of serious injury occurring to a person who used the service without delay.

On the first day of our inspection there was no designated manager in the home. The deputy manager's post was vacant, the area manager was on leave, as was a manager from a neighbouring home who had been asked by the provider to support the home on a daily basis. The home was being managed by two nurses one taking charge of the ground floor and the other taking charge of the first floor. The nurse in charge on the first floor told us that they were employed by an agency, but had worked at the home several times over the preceding two weeks. The nurse appeared to know the people she was caring for well and was able to describe various care needs and treatments different people needed. The nurse had identified those people that were the most dependent and had made time to personally oversee their care, to ensure they were able to assess and review their condition. The nurse in charge on the ground floor worked diligently to meet the needs of people but there was a lack of organisation and prioritisation. Whilst care staff were aware that two extremely vulnerable people were at increased of risk dehydration they attended to the needs of more able people first. This lack of basic organisation meant that the most vulnerable people were at risk of their needs not being met.

The notification we had received from the provider on the 1 June 2015 which informed us that the registered manager had left indicated that she was not due to return, however when we visited the home again on the 23 June 2015 we found that the registered manager had returned for a temporary period. The registered manager was not in the home at the time we started our second day of inspection but came to the home shortly after 10.20am. We were concerned to find that the nurse in charge on the ground floor had failed to record the morning's shift handover meeting and important issues affecting the well-being of the people who lived at the home had not been passed on effectively or shared with care staff. For example staff on duty on the ground floor were unaware that a person who had recently moved into the home was diabetic and required their blood sugars monitoring on a daily basis to prevent hypoglycaemia. This had not been done even though they were refusing foods and fluids which placed them at increased risk of hypoglycaemia.

People spoke highly of the staff and the standard of care provided but the absence of the registered manager had not gone unnoticed. One person told us that they had no option but to remain in bed for the last 10 days because the sling staff used to hoist them had ripped and was unsafe and staff had not obtained a replacement sling. We asked the registered manager why it had taken so long to obtain a replacement sling. The registered manager told us that she had spoken to the supplier that day and a

replacement sling would be delivered shortly but was unable to explain why there had been a delay because there was no record of any staff member ordering a replacement sling and the registered manager did not know who had completed the task.

Rowans Care Centre had its own internal quality assurance system in place. These included audits on care plans, 10% of these were looked at each month, medication, infection control, health and safety and the kitchen. We could see that these checks were being routinely completed but were not always effective at identifying necessary improvements or resolving problems identified. For example we looked at a person's care plan that had been audited on the morning of the second day of our inspection. The audit identified that several improvements were required but the auditor failed to notice that staff had identified serious health care needs which weren't being met. Pressure relieving mattresses were being checked by staff on a daily basis but the checks did not identify that several were set on an incorrect setting and therefore posed hazards to the wellbeing of the people they were being used to protect. A medicines audit carried out in May identified errors in recording, administration or safekeeping of medicines but a satisfactory plan to address such failings had not been devised or implemented and therefore same or similar errors were identified when we checked medicines almost a month later.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not operate systems or processes to effectively assess, monitor and improve the quality of the service being provided.

Records showed that there had not been a staff meeting for nurses since 6 January 2015 and the last care staff meeting had been held 29 April 2015. Staff told us that morale amongst the staff team was low, they were concerned about the lack of management and leadership and poor communication in the home.

As part of the on-going quality monitoring system there were a number of maintenance checks being carried out weekly and monthly. This involved the completion of record books that covered a variety of areas such as; health and safety, moving and handling, fire safety, catering and water quality. Each book contained the checks undertaken within each area covered by the specific book. For example the health and safety record contained checks on the call system, the safe operation of window restrictors, a visual check on any wheelchairs, shower chairs, portable electrical appliances, extractor fans and any step ladders used within the home. In addition this book also contained a monthly bedroom checks, including any bed rails and further environmental checks including external paths and walkways. We looked at all of the books being maintained and could see that they were all being completed appropriately, any issues identified were recorded and dealt with and all of the checks we saw were up to date. The books were being audited by the regional manager on a monthly basis in order to ensure they were being maintained appropriately. In addition to the above there were also certificates covering the gas and electrical installations, portable electrical appliances, any lifting equipment such as hoists and the lift. If there were any issues requiring attention these were entered into a maintenance repair book and then 'ticked off' as they were addressed.

In order to gather feedback about the service being provided, Healthcare Management Solutions another part of the providers business, had undertaken a quality assurance survey in April 2015. This was sent to the people using the service, family members and staff members. At the time of our visit the findings were still being collated and therefore were not available for our perusal or to guide the management and conduct of the home.

Representatives on behalf of the provider visited the service and spoke to the people living there on a monthly basis. This would help to ensure any issues were identified and addressed quickly. The last of these visits took place in May and was undertaken as an 'impact audit" that covered the following areas, quality, infection control and cleanliness, individualised care and treatment and medicines management. The report from this audit was not yet available at the time of our inspection.

The provider had developed a full list of policies and procedures. These were all within two folders. The first of these contained policies and procedures relating to care, administration, human resources and maintenance. The second contained information relating to health and safety, housekeeping, catering, quality assurance and infection control.

Following our inspection we were informed that a suitably qualified, experienced and competent person had been appointed and deployed to manage the home. This person

Requires improvement

Is the service well-led?

told us that they were in the process of applying to the Commission for registration as manager. This will help to ensure that the people who live at the home receive safe, responsive and effective nursing and personal care.

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.

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 Care and treatment of the people who lived at the home was not provided in a safe way because medicines were not managed safely. Regulation 12.-(1), 12.-(2) (g)

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 Care and treatment of the people who lived at the home was not provided in a safe way because risks were not managed safely and effectively. Regulation 12.-(1), 12.-(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The hydration needs of the people who lived at the home were not being met. Regulation 14.-(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence The provider and or the registered manager failed to notify the commission of the registered manager's proposed absence 28 days before they left.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 14 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider and or the registered manager failed to notify the commission of serious injury occurring to a person who used the service without delay. Regulation 18.-(2)

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 registered provider did not operate systems or processes to effectively assess, monitor and improve the quality of the service being provided. Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care was not always carried out in accordance with people's care plans. Regulations 9 .-(1) (a) (b)