Bupa Care Homes (CFHCare) Limited

Rowan Garth Nursing Home

Inspection report

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Date of inspection visit:
11 April 2016
12 April 2016
13 April 2016

Date of publication:
02 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 and 24 September 2015 when nine breaches of legal requirements were found. The breaches of regulations were because we had some concerns about the way medicines were managed and administered within the home, staffing levels, the effective deployment of staff, the planning and review of care needs, the accuracy and fitness for purpose of people's care records, the safety of the environment, and the effectiveness of management systems to regularly assess and monitor the quality and safety of service that people received.

We asked the provider to take action to address these concerns.

After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breaches. We undertook an unannounced focused inspection on 11, 12 and 13 April 2016 to check that they had they now met legal requirements. This report only covers our findings in relation to these specific areas / breaches of regulations. They cover four of the domains we normally inspect; 'Safe', 'Effective', 'Responsive' and ' Well led'. The domain 'Caring' was not assessed at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Rowan Garth Care Home' on our website at www.cqc.org.uk.

Rowan Garth Nursing Home is a large facility located in the north of Liverpool. The provider is BUPA Care homes (CFH) Limited. The location provides accommodation for up to 150 people across 5 separate units set within extensive grounds. Each of the units is single-storey and can accommodate 30 people. The service supports people with a range of care needs from nursing to end of life care. The units within the home are as follows;

Heather Unit (Dementia and Nursing Care)
Moss Unit (Dementia and Residential Care)
Oak Unit (Nursing Care)
Beech Unit (Residential Care)
Clover Unit (Intermediate Care)

The service is registered to provide nursing and personal care, diagnostic and screening procedures and treatment of disease, disorder or injury for older people.

A registered manager was in place. 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.

We found the breach in the safe management of medicines had not been met. Medicines were not always stored and administered safely in accordance with current guidance and best practice.

The concerns we identified are being followed up and we will report on any action when it is complete.

We found the breach regarding how the service was quality assured and monitored had not been met. The quality assurance systems at the home had failed to identify a number of significant issues and generate improvements in safety and quality.

The concerns we identified are being followed up and we will report on any action when it is complete.

During the course of this inspection we saw evidence that the home had not operated in accordance with the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Some applications to deprive people of their liberty had not been submitted as required.

The staffing levels reported and observed were appropriate to meet people's needs safely. We saw evidence that staff were deployed flexibly across each of the units to meet people's care needs.

Improvements had been made to the safety of the physical environment. Regular checks were made on equipment and premises and actions had been undertaken to maintain people's safety. Improvements had been made to the security of each unit. For example, additional keypad locks had been installed and other means of entry/exit had been made more secure.

Care records were completed and showed evidence of regular review. Care plans and records in relation to pressure area care showed clear evidence of improvement. Pressure area care was safely managed in conjunction with input from community healthcare professionals.

Changes had been made to cleaning practices which had reduced the risks associated with cross-infection and the incidence of strong odours in each of the units.

Concerns and complaints were recorded and responded to within the timescales specified in the relevant policy. Each of the people that we spoke with was able to explain what they would do if they needed to complain about the home.

People had access to a range of social activities which were promoted in each of the units.

People told us that they enjoyed the food and drink available at the home and were supported to eat by staff where required.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always stored and administered safely in accordance with best-practice guidance.

Staff were deployed appropriately to meet people's needs. Additional staff had been deployed where a need had been identified.

Improvements had been made to the safety of the physical environment.

We have noted the improvements made and have revised the rating for this key question to 'requires improvement' from 'inadequate'.

Is the service effective?

Requires Improvement

The service was not always effective.

People were being deprived of their liberty without the necessary applications being made.

People told us that they enjoyed the food and drink available at the home and were supported to eat by staff where required.

The home worked effectively with community-based healthcare professionals to ensure that people's needs were met.

Is the service responsive?

Requires Improvement

The service was responsive.

We found improvements had been made to meet necessary requirements in relation to the completeness and quality of care records. We saw evidence of people being involved in their care planning.

People had access to a range of social activities which were promoted in each of the units.

Concerns and complaints were recorded and responded to within the timescales specified in the relevant policy. Each of the people that we spoke with was able to explain what they would do if they needed to complain about the home.

While improvements had been made we have not revised the rating for this
key question. To improve the rating to 'Good' would require a longer term
track record of consistent good practice. We will review our rating for 'responsive' at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems were still not robust as they failed to identify concerns relating to medicines and safety.

The registered manager provided clear direction and leadership to staff and had improved systems for communicating with people.

Staff were supported by the provider and were motivated to provide good quality care.

Rowan Garth Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 11, 12 and 13 April 2016 and was unannounced.

The inspection was carried out by a team of four inspectors. The team included three adult social care inspectors and a pharmacist inspector.

Before the inspection we contacted the local authority contract and commissioning teams, Healthwatch and the clinical commissioning group and requested any significant information.

During the inspection we talked with six people using the service, five relatives, one visitor, twelve care staff, three nurses, three managers and two visiting healthcare professionals. We observed the delivery of care and 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 with us. We looked at nine care records, nineteen medicines records, four staff files and other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection of this service in September 2015 when breaches of legal requirements were found. The breaches of regulations were identified because we had some concerns about the way medicines were managed and administered within the home, the deployment of staff, the completion of care records, cleaning practices and the safety of the environment. We asked the provider to take action to address these concerns.

At our previous inspection in September 2015 we had some concerns about the way medicines were managed and administered within the home. We asked the provider to take action to address these concerns.

During this inspection we visited three out of the five units in the home to look specifically at medicines. On this inspection we checked to make sure requirements had been met.

We found this breach in the safe administration and management of medicines had not been met.

We looked at 19 medicines administration record (MAR) charts and care plans relating to medicines. These were not always completed correctly. On the day we inspected one person's night time dose for one medicine had been signed as being given, however the medicine had not been given as it was still in the medicines trolley and had therefore been signed in error. Another person had been recorded as being fluid restricted in their care plan, the home could not explain why the person had been fluid restricted and had to ring the person's doctor to find out. The person was on a fluid restriction, but in the afternoon of the inspection no fluid intake had been recorded despite the person having had drinks during the day.

Medicines were not always given as directed by the doctor. Two units did not have medicines to give for two people. The first person did not have their food supplement for two days and the second person did not have one of their inhalers for two days and another inhaler for five days as it could not be found. One person who was taking a time specific medicine for Parkinson's disease was given their medicine an hour late on the day we inspected. Another person who had been recently discharged from hospital had been given the incorrect dose on one day as the directions on the MAR were different to those on the box of medicines supplied by the hospital.

Two people had medicines and liquids administered into a stomach tube. There were no clear records of the amounts of water put down the tube and no clear instructions on how medicines should be administered down it. It is important to properly flush the tube with water to prevent blockages.

We checked the stock levels for medicines belonging to five people. The quantities recorded for medicines belonging to three people were different to what was in the home; this meant these medicines could not be fully accounted for. One of the units automatically ordered a new supply of medicines for people who were admitted into the home before using their current supply. Therefore large quantities of medicines were subsequently disposed of. The records relating to these medicines were not checked at the point of disposal

meaning that the medicines could not be accurately accounted for.

The fridge temperatures were recorded daily in the units that we visited, however one of the units had a fridge that had temperatures outside the recommended range. The temperatures had been outside of the recommended range since February 2016. Although a new fridge had been ordered, medicine was still being stored inside the fridge on the day we visited. This meant the medicines stored in this fridge may not have been safe to use.

On the day of our inspection we were informed that one person on one of the units had been given another person's medicine as they had the same surname. The registered nurse had asked another member of staff to identify the person, rather than using the photograph for identification.

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

Controlled drugs (medicines which require special storage and record keeping arrangements because of their potential for misuse) were stored securely as per legislation and the levels of medication were checked weekly.

At our previous inspection in September 2015 we had concerns about the deployment of staff within the home. On this inspection we checked to make sure requirements had been met. We found improvements had been met and this breach was met.

During this inspection we visited each of the five units in the home, we checked the records relating to staff deployment and observed staff providing care.

We saw that staff were deployed in sufficient numbers to provide safe, effective care in each of the units. We saw that unit managers requested additional staff from other parts of the home to meet needs and that staff were safely redeployed. Safe staffing levels were assessed at a local level and records showed that these levels had been consistently maintained. The majority of staff told us that the staffing levels were safe and adequate to meet the needs of the people living at the home. A visiting healthcare professional said, "There's always enough staff." A unit manager told us that additional staff were regularly funded by commissioners when people with complex needs were admitted. We saw evidence that this had happened recently.

At our previous inspection in September 2015 we had concerns about the completion of care records.

On this inspection we checked to make sure requirements had been met. We found improvements had been made and this breach was met.

During this inspection we looked at nine care records and focused on information relating to pressure area care. We found the staff that we spoke with had good knowledge of wound management and had provided effective care. Practice relating to wound care was assessed as part of the senior management clinical reviews.

We also looked at records relating to people deemed at risk of falls. We saw that each of the records was complete and contained sufficient information to instruct staff. The records had been regularly reviewed and updated. However, in one case staff were instructed to check on a person at risk of falls every hour. There was no record of these checks being completed and we were told that a suitable form was not

available to record them. We spoke with the unit manager and staff and we saw that the checks were being completed according to the instruction. A suitable form was subsequently identified to record that the checks had taken place.

At our previous inspection in September 2015 we had concerns about the safety of the environment.

On this inspection we checked to make sure requirements had been met. We found improvements had been met and this breach was met.

At this inspection we spoke with the person responsible for maintenance and were escorted on a tour of each unit. We saw that improvements had been made to the security of each unit. For example, additional keypad locks had been installed and other means of entry/exit had been made more secure. Prior to this inspection we had received information of concern relating to the safety of personal items and money. We saw that each person had been given access to a safe to store personal items. The risks associated with not using these facilities had been explained to each person living at the home or their representative. We also saw that improvements had been made to the safety of the physical environment and equipment. For example, covers had been installed where sharp edges had been previously exposed. Changes had also been made to cleaning practices which had reduced the risk of cross-infection and the incidence of strong odours in each of the units.

People were protected from the risk of abuse because staff were vigilant in monitoring indicators of abuse and intervened to de-escalate situations where appropriate. We spoke with staff about their understanding of adult safeguarding. They confirmed that they had been recently trained and that they understood what action to take if they suspected that abuse or neglect was occurring.

Staff were recruited safely following the completion of appropriate checks. Each staff record that we looked at contained evidence of a recent Disclosure and Barring Service (DBS) check. DBS checks are used to help establish if people are suited to working with vulnerable adults. Each record also contained two satisfactory references.

We have noted the improvements made and have revised the rating for this key question to 'requires improvement' from 'inadequate'.

Requires Improvement

Is the service effective?

Our findings

We carried out an unannounced comprehensive inspection of this service in September 2015 when breaches of legal requirements were found. At our previous inspection we identified concerns relating to admissions and in particular to the lack of detailed pre-admission information. There was evidence that this had led to people being referred whose needs could not be met by the home. We asked the provider to take action to address these concerns.

On this inspection we checked to make sure requirements had been met. We found improvements had been met and this breach was met.

During this inspection we looked at care records for three people who had been recently admitted and spoke with the manager of the intermediate care unit. This unit (Clover) saw the highest turnover of people because it specialised in short-term care. We saw that pre-admission information was detailed and had been provided by a range of healthcare professionals. There was evidence that people and their families had also been involved. A unit manager told us, "We can refuse admissions. [Registered manager] will back our decision if we can't meet clinical needs."

At our previous inspection in September 2015 we identified concerns relating to the provision of care at mealtimes.

On this inspection we checked to make sure requirements had been met. We found improvements had been met and this breach was met.

During this inspection we observed staff providing care at mealtimes in three of the five units. We saw that people were given support with food and drinks in a timely manner. Staff sat with people who required more intensive support and offered more food to people who had finished their meal. People told us that they enjoyed the food and drinks available. One person said, "We get a good choice of food. It's good quality and we get plenty of tea and coffee."

At this inspection we looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. 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. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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).

According to information supplied by the home 65 people were being deprived of their liberty as of 11 April 2016 32 applications had been submitted. One application had been declined and 33 applications had lapsed or not been submitted at the start of the inspection. The registered manager was alerted to the

omission. The registered manager said they understood the processing of applications may be delayed because of a significant back-log. As a consequence the home had considered depriving people of their liberty on a best-interest basis pending submission of the applications. The necessary applications were submitted before the inspection was completed. The home had deprived people of their liberty without making applications for appropriate authorisation.

This is a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff had the right skills and knowledge to provide safe, effective care. Staff were trained in a range of health and social care topics and were supported through the provision of regular supervision and appraisal.

People's day to day healthcare needs were met by staff in conjunction with community healthcare professionals. We saw evidence in care records of regular communication and meetings which involved people where appropriate.

Requires Improvement

Is the service responsive?

Our findings

We carried out an unannounced comprehensive inspection of this service in September 2015 when we were concerned that people's care plans lacked detail and were not person-centred. We were also concerned that the review of care plans had not been completed consistently. The risk of not reviewing and updating changes to people's care plans is that staff may be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed. We asked the provider to take action to address these concerns.

On this inspection we checked to make sure requirements had been met. We found improvements had been met and this breach was met.

At this inspection the majority of care records we looked at had been reviewed and updated to reflect people's current care needs. We saw that staff identified a person each day and completed a full review of their care records. However, we saw that some care records had not been updated to reflect recent changes. We discussed this with staff and the information was updated before the end of the inspection. We saw evidence of people being involved in their care planning. For example, we saw that in some instances people had signed their care plan and in others they had signed to say they had seen their care plan or it had been discussed with them. The evidence was not as strong in other care records to evidence their inclusion.

When we spoke with people they told us they felt involved in the planning of their care. Most people confirmed that staff regularly asked them how they felt or if they were okay, and all said they felt they could communicate their feelings or likes and dislikes to the staff. One person said, "We sit down and talk about our care."

Relatives spoken with were able to describe a high degree of involvement. We were given examples of relatives working in partnership with staff and community healthcare professionals to secure equipment and specialist care. However, we were told that involvement in the planning of care had not always resulted in the care being given as planned. For example, we told about one person who was admitted to the home with a programme of physical activity to aid their recovery. A relative said that the treatment plan was not acted on for the first week. We checked the care records relating to this person and saw that there had been a delay in starting the treatment plan. We were told that this was because the person was experiencing pain and was reluctant to participate.

People had access to a range of activities which were promoted in each of the units. These included entertainment provided by singers and parties for special events. People also had access to community facilities for example trips to The National Wildflower Centre and local football stadiums.

Concerns and complaints were recorded and responded to within the timescales specified in the relevant policy. Each of the people that we spoke with was able to explain what they would do if they needed to complain about the home. Notices were displayed in each of the units and the main reception explaining

the complaints' procedure and other methods for communicating concerns. We saw from records that changes in practice had been made following the receipt of complaints.

We have noted the improvements made but have not revised the rating for this key question to 'good' from 'requires improvement'. To improve the rating to 'good' would require a longer term track record of consistent good practice. We will review our rating for 'responsive' at the next comprehensive inspection.

Requires Improvement

Is the service well-led?

Our findings

We carried out an unannounced comprehensive inspection of this service in September 2015 when we were concerned about the effectiveness of systems in place to identify, assess and manage the quality of service provision including risks relating the health, safety and welfare of people. We asked the provider to take action to address these concerns. On this inspection we checked to make sure requirements had been met. We found improvements in some areas but failings still in the overall governance and monitoring arrangements for the service.

We looked at and reviewed some of the processes in the home that we had identified on the previous inspection to see if they had improved quality and safety. We enquired about quality assurance systems in place to monitor performance and to drive continuous improvement. We saw that audits were completed by managers with local, regional and national responsibilities. This approach had generated some improvements in quality, however we saw that significant concerns relating to safety had not been identified and/or addressed. For example, a safety concern relating to ill-fitting mattresses had been reported over a period of months but had not resulted in remedial action. We spoke with the registered manager regarding this and were assured that steps had been taken to ensure the mattresses did not present any immediate risk. We were also told that replacements had been identified and would be ordered as a priority.

Quality assurance systems had failed to identify significant errors in the management of medicines. This is particular concern in light of previous failings in the safe management of medicines identified at the last inspection and in other homes operated by the provider. The risks associated with medicines errors remain significant and relate to the ordering, storage, administration and recording systems. The persistent failure of audit processes to identify errors and drive improvements in safety places people living at the home at significant, avoidable risk.

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

At the previous inspection we were concerned that the home was not submitting statutory notifications informing us of significant events in the home. We looked at the records relating to accidents, incidents and notifications. Since the last inspection we have received notifications as required.

At the previous inspection we were concerned that there was inconsistency in quality and values across each of the units. We also noted that staff were unclear about the visions and values of the home. Staff comments during the inspection indicated that there was a greater understanding of the visions and values of the home. We saw that the quality of care in each of the units was more consistent.

At this inspection we saw policies, procedures and overall governance [management] processes were in place to help ensure consistent and improving standards. The home had also developed a service improvement plan which detailed the concerns identified at the previous inspection and established clear steps to generate improvement. The registered manager had provided regular updates to this plan since the

last inspection.

The action plan submitted by the provider told us that the service intended to include feedback systems into the home to collect people's views as to the running of the service which would then be used to plan any future changes. This included a revised schedule of resident and relative meetings and a commitment to communicate progress on the service improvement plan to staff. The people that we spoke with during this inspection confirmed that improvements had been made regarding engagement and communication.

We saw greater consistency of systems and processes in each of the units. A unit manager told us, "Questionnaires are done by the activities coordinator. We generally supervise staff once a month. We have team meetings, but they're less formal. We've been given more supernumerary hours." We were shown notes of recent meetings held with people living at the home, their relatives and staff. Other unit managers confirmed that additional hours had been provided to help them with administration tasks. A member of staff commented, "We get asked for our ideas. The managers are very approachable."

The staff that we spoke with were motivated to provide good quality care. A unit manager said, "I'm happy to come to work every day." Another member of staff told us, "It's such a rewarding job."

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Applications to deprive people of their liberty had not been submitted as required.