Canterbury Care Homes Limited

Rowans Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30, 31 January 18 and 2 February 18 and was unannounced.

We undertook an unannounced focused inspection of Rowans Care Centre on 30 January 18. The urgent focused inspection was triggered following a serious incident which other agencies including the police were looking into. We found concerns on the focused inspection and we therefore undertook a full comprehensive inspection on 31 January and 2 February 18.

The service is a 36 bedded care home providing nursing care. At the time of our inspection there were 33 people living in the care home. There were two floors with a lift and adapted facilities.

We found concerns on this inspection related to safe care and treatment, staffing levels/deployment, care planning, person centred care and governance.

Rowans Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. 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 looked into staffing levels and found they were not always sufficient to meet the needs of people. There were a high number of people remaining in bed and staffing levels were inconsistent on the rotas.

A safe level of care was not always being provided. Care plans we viewed were lacking in specific detail required to safely care for people.

During our inspection we found one person had not been supported to eat and drink according to their speech and language therapist's recommendations to reduce the risk of aspiration. Aspiration is the risk of a substance entering the lungs such as food/drink debris.

Risks were not being actioned upon or escalated in a timely way to always protect people from harm. For example, the registered manager was aware there were some areas within the care home where the call bell system was not working but had not escalated this to be repaired in a timely manner.

Staffing levels were inconsistent. The dependency tool was not being used in conjunction with other methods of assessing an appropriate staffing ratio in line with National Institute of Health and Care Excellence and Royal College of Nursing guidance.

The system of communicating important clinical information to care staff was at handover or to ask the nurse in charge. We were therefore, concerned care staff were not provided opportunities to read the care plans to appraise themselves of the important details they needed to know to care for a person. Care staff were seen asking the nurse in charge their queries and were not seen accessing the care plans.

The premises were in the process of some refurbishment. The garden/exterior of the care home was not being utilised. Its design required further adaptation to meet people's needs.

People's dignity was not always being upheld. A high number of people were seen remaining in bed when some people were able to sit out but were not being encouraged to. We observed staff rushing when delivering care leaving one person with a wet top on after providing them with care.

People were not always being provided with choices. Staff were unable to provide person centred care when information in care plans had not always been kept up to date for staff to know how to best support each individual person.

There was a system of recording when deprivation of liberty applications (DOLs) were being sent to the Local Authority and approved.

Further systems of communication were needed to obtain people's views about how the service could be improved. We found only one concern had been logged in the complaints file. Although the complaints procedure was on display there were no easier methods for people to raise a concern such as suggestion boxes/complaints forms at reception.

The registered manager was not undertaking spot checks within the care home to identify any immediate concerns or observe how staff were being deployed to deliver care of the highest possible standard and quality. Governance and quality assurance systems had not identified all the concerns we found on this inspection.

People told us they felt cared for and staff were caring. We observed staff were caring and respectful towards people and their relatives. Staff had developed efficient task based systems to deliver compassionate care as much as possible.

We observed a medicines round and inspected how medicines were stored. Medicines were being managed safely within the care home.

Staff understood the different types of abuse and had received training in Safeguarding. There was a system of logging and reporting incidents and accidents in the care home.

There was a training matrix system in place. Staff were receiving supervision and appraisals. Staff recruitment practices were looked into and included safety checks such as Disclosure and Barring Service (DBS) checks. Most staff were receiving an induction with the exception of one agency worker who told us they had not received an induction.

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

Not all risks identified were being mitigated to do all that is reasonably practicable to protect people from potential harm.

Care plans did not always provide accurate and detailed information for staff to know how to manage risks for people.

Medicines were being managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always being provided with choices.

The design, adaptation and aesthetic aspects of the environment were in need of improvements.

Mental Capacity Act 2005 legislation was being adopted with a framework seen in the records we viewed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff had developed effective task based systems to deliver care with as much compassion as possible.

Staff were seen interacting with people they were caring for in a positive way, respecting their wishes.

Staff were listening to people and their relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always reflecting the care needs of people for staff to provide person centred care.

Activities being provided were limited.

The processes in place for people to raise a concern/complaint needed further improvements.

Is the service well-led?

Inadequate

The service was not well led.

There were no spot checks or walk around checks being undertaken by the registered manager to identify any issues such as deployment of staff.

The quality assurance systems had not identified all of the issues we found on this inspection.

Known risks had not always been escalated by the registered manager in order to mitigate them.

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.

The inspection was prompted by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of deployment of staff and staff knowledge of people they were caring for. This was brought to the attention of the police and the Safeguarding Authority.

This inspection was unannounced and took place on 30, 31 January and 2 February 2018.

The inspection team included an adult social care inspector, 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 reviewed all the information we hold about the service including statutory notifications which are a legal requirement and a provider information return (PIR) which is a document we ask providers to send to us with specific information about the service.

Numerous methods were used during this inspection including talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking, structured observational framework assessment (SOFI), observation and a review of records.

We reviewed five care plan and case tracked two people which means we reviewed all their records, observed a medicines round and how prescribed medicines were managed, spoke with 19 staff within the care home including the registered manager, regional manager, maintenance, activities coordinators and the chef. We spoke with nine service users and six relatives/visitors.

During the inspection we spoke with three healthcare professionals who had input into the care home and contacted the Commissioners of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at the care home if they felt safe. One person told us "Feel secure here", a second person said "Feel secure when helped into toilet and shower". We spoke with visitors and one visitor told us "[Service user] is well looked after", "This is an exceptional care home. Facilities are very good. Kept very clean". However, we found the following concerns within the home.

We checked if systems were safe within the care home. We found there was a mobile call bell system in place. We found no call bell in a ground floor toilet/bathroom used by service users on the ground floor. On closer inspection of the call bell system the screen monitor which displayed the room number in which the call bell had been activated was not accurate. We spoke with the registered manager about this who explained they were aware the call bell system was not functioning as they had ordered three new mobile call bells to replace the three which had stopped working. We found one toilet had no mobile call bell. The registered manager confirmed the issue was that there were no staff within the care home who were trained to install the three new mobile call bells. The registered manager told us that a work around was in place in that a note was placed above the office door to inform staff of which rooms to go to when particular numbers were displayed on the call bell monitor. We asked an agency worker who was working on the ground floor on 30 January 2018 if they had been told about the call bell system work around on their induction. When asked if they had been told about the call bell system work around they said they had not been made aware. This meant there was a risk that in the event a call bell was activated in an emergency, staff would not know which room to respond to and this placed people at increased risk of not receiving assistance in an emergency. We asked the registered manager to escalate this to ensure the call bell system was made safe. This was actioned by the second day of the inspection.

We found one person had a large purple area of discolouration to their right hand which appeared to be bruising but we found no record of a body map illustrating this. Although we found other body maps illustrating bruises the system of ensuring all bruises were body mapped and medically assessed for a likely cause was not sufficiently robust.

We looked at five care plans and found that in some cases the information provided was contradictory or lacking in detail. For example we asked the nurse in charge how much assistance specific service users needed to mobilise. The nurse in charge told us that one service user needed the assistance of one or two carers depending on how confident staff were. We read the person's moving and handling care plan and found it stated "needs two for all transfers". This meant that staff were not always being given clear direction as to the safest way to help someone move.

We viewed the care plan for another service user and asked the nurse how staff were to support them because they had a fractured arm. The nurse explained how staff were to support the person to change their position due to pressure areas and was observed explaining this to a care worker who asked how they were to re position and turn the person. The instructions which the nurse provided to the care worker were not written in the person's care plan.

We asked the registered manager how staff were to know how to support people when they came to deliver care and the registered manager responded they were to ask the nurse in charge. The care plans were not always detailed enough and staff on the top floor were observed to not have time to read the care plans. Staff were relying on information being passed to them verbally by the registered nurse or in handover. This system was not robust enough as the nurse was observed rushing and attempting to respond to requests by staff. In the absence of a nurse to ask for specific information, the care plan is required to be up to date with information for staff to refer to and know how to care for the person. We found care plans were not always detailed enough with the information staff would need to safely care for people.

During the inspection we became concerned about one person who appeared to be unwell. We spoke with the care worker who had last supported the person and asked them if the person had eaten their lunch. The carer said they had eaten their food and drink without any problems. We asked the carer if there were any specific instructions to be followed for giving food and drink and the carer said there were not. We viewed the person's care plan and found an entry in their care records from the speech and language therapist stating a 20 minute rest period was needed in between half portions of all meals. On closer inspection of the person's room we found a piece of paper stuck to the wall which was a photocopy of the instructions written by the speech and language therapist in the care plan. The instructions were not clearly visible for staff in the person's room. We asked the care worker and a second care worker to view the care plan with us. Both care staff told us they had not seen the instructions in the care plan or on the wall previously. They were unaware the person needed rest breaks of 20 mins and one of the staff had assisted the person that day.

The nurse in charge was also asked if they were aware of any specific instructions for the person's eating and drinking. The nurse was inconsistent and was unclear what the instructions were. We were therefore, concerned that the system of communicating specific instructions for eating and drinking was not robust enough to always keep people as safe from harm as possible. We asked the registered manager to ensure their system was improved as a matter of urgency. When we returned on the third day the registered manager had ensured specific instructions for each of the 10 people who had specific speech and language therapy instructions for eating and drinking had been communicated to staff.

These issues were a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We checked whether there were enough staff to meet people's care needs. We were informed by the registered manager the majority of people living in the care home required assistance with transfers and use of a hoist. A hoist is a piece of equipment used to transfer someone. They also confirmed people who were in bed during the day who were unable to press a call bell were checked every hour. We were informed by the registered manager the staffing included a nurse and three care staff on each of the two floors within the care home.

We observed one person who had received their morning personal care but had a food stain near their mouth and a wet T-shirt. When we inspected more closely with the person's consent we found their shoulder was wet and pink in colour. We asked for the person to receive assistance from a staff member. A staff member then cleaned the person's mouth but left without changing the person's wet T-shirt. The person said to us "Don't read too much into this. Staff are very busy as they are." A second person living in the care home told us "Staff are very busy". A relative told us they were concerned their relative who lived in the care home had not been receiving showers frequently enough and they had been informed by staff it was due to them not always having enough staff. Another relative also raised this with us as a concern. We therefore, considered people's dignity was not always maintained due to staffing issues.

This is a Breach of Regulation 10 Dignity of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We spoke with staff about the staffing levels and if they were sufficient. One staff member told us - "I'm never worried about staffing numbers, if someone goes off sick we can usually cover with our own staff and can ask for agency staff if we need it". A second staff member told us "There is always staff walking about here to give help." A third staff member said "We could do with four staff up here", meaning the top floor. A fourth staff member said "It's very hard up here, we spend a lot of time with people who have dementia, dependency is high up here". A fifth staff member said "People are getting care but staff are worn out, staffing levels is the only thing that needs to improve". A sixth staff member who spoke with told us they were present in the care home when they had difficulty covering for staff sickness. They told us a staff member was moved from the top floor to the lower floor leaving two carers on the top floor and a nurse. We were present when one staff member told the registered manager "I don't have the time" when the registered manager asked them to complete a task.

The registered manager was reviewing dependency levels in conjunction with a dependency tool to assess and review staffing levels. We found the dependency levels on the top floor were higher than on the lower level. Out of 20 people living on the top floor, 16 of those people required two care staff to support them. Staff told us they found two care staff could provide care for people who needed the support of two carers but then the third carer was limited which care tasks they could undertake on their own. Out of 21 people on the top floor nine of those people required support and assistance with eating and drinking. By midday on the first day of our inspection five people were still waiting for their morning care. We discussed staffing numbers and deployment of staff with the registered manager. They told us if another staff member was needed on the top floor a carer from the lower floor could go and assist, however we did not observe a system of deploying a fourth carer to work on the top floor if assistance was needed.

We viewed the rotas and found inconsistencies in staffing levels despite being informed by the registered manager there were six carers and two nurses throughout the day. The rotas we checked confirmed some days staffing levels dropped down to five carers in the afternoons. On 29 January 2018 there were six carers in the morning dropping down to five carers in the afternoon. On 1, 2 and 3 February 2018 there were six carers in the mornings dropping down to five in the afternoon.

We also viewed the daily charts for two people who relied on staff for personal care. We found one person had a gap of seven hours during which time they had not had their personal care and pad changed. The person's incontinence pad was changed two hourly and then a gap of seven hours before reverting back to two hourly again in the evening. A second person whose records we checked had up to a nine hour gap in between their incontinence pad being changed with no explanation why.

These issues were a breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

Staff we spoke with were knowledgeable in safeguarding and could describe the different types of abuse. They explained how they would report safeguarding concerns. Staff had heard of whistleblowing but not all staff knew there was a policy or where they could access the policy.

We checked the safety of the premises. We found some areas were unkempt and needed updating. During the inspection we observed maintenance work being undertaken to refurbish some of the rooms within the care home and we were informed by the registered manager there was a plan to refurbish additional rooms. During our walk around with the registered manager we found one call bell in a toilet was not operating as a

battery had run out. This was replaced immediately. Monthly maintenance checks of the call bell system were seen in the records.

We checked the maintenance log book and found a system of jobs to be completed within the care home and actions dated and signed when completed. For example, we viewed an entry on 31 January 18 'downstairs nurses clinical room door needs oiling, disturbing residents at night'. It had been signed to confirm it had been rectified and actioned. Personal Evacuation plans (PEEPS) were seen within people's care files and fire drills were seen in the records we viewed.

We looked into whether medicines were being managed safely within the care home. We found as and when prescribed medication (PRN), were administered according to a written protocol. The protocol included: circumstance, known side effects, special instructions and prompts to request a GP review should the frequency of administration increase. Known allergies were detailed on the medication administration sheets seen and all MARS seen had been correctly signed /dated and coded. All MAR sheets seen had a photograph of the person. We found people requiring insulin therapy had twice daily blood sugar levels both tested and recorded. These records were held within the corresponding MAR sheet.

As part of our checks we observed a medicines round and inspected the clinic room, fridges or Controlled Drug cabinets. The nurse who we accompanied on a medicines round wore a 'Do not disturb' tabard and followed appropriate hand hygiene practices in between administering medicines for people. The fridge temperature records were observed to have been maintained correctly and the level of stock of prescribed controlled drugs checked were appropriate.
The infection control systems within the care home were effective. We undertook a tour of the home and observed cleaning practices were being followed with enough personal protective equipment for staff to use.

Systems for recording incidents and accidents were in place and we viewed incidents were being logged to identify trends or themes.

Requires Improvement

Is the service effective?

Our findings

We asked people if their needs were being met. One relative said "[service user] is well looked after, clean and well kept. [Service user] has good 24 hour care here."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met."

We found a DOLS Applications Form/tracker was being used by the registered manager which clearly documented when a DOLS application was sent, the date when the DOLS was authorised and when it expired. There was a system in care plans of documenting people's mental capacity and best interests decisions when appropriate. We observed staff were asking for people's consent during every day care tasks being delivered.

We looked into how people are provided with choices and how their needs were being met. As we found a high number of people remaining in bed during the daytime we looked into how people who could sit out were being offered the choice to do so. We spoke with one staff member who said people were given the choice of sitting out if they wished and some people didn't want to get out of bed. They went on to tell us they weren't able to transfer people out at times due to a limited number of curtain chairs and staff time to support people out of bed. We did not identify a shortage of curtain/bucket chairs on the inspection. We asked why one person who was living with dementia was in bed for the three days when we were present in the care home. The staff member told us the person could sit out in a bucket chair but was most of the time in bed due to not having enough staff. According to the care records the person was at risk of chest infections and was last treated for a chest infection in January 2018. We found another person who was living with dementia had not been sitting out of bed on 30 and 31 January 2018 when they were able to sit out and was seen sitting out on the third day of the inspection. The care records we viewed did not evidence staff had considered supporting the person to sit out or that they had been encouraging the person to sit out. Therefore, the Commission were concerned the staffing levels were not sufficient for people who were able to sit out of bed to always be encouraged and be supported to sit out of bed if they chose to. Immobility is a factor which can contribute to serious health risks such as a chest infection.

This was a further breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We visited the kitchen to speak to the chef. We found there was a four week rolling menu and there was a

choice of two meals for people at each meal time. They were offering people choices according to their dietary requirements. We found foods low or high in potassium, vegan, reduced fat, low sugar including sugar free jam for people who had diabetes, gluten free foods and almond milk for people who were lactose intolerant. People were being asked what they liked or disliked from the menu each morning and evening each day. We observed the hostess serving food and drinks during this inspection and observed choices being offered to people. We found the chef had a file with information about foods and dysphagia (medical term for swallowing difficulties).

We asked the registered manager for details regarding which staff had completed dysphagia training in view of some of the concerns found on this inspection. The document titled "Dysphagia" provided on the inspection detailed only 7 staff who had completed dysphagia training. The registered manager confirmed more dates for dysphagia training were being arranged. Following the inspection we were provided with names of staff who were on the list for dysphagia training and a senior carer who we identified had not undertaken the training was on the list to complete it. Other aspects of training were being offered to staff including, bed rail management, health and safety at work, nutrition and hydration, safeguarding awareness, moving and handling were being tracked on a training matrix.

Most staff told us they were provided with an induction lasting three to four days. The induction included policies and procedures handbook, service user guide, care practices, fire safety, management arrangements and the statement of purpose. We found the registered manager had overseen the induction undertaken. An agency staff member told us they had not received an induction and were learning as they were going along and were reliant on verbal instructions being given to them how to care for people living in the care home. After the inspection the provider did offer us a record to demonstrate that agency workers undertook a form of induction. This was signed by them to say they had been offered information pertaining to the home and people who used the service. Staff told us they were having supervision and appraisals regularly. One nurse told us "I have monthly supervision and an annual appraisal".

The design of the layout of the interior and exterior of the care home was not always conducive for people to be as independent as possible. There were adapted bathrooms for people with specialist equipment but they were not always accessible for people. A bathroom on the ground floor which contained a bath was inaccessible and was being used for storage at the time of our inspection. Areas of the care home were in need of further improvements and refurbishment. We observed the mobile call bells within the toilets were not within easy reach and one toilet seat on the ground floor was low. A visitor commented on this and told us "The resident's toilet on the ground floor needs refurbishing. The emergency buzzer is at the other end of the toilet seat. The toilet seat is too low." The registered manager acknowledged areas of the care home were in need of refurbishment or improvements. The exterior of the care home contained a garden and raised beds which were low. There was also an open grassed area adjoining the local park. This area was not being utilised due to the design.

Requires Improvement

Is the service caring?

Our findings

We asked people how they were being treated. One person we spoke with said - "Care is very good. If you want help, it is there any time. Feel being taken care of, certainly." A second person said - "Good, very good staff. They are all good. They help me when they can. Sometimes have to wait don't know how long for but not often. Not so long that I am left to feel very uncomfortable." A third person we spoke with said - "Getting better here. Can't complain. Staff OK, all of them." A fourth person told us - "Some staff are very good, some are better than others. Just little things". A fifth person said - "I feel I get heard as a resident here and not ignored." A sixth person said - "I am treated well as an individual. They talk to me well, not nasty, but polite." Staff were respectful of people they were caring for. One staff member said - "this is their home [meaning service users], I treat them like they are my mother or father".

We also asked relatives/visitors to the care home. One visitor told us - "Care is smashing. Everything has always been fine. Very pleasant staff. Always welcoming." Another visitor who spoke with us said - "Fantastic home. Everyone is caring. Comfortable. Staff all very good. We feel the staff really care for the people they look after". Another visitor said - "Staff work very hard. Would make drinks on request. Nothing is too much trouble."

Staff were efficient following a task based approach in order to meet people's care needs. We viewed a staff member's list of names of people on a piece of paper which they were ticking off as they delivered care for them. This was seen at lunch time when staff were attempting to provide care for everyone who still required their morning care routine. Task led care was being provided to ensure staff were able to keep track of who required care and when. We observed the lunch time in a dining area using a Structured Observational Framework (SOFI). We observed positive caring interactions where staff demonstrated they were supporting people with their food and drinks. We found people were asked if they would like a drink after they had finished their meal. This was noted when a staff member asked a staff member if everyone had had their drink at 1.05pm. People were then offered a drink and a staff member said "Can I tick off everyone's had a drink?" We therefore found people's preferences were not always being taken into consideration as some people prefer a drink with their meal, other people prefer a drink after their meal. The care was compassionate but task focused. Staff were not being awarded with enough time to spend with people to provide each person with a personal approach to their care.

Staff knew people they were caring for well and listened to people. We observed one person with limited verbal communication who was attempting to alert staff they needed assistance. The person did not have a call bell due to their difficulty using it in the past. It took time for staff to realise the person was attempting to capture their attention but eventually a staff member noticed the person and attended to the person. When we asked the staff member how they knew if the person needed care they said - "We would look out for [service user] arching their back, slipping down in the chair or moving their finger to seek attention. They usually get uncomfortable a couple of hours after first sitting out." This provided reassurance staff knew people they were caring for well.

During the inspection we observed positive interactions between staff and people living in the home. Staff

were seen responding to people by using their name, providing eye contact and seeking consent prior to proceeding with delivering care. Staff were courteous and respectful in their interactions with people. We observed one person becoming distressed and agitated with another person who lived in the home. Staff knew the person well enough to understand why the person was becoming distressed and supported the person in a warm and empathetic way. They responded in a timely manner to support the person away from the communal area to maintain their dignity. People were being provided with choices including a choice of foods and drinks.

People who were able were seen moving around the care home freely and were not being restricted thereby encouraging people's independence. We did not see anyone being supported to go outside but became aware of one person who was accompanied outside to the local shop on our third day of inspection. The registered manager assured us people were supported to use the outside garden areas during warmer weather conditions.

A relative told us "[service user] has improved vastly than at home, become more mobile. [Service user] has now managed to walk faster with a zimmer and for longer distance."

We observed a high number of visitors and relatives within the care home during the inspection. Visitors were welcomed and there were no restrictions for visitors creating a warm and inclusive environment. Advocacy services were available for people as and when they required them.

Requires Improvement

Is the service responsive?

Our findings

We checked whether people felt they had control and were involved in their care planning. We observed one person was asked by a member of staff if they wished to have the dessert. The person responded they did not wish to have their dessert now and wanted to have it later. The person's wishes were respected by the staff member. Another person we spoke with told us they had no option how many staff supported them in the shower and they did not have as much autonomy as they would like.

We looked into the activities being provided for people. We spoke with the activities coordinators who said they jointly shared the role of providing activities for people. They both had other duties to provide care and assistance in the kitchen but had designated hours for activities in the care home. They were seen providing some activities for people in small groups during our inspection. Activities being provided within the home included craft based activities and bingo. One person told us they would like to go out but they had been informed there was not enough staff for them to be able to have trips outside. Another person told us they had requested to go out in a wheelchair but they had been told staff were too busy. One relative we spoke with told us "Don't feel [service user] is stimulated enough. [service user] is bored sometimes. There is an activities co-ordinator, but not seemed to be involving residents much only bingo seems to be a regular feature".

We viewed in the care plans person centred information about people including preferences, likes and dislikes. For people who did not have capacity to make their own choices we could see others who were likely to know them well had been consulted with.

We looked into how care plans reflected the care people needs of people. We case tracked one person who was seen to have a very red, inflamed sore mouth with a coating on the inside of their mouth on 30 January 2018. We asked a nurse in charge to accompany us to assess the person's sore mouth. The nurse used a dry soft gauze to gently clean the food debris away from inside the person's mouth. When asked how staff were to care for the person's sore mouth the nurse replied that the General Practitioner (GP) had asked staff to apply Vaseline to their very inflamed sore lips. We asked the nurse to show us the oral care plan but the nurse could not locate it. When the nurse did later locate an oral care plan it was not stored within the appropriate section of the care records according to the index. This can impact on staff being able to quickly find the information they need to care for the person. The registered manager told us going forwards they would dedicate set times for them and the deputy manager to further improve the detail within care plans and ensure the index correlated with each section within the care plan.

The oral care plan seen was dated 16 January 2018 and did not detail the current advice from the GP. We asked for the care plan to be reviewed to include the up to date advice from the GP. The nurse in charge provided us with a copy of an updated oral care plan but it still did not provide enough detailed information. We asked for more detailed instructions to be provided for staff which the nurse then provided signed on 31 January 2018.

On 2 February 2018 another nurse in charge told us they were concerned about the person's sore mouth and

had asked the GP to reassess as they thought the person had developed oral thrush. The GP assessment note seen confirmed the GP diagnosed oral thrush on 2 February 2018 and commenced treatment for this. Poor oral hygiene is one cause of oral thrush. We were therefore, concerned we had observed the person had not had their mouth cleaned on 31 January 18 until we brought it to the nurse in charge's attention. The oral care plan was also not updated to reflect what advice the GP had given. This was demonstrating the person had not received person centred care.

This is a Breach of Regulation 9 Person Centred Care of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We asked people if they felt they could raise a concern or complaint. One person told us "If I am unhappy about anything, I will ask for the manager. She will sort things out. I once had a staff member who made me feel I was a nuisance. I told the manager about it. The manager obviously sat this staff down and talked to them. There was no similar 'misbehaviour' from this staff again." A relative told us "Don't know what the complaints procedure is, but feel able to approach anybody about complaints or anything." Another relative said "don't know about the complaints policy but feel can go to the manager if we have any concerns."

People told us they felt able to raise any concerns and complaints. We viewed the complaints file and found a log of one complaint which had been recorded since the last inspection in 2017. There were no concerns/complaints logged for 2016 in the file. Therefore, there was no analysis of concerns people had raised to demonstrate there was continuous learning and improvements. We found a copy of the complaints procedure in the reception area of the home but there was no suggestions box or easily accessible concerns/complaints form for people who wanted to raise a concern/complaint to encourage people to raise anything which could be improved. There were residents meetings taking place within the care home and we found future dates up to December 2018 had been planned.

The home had been providing end of life care but there was no one at the end of their life at the time of our inspection. We spoke with one relative who said staff cared for their relative well who passed away at the care home. There was a GP for the care home who was in regular contact with the staff regarding clinical concerns where people were deteriorating.

Inadequate

Is the service well-led?

Our findings

We asked people and their relatives how they found the management of the care home. One relative said - "We feel staff have got a very good caring ethos. This is credit to the manager. We got to know the manager and her personality". Another relative said - "The staff are lovely, we have no issues with the staff, what we need is spot checks by the manager". The relative was concerned there were issues that were not being identified by the manager.

Staff meetings were being held with staff and the registered manager. We viewed the minutes of one meeting dated 17 April 2017 and other minutes dated 27 July 2017. They were a list of items communicated by the registered manager to staff. The minutes did not contain information whether staff raised any issues during the meeting and did not evidence staff were encouraged to have a voice to contribute their ideas.

We viewed regional manager monitoring visits were being undertaken with the last visit by the regional manager logged on 27 November 2017. The quality monitoring report completed by the regional manager identified some issues within the care plans audited including improvements needed in documenting clearly the Precutaneous Endoscopic Gastrostomy [PEG] feed regime in one care plan. Agency staffing was discussed with the registered manager according to the report but no evidence of reviewing the staffing ratio/skill mix or deployment of staff within the home. Other quality checks undertaken included in infection control, medication management and house-keeping audits. The registered manager had written memorandums to staff in order to pass on information seen in a file. However, none of the quality assurance checks we viewed confirmed they had identified the issues we found on this inspection. This meant the quality assurance systems were not robust enough.

There was no evidence of walk around spot checks being undertaken in the home by the registered manager. We were therefore, concerned about the lack of visibility of the manager to provide leadership to promote the culture within the care home. In the absence of spot checks and walk arounds we were concerned the manager would not have maintained an overview of how staff were delivering care including whether the care being delivered was person centred. The manager confirmed they would undertake walk around spot checks going forwards. Whilst undertaking a walk around with the registered manager during our inspection we found the call bell in one toilet was not working. The manager asked the maintenance staff member to check the mobile call bell and they found it required a new battery. This was actioned immediately by the maintenance staff member. We were concerned the registered manager had not escalated the call bell system not working efficiently prior to our inspection. A staff member told us the call bell system had been an issue since December 2017 and it had been reported to the manager.

We asked the registered manager if the issue of installing the new mobile call bells to reset the system had been escalated. The registered manager told us it had been escalated and provided us with a copy of an email dated 20 December 2017. It was an email from the administrator in Rowans Care Centre to the company who installed the call bell system informing them the maintenance staff member who had a working knowledge of the call bell system was not at work for some time. They asked the company to send an engineer to train the maintenance staff member working in the care home how to install new mobile call

bell units and reset the system. We asked the registered manager to escalate the concerns regarding the call bell system immediately which the registered manager asked her administrator to escalate. By the second day of inspection on 31January 2018 the engineer was seen in the care home and had installed the new units and reset the system. We were concerned that if not for this inspection the concerns regarding the call bell system would not have been escalated by the manager. There was no evidence the registered manager had escalated the concerns themselves as a matter of high priority.

We found information in care plans was not always in appropriate sections to find information. . The registered manager told us they had delegated the task of creating the index and subsequent sections of the care plan to the deputy manager. The registered manager also told us the nurses were responsible for auditing the care plans. Therefore, we were concerned the registered manager was unaware of the concerns we found in relation to the care plans. We were present when the registered manager asked one nurse in charge to change the format within one person's care plan according to the index. The nurse responded "I don't have time". We observed the nurse in charge being constantly interrupted by staff who needed their advice or assistance. In the absence of walk arounds by the registered manager they would not have had the opportunity to observe this. We discussed with the manager that by undertaking walk arounds they would then have the opportunity to observe how busy staff were and proactively deploy staff where they were needed most.

We highlighted to the registered manager the system of communicating swallowing prescriptions from healthcare professionals was not robust enough placing people at risk of harm. We found specific recommendations written in their care plan and on the wall of one person's room had not been effectively communicated to care staff as they had confirmed they had not noticed the recommendations on the wall and had not seen the recommendations in the care plan dated November 2017 which we showed to them. The person had undergone an investigation for their swallow on 23 January 2018 but the most recent advice had not been updated in the care plan we viewed or in the instructions on the wall. The person was assessed by their GP at our request and was found to have a lung infection and was commenced on antibiotics. We were concerned systems for communicating important information were not robust enough within the care home to keep people safe from harm. We were provided with a most recent care plan for eating and drinking for the person dated 8 February 2018 following the inspection and found it had several instructions some of which had been crossed out. The instructions listed on the speech and language therapy report we viewed stated clearly what the recommendations were and these were seen updated on the wall when we returned to the care home however the recommendations had not been clearly transcribed onto the care plan. For example, it did not state one recommendation was 'allow time for clearing swallows'. The registered manager agreed to ensure the systems were made more robust by undertaking a themed supervision with the nurses in charge and updated visual instructions for staff to follow written in people's rooms. This ensured staff were very quickly appraised of what they needed to do when supporting people with swallowing difficulties to reduce the risks of aspiration or choking.

We were concerned about the staffing levels in the home and use of a dependency tool in the absence of other means of assessing appropriate staffing levels including walk arounds by the manager. The registered manager provided us with a copy of the dependency scores for people and how the care hours needed were determined. We were told that the scores were re-evaluated at the end of every month. If people deteriorated within the month this would not be entered into the dependency tool until the end of each month. We were concerned that in the event more than one person showed a level of deterioration to a higher level of dependency and risk, staff would be expected to continue to meet people's care needs until the end of any given month. We viewed the descriptions of the dependency levels of low, medium and high dependency. A description of high dependency listed characteristics which were task orientated. For example, 'sometimes doubly incontinent', 'Has to be fed', 'Cannot make needs known'. We scrutinised the

care hours totalled on the dependency calculation according to the staffing risk assessment seen. In the event there were two nurses and six carers on 12 hour shifts this totalled 96 hours of time to care for people without including breaks or lunch. The dependency tool score we viewed did not provide a breakdown of how the staffing numbers were calculated in detail to reach a total of 135 hours. We were concerned this tool was unclear and found no other method of considering staffing or skill mix being used.

The RCN produced guidance around staffing and skill mix in their paper titled 'Guidance on Safe Nurse Staffing Levels in the UK', published in 2010. It states that 'Predicting the number of staff required to provide safe care to an agreed standard cannot simply be based on the number of patients/clients requiring care, or even on a measure of workload related to patient need or 'dependency'. The volume of care required may be the primary factor in determining staffing, but it is not the only one. A host of factors affect the nurse staffing and skill mix needed'.

These issues are a Breach of Regulation 17 Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We asked staff about the management of the care home. One staff member said - "I feel confident in managers, anything brought up is followed up. We're a happy family here". Another staff member told us "I have a good relationship with the manager and feel there is a code of candour here, this place is transparent".

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans were not always reflecting the care needs of the person and people were therefore, not always receiving person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	We found people's dignity was not always being upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks were not always being mitigated to ensure all that could be done was being done to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The quality assurance systems in place did not highlight all of the concerns found on this inspection. The governance systems were not robust enough.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

Deployment of staff/staffing levels were not always effective enough in meeting people's care needs.