Avery Homes (Nelson) Limited

Rowan Court

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?	**Requires improvement**

Overall summary

The inspection took place on 11 November 2015 and was unannounced.

Rowan Court provides care and support, including nursing care, for up to 76 people, some of whom may require dementia care. At the time of the inspection there were 74 people living in the home.

A registered manager was 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.

The home was divided into three separate units. These were the Nursing Unit which accommodated up to 42 people requiring nursing care. The Memory Unit which accommodated up to 19 people requiring dementia care and the Residential Unit which accommodated up to 15 people requiring personal care. We visited all three units and found some areas of concern in the Nursing Unit and the Memory Unit.

Staff did not always adhere to relevant risk assessments and people were sometimes placed at risk of harm.

Summary of findings

People who used the service did not always receive their medicines as prescribed and sometimes action was not taken to address this when people refused their medication.

People did not always receive the care and support they required in a timely way.

Staff were trained to carry out their role and the provider had plans in place for updates and refresher training.Staff thought that the training had improved at the home.

The provider had safe recruitment procedures that ensured people were supported by suitable staff.

The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. People who required this had a mental capacity assessment in place ensuring that consent was obtained. Staff had a good understanding of why people may be considered to be deprived of their liberty. People and/or their representatives had consented to their care.

People's health needs were monitored and referrals to health care professionals had been made where required. People were supported to access health care professionals and to attend clinics and outpatient appointments.

People had enough to eat and drink and were supported with their nutritional needs.

People told us that staff were kind and caring but that sometimes their dignity was not upheld. People did not always receive the care and support they wanted in a timely way.

There was an activities and entertainment programme in place which was overseen by two activity coordinators but not all people felt they had opportunities to be involved in hobbies and interests that were important to them.

People felt that the registered manager was "excellent"and always approachable. Staff felt supported by the registered manager and there was management support for staff on all three units in the home.

The provider had a complaints procedure available for people who used theservice. People and families thought that complaints were appropriately managed. Staff also felt able to raise concerns about poor practice knowing that they would be supported to do so and felt supported by the registered manager.

The registered manager had systems in place to monitor and improve the service. However these had not picked up on the need for improvements with medication management, manual handling techniques and the lack of dignity afforded to some people.

Appropriate records had been maintained in respect of care plans, daily care charts, staff recruitment and information about menus. Appropriate records had also been maintained in respect of maintenance of the building.

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 consistently safe.

Risks to individuals were not always appropriately managed and people felt there was sometimes not enough staff provided to meet their needs.

Staff knew how to raise concerns about poor practice and abuse.

Medicines were not always managed and some people did not always receive their medicines as prescribed.

Requires improvement

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

Staff training and development was in place but this was not always effective. Staff did not always follow correct procedures which meant sometimes people were placed at risk of harm.

Consent to care and treatment was sought in line with the Mental Capacity Act 2005.

People were supported to have enough to eat and drink and people's health care needs were monitored. Timely referrals to health care professionals were made when people's needs changed.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff were kind with people but people's dignity was compromised when they had to wait for the support they needed.

People and their families felt involved in making decisions about their care and support needs.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People did not always receive care and support in the way and at the time they wanted it.

Not everyone felt they were given opportunities to be involved in activities and entertainment and maintain hobbies and interests.

People and their families knew how to raise concerns and the provider acted on information received.

Requires improvement

Summary of findings

Is the service well-led?

The service was not consistently well-led.

There was a quality monitoring system in place to help bring about improvements. However the provider's audits had failed to identify problems in the areas we had found concerns.

People who used the service and staff felt that the home was well managed and the manager was approachable and supportive.

People who used the service felt able to raise concerns with the manager and knew that they would be taken seriously.

Requires improvement 

Rowan Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 11November 2015 and was unannounced.

The inspection team consisted of three inspectors 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.

The provider had kept us updated of events by sending us relevant notifications. Notifications are reports of accidents, incidents and deaths of service users that the provider is required to send to us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with the regional manager, the registered manager, a unit manager, one nurse, nine care assistants and the activities person.

We spoke with 17 people who used the service and 12 relatives. We observed the care and support people received in the home. This included looking in detail at six people who used the service and whether the care and support they received matched that contained in their care plans. This is called case tracking. We also looked at these people's daily care records and records of their medication.

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 with us.

We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incident, accident and complaints records and minutes of meetings. We also looked at records relating to the maintenance of the home.

Requires improvement

Is the service safe?

Our findings

People who used the service felt that there was not always enough staff available to meet their needs. A person on the Nursing Unit said, "We are constantly having to wait for staff to come to us. They haven't got enough staff". A relative on the Memory Unit said, "I have been asked to watch everyone in the lounge because there is no staff around. [Person's name] has a bath once a week but it often doesn't happen if they are short of staff".

On the Nursing Unit we saw that a person wanted to go to the toilet and had to be taken to a lounge to wait until a member of staff was available to take them. A person told us that they often had to wait and said, "when you have to wait it is painful and you sit and fume." On the Nursing Unit there were a high number of people being nursed in bed. We saw that staff should carry out hourly 'comfort and safety checks' for people in their bedrooms, according to their assessments. Records for these checks showed that sometimes people had not been seen for up to three hours.

We pointed this out to the unit manager who said they would address this with staff.

We saw that staff were very busy on this unit and sometimes people were left unattended in communal lounges for long periods of time. We saw people sitting unattended in one loungefor 25 minutes with no access to a call bell which meant they could not summon help if they needed to.. We saw that people were left waiting for their lunchtime meal for 30 minutes at tables with little or no staff interaction as staff were busy elsewhere.

On the Residential Unit a relative said that people having access to call bells was an issue they had raised before and gave an example of when their relative had fallen in their bedroom unable to call for assistance.

The above is a breach of Regulation 18 of the Health and Social care act 2008 and Regulations 2014 - Staffing

Prior to this inspection we had received concerns that people who used the service were sometimes being moved and handled inappropriately. We saw, on the Memory Unit, a person who required the use of a hoist being physically lifted by two staff. Each member of staff held the person's elbow and wrist and lifted the person from wheelchair to chair. Their feet were not on the floor. The person's care file stated "When being transferred from bed to chair and vice versa a hoist and wheelchair are used. Due to [person's name] not weight bearing". This risk assessment was reviewed on 24 October 2015 and was assessed as, "Remains effective and relevant for this period". The same person was also taken to the bathroom before lunch to receive personal care. Again, the required specialist hoist was not used. We asked a staff member why the hoist was not used and they said, "The staff should have told me they were hoisted, no one told me. No I do not read care plans" Therefore the person was put at risk due to unsafe manual handling techniques being used.

On the same unit we saw staff supported a person to have a drink. According to the person's risk assessment in their care plan, they had been assessed by the Speech And language Therapist (SALT) on 16 June 2015. Their assessment stated the person was at risk of choking and should only receive thickened fluids of a "syrup consistency". We saw that the drink they were having did not contain thickener. The person started to cough as they were drinking and we intervened and informed the staff who took the drink away. A staff member said, "Some days [person's name] is ok, and can have drinks with no thickener and some days she is not. We decide". This meant that this person was placed at risk of harm due to not receiving drinks safely. .

Medicines were not always managed in a safe way. We observed the medication trolley being left open on the Nursing Unit whilst the nurse was away administering medication to people in another room. We saw staff signature omissions on the medication charts for one person on four separate occasions. On the Nursing Unit the nurse said that some people had medicines "crushed in another substance or sprinkled on food". The nurse said that this had been agreed with the GP and Pharmacy but there was no evidence that these covert medicines had been agreed. On the Memory Unit staff were unsure whether a person had their medication crushed onto food. We saw recorded that a person had refused to take their medicines (four medicines in total) for six consecutive days. We asked staff about this. One staff member said, "I don't know, I didn't know [person's name] had been refusing their medication". Another staff member said, "I wasn't aware that [person's name] had been refusing to take their medication for so long". We saw that, following a meeting between the GP, the person's relative and the unit manager, there was an additional plan in place stating 'it would be in

Requires improvement

Is the service safe?

[person's name's] best interest to try covert medicines.' There was no date on the plan and staff said, "It doesn't work so we don't do it". This meant that this person was not receiving their prescribed medication.

We discussed our concerns about what we had seen on the Memory Unit with the manager and regional manager at the time. They told us that all staff had received appropriate training and could read care plans and that they would take immediate action to investigate the issues and make improvements

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 Regulations 2014. – Safe Care and Treatment

Staff knew how to raise concerns about abuse and poor practice. Staff we spoke with told us they had received training in how to recognise and report any suspected abuse and were able to provide examples of what could constitute abuse. One staff member who was responsible for staff training told us, "All staff do training in recognising and reporting abuse so that staff know what to do. Also all staff are made aware of the Whistleblowing Policy so they know they will be supported to raise concerns about poor practice". The registered manager was aware of their responsibilities in making safeguarding referrals to the relevant local authority and had done so on several occasions. Local safeguarding procedures including contact details were clearly displayed for managers and staff to refer to.

Staff were carefully selected to work at the home to ensure they were suitable to work there. There was a staff recruitment procedure in place including carrying out relevant checks such as Disclosure and Barring Service (DBS) to ensure that staff were suitable to work with people who used the service. The provider obtained suitable references, employment history and DBS checks for each person before they were offered employment.

We spoke with three visitors of people accommodated on the Nursing Unit and all of them felt that their relatives were safe and well cared for. None of the visitors had any concerns about the safety and/or welfare of their relatives on this unit.

Requires improvement

Is the service effective?

Our findings

We saw that staff knowledge and skills was varied throughout the home. Although staff had received training for their job role, the principles of the training were not always adhered to. For example, on the Memory Unit staff had received training on manual handling but were moving and handling a person inappropriately. This was putting both the person and staff at risk of injury. Staff on this unit were also unsure how to support a person who was at risk of choking on their food as per their SALT assessment. There was a lack of staff understanding and awareness of the process to follow when people refused medication to ensure that people received their medication as prescribed. This showed us that people were not consistency receving effective care. We discussed our concerns with the manager who said that staff had received training in the above areas but that this would be reviewed.

In other parts of the home we saw examples of good manual handling techniques using special equipment. For example, we saw three staff transferring a person from a wheelchair to an arm chair. The staff explained what they were doing and moved the person using correct techniques. Staff explained to us how each person had their own hoist sling and why.

Staff we spoke with thought that the training and support they received had generally improved with the new provider. A staff member said, “We have training on everything, pressure area care and manual handling, it’s very interesting”. A new staff member told us that their induction training had been good, “I had all the training before I started to work with people”. Staff told us that they received regular supervision sessions with their line managers where they discussed their job roles and any further training needs. Staff thought that these sessions were helpful to them.

We spoke with a staff member who was an in-house staff trainer. They explained how a staff training matrix is maintained and reviewed to ensure that all staff are regularly updated in mandatory training. Staff were also supported to access other training courses which were applicable to their job roles and to help them meet the needs of people. Such courses included dementia care training, continence care, National Vocational Qualification (NVQ) in care and the care certificate.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA and the DoLS set out the requirements that ensure where applicable, decisions are made in people’s best interests when they are unable to do this for themselves. We saw that mental capacity assessments had been completed for people whose ability to consent was in question. We observed staff asking people and gaining consent from them before carrying out personal and/or nursing care. We were shown a list where the provider had applied for some people to be considered for a DoLS order. Staff understood the reason for this

On the Memory Unit a staff member said, “There is a DoLS in place for everyone on this unit as the doors are locked all the time”. The staff member explained, “[Person’s name] would go and wander off so we have to stop them”. We observed the person pushing at the door several times during the inspection visit. We noted that people’s bedroom doors were locked during the day whilst people were in the lounge and dining areas. A staff member told us, “We lock them to keep other people out. One person takes other people in to a room and then locks the door and locks them both in and moves furniture around”. The locking of bedroom doors had been investigated under the safguarding process.

People who used the service had different views about the food provided but generally people were pleased with the meals. A relative told us, “The food is very good here; they can have whatever they want to”. A person told us that they didn’t always get what they had ordered and it was a bit “hit and miss”. They said the meals and menus were something that was discussed at resident’s meetings. We saw that people had choices for lunch and that this was evident throughout all of the units in the home. A visitor told us how pleased they were in the way the cook had responded to their relative’s dietary needs. They said, “Because there is not much [person’s name] likes on the menu, they have been making soup for them. I think they have been very good about this”.

People received help and support to eat a well balanced diet. We saw staff giving help to people who required help to eat and drink. People’s nutritional needs were assessed and monitored. Where people were at risk of not eating or

Requires improvement

Is the service effective?

drinking staff had monitored this and kept good records. People's weights were monitored and we saw where a person had significant weight loss they had been referred to the GP.

People's health care needs were monitored and people were supported to access health care professionals when their conditions changed. People were supported to attend clinic appointments when required. However staff had not always followed up on referrals. For example, for one person with a pressure ulcer it was suggested in their care plan by one nurse that a second referral to the Tissue Viability Nurse Specialist should be made [one having taken place in April 2015]. This was because the person's wound was now deteriorating. However the suggestion had not been taken up by other staff and the referral had not been made. This meant that the person had not received the right advice/treatment in a timely way.

One visitor, who came to visit their relative frequently, said that they and their family were very pleased with the care [their relative was receiving from the home. Their relative was having support with a nebuliser twice per day. The visitor said their relative had a skin problem which was being treated by the nurse. They said that the staff were "lovely" and described the home as a "luxury hospital." They said that visitors were always made welcome. Another visitor told us that their relative was, "very well cared for" on the Nursing Unit and that staff had been attentive to their relative's needs and had referred them to the GP "straight away" when this was required.

Requires improvement

Is the service caring?

Our findings

People had mixed feelings about how caring staff were. One person told us, “Some staff are really nice and caring, but four out of six don’t care”. Whereas another person said, “The staff are all lovely”. A person told us, “If you want something, the staff do their best to get it for you. They do look after you and come and talk to you.” Another person thought that care staff did not have enough time to spend with them and, “It’s very rare you see the staff unless they are helping you out. They are quick and short. They haven’t got time to sit with you.” The person had particular praise for the male carers. Another person said, “the staff are excellent. They pick up your quirks very quickly.”

People who used the service sometimes felt isolated. A person said they liked their bedroom door kept open as, “It keeps me in touch with the world”. The person said that sometimes staff talked to each other over them. They said, “Sometimes you feel as though you are not there. It is considered rude to carry on a conversation when a third person is not involved, but there are lots of conversation by carers loudly across the room with each other”. Another person said they also liked their bedroom door kept open because “It’s the only contact with people going past”.

Sometimes people’s dignity was compromised.. On the Nursing Unit a person told us it was degrading having to wait for the toilet. They said, “Having to wait for the toilet is upsetting. One gentleman waited so long he had an accident”. I know I’m getting older but I’ve got my dignity”. The person also said that they had on occasions been left in the toilet on their own while the carer went off and attended to someone else. They said, “You panic and end up shouting through the door. It’s very scary.” Another person told us, “I press the call button. You can wait and wait. If you want to go to the toilet, you have to wait. You use your pads. It’s embarrassing. The staff say ‘I’ll be back if I can’, but nine times out of ten they are not there. I don’t think there are enough staff.”

On the Memory Unit a staff member took a comb out of their pocket and combed a lady’s hair then went round the lounge and combed two other people’s hair with the same comb. The staff member had good intentions but did not understand the principles of maintaining dignity for people. They said, "I have three combs, one for men and one for ladies and a spare, I want to make people look nice". A person in the lounge discreetly asked to be taken to the toilet. A staff member was at the other side of the lounge and shouted, “If you want a wee, you have a catheter just do it and will go in the box”. On this unit we also heard a staff member shout at a person, “Sit down”. We discussed our concerns with the manager at the end of the inspection. The manager told us they would look into these concerns.

We saw some good caring staff interactions. We saw a staff member talking to a person about their lunch. The staff member said, “Would you like an apron on to keep your clothes clean?” A staff member asked another person, “Do you need any help with your lunch?” The person said they didn’t want any lunch so the staff member plated the meal up and took it to them to show them. The person then said, “Oh yes I like that” and they ate the meal.

Requires improvement

Is the service responsive?

Our findings

People thought they were not always able to exercise much choice in how they spent their time in the home. On the Nursing Unit people told us that they often had to fit in with routines of the home. A person said, "Is it right that we have to go to bed when the staff tell us we do? I don't like to go to bed at 8pm, so that doesn't go down well, I'm often then left for ages". Another person said, "They tell you where to sit". The person said, "I'm careful what I ask for. You have to fit in". People sometimes felt they were persuaded to fit in with routines. A person said, "Some people have been persuaded to go to bed early. Another person said, "The staff ask, 'Are you ready for bed?' and I don't want to go to bed before 6.30 pm." Another person told us they had been asked by the staff, "Are you ready to go to bed" and said that they firmly told them 'no'. They said "Staff are eager and say 'Will you have your nightie on and sit in it? Why would I want to do that?"

A visitor told us that their relative tended to go to bed earlier than they would like at 7pm. On the Memory Unit after lunch everyone was taken to lounge, no one was asked if they would like to go there. People were taken to chairs but no one was asked where they would like to sit. Staff put the television on but did not ask anyone what they would like to watch.

We sat and observed for a period of time how people were cared for in the lounge in the Memory Unit from 2.30pm to 3.10pm. During this time people were either asleep in their chairs or awake and passive. There was no interaction from staff with people during this time. There were no staff present in the lounge other than at one point a staff member appeared, looked around and walked out again.

People had mixed feelings about the activities on offer. People accommodated on the Nursing Unit felt that they did not receive much in the way of social stimulation. One person said, "We don't go out at all. There is a van outside that just stands there and we've asked to go out on a trip but it hasn't happened". A relative told us, "They don't go out anywhere it's a shame really". "There is nothing to do, it's same old, same old". One resident said, "I used to do lots of knitting. I don't do that now. I just watch TV. I've lost track of time. There is nothing to do." People on this unit felt that most activities and entertainment went on downstairs on the Residential Unit. People on the Nursing Unit said they were not often, or ever, asked if they wanted to join in with an activity. They said that they had never been taken downstairs to join in an activity.

People on the Residential Unit thought that the activities and entertainment were good. A person said, "The entertainment is good, we have games and stuff. There is a schedule of what's on somewhere". It's nice to have someone to talk to".

We saw some good examples of how staff had responded to people's individual needs. For example a person who had difficulty with their sight had thought that the light in their bedroom was inadequate. They noticed that when they took a bath, the lighting in the bathroom was brighter and they could see much better. The person said, "I asked if I could have the same type of light in my bedroom and they did this for me. That was very good of them I can see my photographs now and all around me much better". The person had also asked if they could have a bath more than once a week and this had been increased. The person said, "I have a bath at least twice a week now which is good". Another person thought that the staff had been very good in responding to their request for a telephone to be installed in their bedroom. The person said, "I haven't been here very long but I wanted a telephone in my room and they sorted it out straight away". We noted that the telephone was being installed on the day of the inspection. Another person had complained about a 'lumpy mattress' and said the mattress had been replaced very promptly. A visitor was very happy with the way staff communicated with their relative. They said that their relative had difficulty communicating but that staff soon picked up how to communicate with them very well.

People felt they were involved in their care to a certain degree. They knew about their care plan and detailed assessments were in place in respect of personal needs, likes, dislikes, preferences and hobbies. There was evidence of some people's involvement and signatures in agreement with their care plan. Reviews had been carried out with people and/or their relatives. A relative told us they were involved in the care and decisions relating to their relative. They said, "I can visit anytime and as a family there is someone here at least two or three times per day".

Requires improvement

Is the service responsive?

They keep us informed and ring us if [person's name] is unwell". Another visitor said, "The staff asked me if I would look at the care plan. I did and I signed in agreement with it. They are very good at keeping me informed."

There were meetings held for people and relatives to make suggestions. A person said, "There is a residents' committee, I have been asked to take part, the next meeting is tomorrow". We saw posters telling people of the time and date of the meeting on display in all communal areas.

There was a complaints procedure in place and this was displayed and accessible in all areas of the home. Some people said they knew how to complain but said that nothing was done about it. A person said, "A lot of our concerns are ignored". However other people told us that complaints had been handled appropriately. We saw that the manager had addressed complaints within the timescales of their complaints procedure. People who had raised formal complaints had received written responses. When complaints were upheld we saw that these had been discussed in staff meetings and improvements implemented.

Requires improvement

Is the service well-led?

Our findings

There was a quality monitoring system in place where the provider carried out regular audits of the services provided across all of the units within the home. However this had not always been effective in identifying where improvements were required. Auditting of services had not picked up the areas where we have identified failings in ensuring people are safe.

People thought that the management of the home was good. A relative told us, “The manager is very good. I can go to her at any time”. Another person said, “Rachel is an excellent manager she is very approachable and very friendly”. Some people were unsure who the manager was. One person we spoke with had attended a “residents’ meeting” recently. They said that as far as they knew it was the first one that had been held or that they had known about. The person said, “I have been here for just over a year and we have not had a meeting before.” They said that at the next meeting which is scheduled, they would be discussing the menu amongst other things.

Each unit was managed by a unit manager. A new manager had started to work on the Nursing Unit that day and there was an experienced nurse also working on nights on this unit who had worked as a manager previously. The registered manager told us that this helped to support staff on nights as the nurse carried out staff supervision and organised training of night staff. She said that the senior nurse also carried out audits of medication and care plans and acted as mentor for new night staff. There were unit managers provided on the Residential Unit and Memory Unit. There were also two training managers provided to oversee staff training and a catering manager. The registered manager confirmed that they held regular meetings with the unit managers to ensure good communication and provide updates.

Staff thought the manager was open and approachable and offered support and guidance to them. A staff member said, “Rachel is always there if you need her or just to go and have a chat”.

The manager confirmed that the provider supported them and that they received regular visits from the Regional Manager. She told us that the service now had more autonomy and that as a result of quality monitoring the provider had increased the staffing ratio. However this should be reviewed again due to the issues of concern we found on the Nursing Unit where people were sometimes having to wait for long periods of time for attention.

The registered manager was aware of their legal responsibilities in relation to making notifications to the Care Quality Commission. The manager had kept us informed of any events in the home and we had received required notifications from the manager and provider.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who used the services were not always kept safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was not always enough staff provided to meet the needs of people who used the service in a timely way.**