HF Trust Limited

Rowde

Inspection report

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Rowde
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rowde is a care home for up to 37 people with learning disabilities and/or autism. Accommodation is provided in five bungalows on one site. People had their own rooms and access to communal areas such as dining areas and lounges. At the time of inspection there were 31 people living at the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. This service did not provide a model of care that maximises people's choice, control and independence. Accommodation was provided in a 'campus' style setting on the edge of a village. People were at times reliant on staff to access their local community and services.

Care was not always person-centred and did not promote people's dignity at all times. People were not living in a service with the right person-centred culture. An incident had taken place whereby staff placed people at risk of harm. The provider had taken immediate action to deal with the incident but the ongoing mitigation of risk of reoccurrence was inadequate. This placed people at risk of harm.

People did not have their medicines as prescribed. There had been multiple medicines incidents and/or errors since the last inspection. Whilst people were not harmed the inadequate systems and governance around medicines management placed people at risk of harm.

Risk management was not safe. Since the last inspection we had been notified or made aware of six episodes of actual or near miss choking incidents. People were at risk of harm as safety measures put in place were not appropriate or personalised. People's care plans and health action plans held conflicting information for staff which could cause confusion. This meant people might not receive the care and support they needed at all times.

Quality monitoring was not effective. This was the fifth consecutive rating of requires improvement or inadequate for this service. The provider had not been able to make sure their systems and processes identified improvement required. Action had not been carried out to improve on the last inspection's findings, therefore the service remained in breach of Regulation. We also found a further two breaches of Regulation at this inspection.

There was enough stock of personal protective equipment (PPE) and we observed staff using it safely. Staff

told us they had been provided with enough supplies of PPE throughout the pandemic and been trained on how to use it.

People and staff were being tested for COVID-19 as per the government guidance. People and staff had also been able to have a vaccination for COVID-19.

Systems were in place for visiting for relatives and friends. The service was clean, and staff carried out regular cleaning for high contact areas.

Sufficient numbers of staff were available. Where there were gaps in staffing numbers the provider used agency staff. To mitigate any risks of cross contamination the provider block booked agency staff to use the same staff at this location. This also provided a continuity of care and support for people.

Staff had been trained and able to have supervision with their line managers. Staff told us they were committed to staying at the service to provide support despite the uncertainty of the location. Staff enjoyed their jobs and the feedback about the staff approach from people and relatives was positive.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 April 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has deteriorated to inadequate. This service has been rated requires improvement or inadequate for the last five consecutive inspections.

Why we inspected
The inspection was prompted to seek assurances about the safety and care of people following information received as part of ongoing safeguarding concerns and a police investigation. As investigations were ongoing this inspection did not examine the circumstances of those incidents. We wanted to seek assurance about the wider safety measures for people at the service. We undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care and treatment and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rowde

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector 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.

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

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. The second day of the inspection was started at 19:00hrs.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan

to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with 10 members of staff including the two registered managers. We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision.

After the inspection
We spoke with eight relatives on the telephone about their experiences of the care provided. We contacted 10 healthcare professionals for their feedback about the service. We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, staff rotas, compliments received, health and safety monitoring checks, meeting minutes, COVID-19 guidance and planning and provider policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Medicines were not managed safely. Since our last inspection there had been 19 medicines errors and/or incidents. Action taken to prevent reoccurrence was not robust and we observed people's medicines folders were not always accurate or consistent.
- We were not assured people had their medicines as prescribed because safety checks had not been completed when staff had handwritten prescribing instructions. Where people had handwritten entries on their medicines administration records (MAR) staff had not always signed the entry or had it checked by a second member of staff.
- The National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes states that handwritten MAR records should only be used in exceptional circumstances. Where they are handwritten the MAR should be signed by two members of staff to check for accuracy and reduce the risks of transcribing errors.
- At a recent safeguarding meeting following receipt of information the provider was advised to check medicines stock. Staff carried out a stock check and found one discrepancy. As part of the providers investigation they found that their policy and procedure had not been followed by staff when signing medicines into the service. This meant one medicine had been in the service for 12 months without staff fully checking the stock.
- The provider took action to put into place systems to prevent reoccurrence. On our second day of inspection we found the same type of medicine in a different bungalow had no stock check recorded on the MAR for one person. Whilst the medicine had not been administered, the providers policy had not been followed which increased the risk of errors. This did not demonstrate lessons were being learned.
- People's risks of choking were not managed safely. Since the last inspection we had been notified or made aware of six actual or near miss episodes of choking. The local authority had investigated one episode of choking and the risks for one person. We reviewed other people at the service who were at risk of choking and found their safety measures were not robust.
- One person had experienced a choking episode in the past, but their risk assessment was contradictory and did not have suitable safety measures in place. Staff had recorded this person could choke while eating alone in their room. The safety measure for this was that if the person did not bring their plate to the kitchen after 30 minutes of eating staff were to go and check on them. This measure was not safe and put this person at risk of significant harm.
- For another person at risk of choking we saw the safety measure was for them to sit next to another person who had 1-1 staffing support due to their risks of choking. This was not appropriate as the two people did not get along and safety measures need to be personalised and suitable for the person. One

member of staff working 1-1 with a person to observe for choking cannot safely observe other people for risks of choking during the mealtime.

The provider failed to manage medicines and risks safely which placed people at risk of harm and was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● This inspection was prompted in part by a safeguarding incident which had led to a police investigation. This investigation is ongoing, and we did not look at the specific incident but wanted to seek assurance about people's safety.
● In response to this incident the provider had agreed with the local authority to complete some actions such as moving some staff who worked in one bungalow. Whilst the provider had carried out this action, it was not robust and did not mitigate risk of reoccurrence. We raised this with the provider during our inspection.
● Despite the shortfalls we found people and relatives thought people were safe. One person said, "I feel so safe and looked after here." One relative said, "I can't speak highly enough of the staff, over very difficult conditions they've kept everyone safe despite their own personal issues, possibly closure, their job security."
● Staff had received training on safeguarding and understood their responsibilities to keep people safe from abuse. Staff told us they knew how to report concerns and they were confident concerns would be investigated.

Staffing and recruitment
● People were supported by a sufficient number of staff. Where needed the service used agency staff to fill gaps in the rotas. The service block booked agency staff in advance to provide a continuity in staffing.
● Staff were employed once they had a number of pre-employment checks carried out. This included a check with the disclosure and barring service (DBS). A DBS check enables providers to make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At our last inspection the provider had failed to robustly assess and monitor the risks relating to the health safety and welfare of people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● At the last inspection we found hospital passports had not always been updated. This meant that any emergency healthcare professional would not know what people's current needs were. At this inspection we observed three hospital passports that did not reflect people's needs. This placed people at risk of harm.
● People had care plans and health action plans which were stored in a separate folder. We observed that these two records contained conflicting information. For example, one person had been assessed as being at risk of choking. Whilst the care plan reflected the current needs the health action plan recorded the person had no problems eating or drinking.
● One person had been assessed in their health action plan as not drinking enough water. We were not able to see what the action was to support this person. Daily notes did not record staff actions to encourage the person to drink water.
● One person had lost a significant amount of weight. Whilst action had been taken to ensure the person saw their GP, we were not able to see how their risks for malnutrition were being assessed. The provider had not used national recognised tools to assess people's risks of malnutrition or developing pressure ulcers.

The provider had failed to assess, monitor and mitigate the risks to people's health, safety and welfare. This placed people at risk of harm and was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff had been provided with suitable training to help them in their roles. All new staff had an induction and were able to shadow more experienced members of staff.
● Staff were provided with refresher training online and face to face where safe and appropriate. One

member of staff said, "We did training for autism yesterday, I found it interesting, they talked about traits, I try not to look at the label, try to work with the person. We look at how the person behaves, get to know them."
● Supervision was provided regularly, and staff told us they appreciated the time with their line manager. One member of staff said, "Supervision is a very useful process, a chance to off load, to discuss concerns, to be praised for good work. This whole year, we have worked really hard to keep the service safe, to keep us all safe. I feel like I have been appreciated for what I have done."

Supporting people to eat and drink enough to maintain a balanced diet
● People were involved in meal planning and shopping and encouraged to prepare their own meals were appropriate and safe.
● Through national lockdown staff had supported people to use online services to do shopping and have it delivered. The registered manager told us they were now encouraging people to go and do shopping locally where safe to do so.
● People had a choice of meal and were encouraged to eat a healthy, balanced diet.

Adapting service, design, decoration to meet people's needs
● People lived on one site in five bungalows. This style of accommodation does not meet guidance in Right Support, Right Care, Right Culture as it is a 'campus style'. This model of care is not in the best interests of people with a learning disability and does not promote their rights of choice, independence and inclusion.
● All the bungalows had communal rooms such as lounges, kitchens and dining rooms. One person had their own lounge to use during the day which enabled them to spend time alone when they wanted to.
● There was a large amount of outside space for people to use when they wished though some areas were overgrown. The provider told us during the pandemic it had been difficult to retain grounds workers. Action was being taken to employ contractors and family members had organised a working group to tidy up the grounds.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.
● Staff had received training on the MCA and understood how the principles applied to their day to day work.
● People were supported to make their own decisions as much as possible and staff used easy read and pictorial documents to help people's understanding.
● Where people lacked capacity, an assessment was completed, and a best interest process carried out.

There were documents available to demonstrate who was involved and the outcome of the process.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to have systems in place to assess, monitor and improve the quality and safety of the service which placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- At the last inspection quality monitoring systems were not robust and did not accurately assess the quality and safety of the service. At this inspection we found this had not improved.
- Quality monitoring was not effective in identifying shortfalls. For example, the medicines checks in place had not identified all the shortfalls we found in medicines management.
- Senior support workers were checking medicines weekly and registered managers were checking medicines monthly. These checks had not ensured people's MAR were completed in line with the provider's policy and good practice guidance.
- People's records were not updated when needs changed or risks increased. The provider's quality monitoring had not identified the updates required so action could be taken. For example, one person had been prescribed a medicine and a course of action to support their health need. When we visited the records had not been updated to reflect the change in treatment. We raised this with the provider who took action to address the shortfall.
- A recent incident involving staff was being investigated by the police. Prior to this incident the provider had not regularly completed any out of hours checks of the site. One member of staff said, "I never see [registered manager] as sat in the office, same with the seniors, they are all up the office, they are hardly in the bungalow. I do go to the manager in the office, if [registered manager] does come over only stays five minutes and goes. Never here evening or weekends."
- In response to the incident the provider had commenced out of hours checks during the night. These checks did not include a visit into the service which did not mitigate the risks of reoccurrence.
- This was the fifth consecutive time the service had been rated requires improvement or inadequate. The provider was not able to demonstrate they could achieve a good rating and provide a good service for people.

The provider had failed to make sure quality monitoring was effective in identifying and driving improvement required to assess, monitor and improve the quality and safety and mitigate risks to the health, safety and welfare of people. This placed people at risk of harm. This was a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had two registered managers who jointly managed day to day operations. Feedback from staff about the management was overall positive. Comments included, "I do get praise from the management. Since being a senior I have had appreciation for the work I have done", "My manager has been great, they have tried to answer the questions I have" and "[Registered managers] are so helpful, they have been in post for so long. They are good."
● One member of staff told us it was difficult to get hold of management though the on-call service had improved. They said, " I trust them [registered managers] to go to them for issues, but you can't get hold of them sometimes because they are busy."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● We observed some examples of care that was not person-centred and did not promote people's dignity. For example, we observed in one person's daily notes staff had recorded they had told the person to wait for staff to be ready before they could have a shower. We observed incontinence products were stored openly in some bathrooms for everyone to see. This practice did not give us assurance the culture of the service was person-centred.
● In one person's risk assessment we observed a safety measure was for them to sit with another person who received 1-1 staff support at meal times. This was not person-centred as it was recorded in the person's care plan they did not like the other person who staff were asking them to sit with.

The provider had failed to provide person-centred care to people making sure their rights of choice and inclusion had been promoted. This placed people at risk of harm and was a breach of Regulation 9 (person-centred care) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our last inspection the provider had made a decision to close this service. Some people's relatives had set up a group to campaign against the closure as they wanted their relatives to continue living at the service.
● Since the announcement of the closure some people had moved out and three people told us they were looking forward to moving on. They said, "When I heard about the place closing, I was very worried and was pulling my hair out. It was a worry but not so much now because I've got used to the idea that we're moving. I will miss it here. I'm looking forward to it now", "I want to move on. I want to get my own house in Devizes" and "I want to move, I want to be near home."
● Some families and people we spoke with wanted their family members to remain living at the service. One person told us they were happy at the service and wanted to stay. They told us, "I have a very nice room, I want to stay here."
● Despite the uncertainty of the future staff enjoyed working at the service and were committed to staying to make sure people were supported by staff they knew.
● People and relatives spoke positively about the staff. Comments included, "The staff are wonderful, very caring, they kept them [people] happy with lockdown, it's just one big happy family" and "If [person] is not well, they contact us straightaway, [person] has never been happier."
● Staff worked in partnership with a range of professionals including social workers, GP's and community

nurses. Staff knew how to make referrals which made sure people had access to healthcare services.

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 The provider had failed to provide person-centred care to people making sure their rights of choice, dignity and inclusion had been promoted. Regulation 9 (1) (3) (b) (d)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to manage medicines and risks safely which placed people at risk of harm.

The enforcement action we took:

We served a Notice of Decision to remove the location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to make sure quality monitoring was effective in identifying and driving improvement required to assess, monitor and improve the quality and safety and mitigate risks to the health, safety and welfare of people. This placed them at risk of harm. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We served a Notice of Decision to remove the location from the providers registration.