Bupa Care Homes (CFHCare) Limited

Rowan Garth Care Home

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 October 2016 and was unannounced.

Rowan Garth Care Home is a large care service in Liverpool which comprises of five separate units, set within extensive grounds, the service can accommodate up to 150 people. Each of the five units are single-storey and can accommodate up to 30 people. The service supports people with a range of care needs from nursing and end of life care, to short term respite care and residential care. Rowan Garth is situated in a suburb of Liverpool, close to transport links. Clover unit closed on 30 September 2016 so only 4 units were occupied at the time of the inspection. The units provide residential, nursing, dementia residential and dementia nursing care. The provider is BUPA Care homes (CFH) Limited.

During the inspection, there were 112 people living in the home.

During the last inspection on 11, 12 and 13 April 2016, we found the provider was not meeting legal requirements in relation to safe care and treatment and good governance and we issued warning notices in these areas. The provider was also not meeting legal requirements in relation to protecting people from abuse and improper treatment and we issued a requirement notice regarding this. During this comprehensive inspection we checked to see whether improvements had been made in these areas and to ensure legal requirements were being met.

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.

At our previous inspections of Rowan Garth in September 2015 and April 2016 we had concerns about the way medicines were managed throughout the home. After our last inspection in April 2016, we issued a warning notice telling the provider that improvements must be made by May 2016 as they were in breach of legal requirements. We found during this inspection however, that medicines continued not to be managed safely and legal requirements were still not being met.

Staff had completed risk assessments to assess and monitor people's health and safety. We found however, that not all identified risks were managed safely.

We looked at how the home was staffed. Most staff told us there were usually enough staff on duty to meet people's needs, but people living in the home had mixed views on staffing levels and relatives felt there were not always enough staff on duty. Our observations showed us there were not always enough staff on duty to meet people's needs in a timely way as we observed people having to wait significant periods of time to receive support they had requested. The registered manager told us they completed an assessment of people's needs to help determine how many staff were required to ensure people's needs could be met and

that this assessment was reviewed regularly. The registered manager told us that based on the number of staff the tool suggested were necessary, the home was overstaffed.

Most people we spoke with told us they felt safe living in Rowan Garth and relatives agreed. All staff we spoke with told us they had completed safeguarding training and knew how to report any issues. We found that appropriate safeguarding referrals had been made. Accidents were reported and actioned appropriately. Records showed that most safe recruitment practices were followed.

Arrangements were in place for checking the environment to ensure it was safe. Internal checks were completed and external contractors were utilised to ensure equipment remained safe.

During our last inspection we found that DoLS applications were not always submitted when required and people were being deprived of their liberty unlawfully. During this inspection we found that although improvements had been made and most applications had been made appropriately, not all restrictions had been identified and acted upon.

When people were unable to provide consent, most care records showed that mental capacity assessments were completed and decisions made in people's best interest through consultation with the relevant people in line with the MCA.

We looked at ongoing support provided to staff and found that although staff told us they felt well supported, supervisions and appraisals were not always provided regularly to help support staff in their roles. Staff underwent a period of induction and completed training that the provider considered mandatory as part of the induction process and on an on-going basis.

People living in the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

Feedback regarding meals was positive. There were choices available to people and specific dietary needs were catered for.

The registered manager had taken steps some within the units for people living with dementia, towards the environment being appropriate to assist people with orientation and safety, such as memorabilia displayed along the corridor walls and pictorial signs.

People living at the home told us staff were kind and caring and relatives we spoke with agreed. We observed a number of interactions between staff and people living in the home that were warm and caring. We found however, that people were not always treated with dignity and respect and their privacy was not always maintained. We observed one person wearing items of clothing that did not belong to them and on occasion, people had to wait significant periods of time to receive support.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting and people we spoke with agreed.

The level of detail within plans was inconsistent. Care files showed that not all identified needs were reflected within people's plans of care, plans sometimes lacked detail as to how to manage identified needs and planned care was not always recorded as provided in a timely way. There was limited information regarding people's background, lifestyle and preferences in relation to their care and support. This meant that it would be difficult to provide person centred care based on people's preferences.

Due to the recent closure of one of the units within the home, there had been some staff changes within the units and not all staff knew the people they were supporting.

The care files we viewed contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission.

We found that there were a limited number of activities available to people and relatives we spoke with agreed.

Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing. Feedback was sought through the use of quality assurance surveys and resident committee meetings. Resident and relative meetings were advertised regularly but often nobody attended as relatives told us they were able to raise issues at any time. People we spoke with told us they knew how to raise concerns and relatives agreed.

In April 2016 we found that the quality monitoring systems in place were not always effective and that they had not highlighted the concerns identified during the inspection and we issued a warning notice. During this most recent inspection, we found that sufficient improvements had not been made and the provider was still not meeting legal requirements.

We observed a range of completed audits; however they did not highlight all of the issues we identified during this inspection, such as the significant risks regarding medicines management. When areas for improvement were identified, actions were not always taken or maintained to ensure adequate improvements were made. There was inconsistency in the quality and safety of care between the units within the home. There were more significant concerns identified on the units that provided nursing care.

Staff and relatives we spoke with told us the registered manager was, "Approachable." Staff told us they enjoyed their job and felt able to share their views. Other staff however, were not always satisfied with how the home was managed.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory requirements.

The home has been rated as 'inadequate' overall and will therefore, be placed in special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve; they will be kept under review and inspected again within six months.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• If we do not take immediate enforcement action, special measures provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action.

We are considering our regulatory response.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were still not managed safely.

Not all identified risks were managed safely.

There were not always enough staff on duty to meet people's needs in a timely way. Staff had been recruited safely.

Most people we spoke with told us they felt safe living in Rowan Garth and relatives agreed. The building and equipment were safely maintained.

All staff we spoke with told us they had completed safeguarding training and knew how to report any issues.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all restrictions placed on people had been identified and acted upon, though improvements had been made since the last inspection.

Staff were not always supported through regular supervisions and appraisals.

Mental capacity assessments were completed and decisions made in people's best interest in line with the MCA.

Staff underwent a period of induction and completed training on an on-going basis.

Some adaptations had been made to the environment to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed a number of interactions between staff and people living in the home that were warm and caring. We found however, that people were not always treated with dignity and respect and their privacy was not always maintained.

When able, people or their families had been involved in the care planning process. Care plans provided information regarding people's preferences in relation to their care and treatment in areas such as activities and meals.

The registered manager told us there were no restrictions in visiting and people we spoke with agreed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care files showed that not all identified needs were reflected within people's plans of care, they lacked detail as to how to manage identified needs and planned care was not always recorded as provided in a timely way.

Not all staff knew the people they were supporting well.

We found that there were a limited number of activities available to people and relatives we spoke with agreed.

The care files we viewed contained a pre admission assessment; this ensured the service was aware of people's needs from admission.

Systems were in place to gather feedback regarding the service. People we spoke with told us they knew how to raise concerns and relatives agreed.

Is the service well-led?

Inadequate

The service was not well-led.

We observed a range of completed audits; however they did not highlight all of the issues we identified during this inspection. When areas for improvement were identified, actions were not always taken or maintained to ensure adequate improvements were made.

The warning notices issued after the last inspection had not been adequately addressed. There was inconsistency in the quality and safety of care between the units within the home.

There was mixed feedback regarding the management of the home.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home.

Rowan Garth Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The last inspection was undertaken on 11, 12 and 13 April 2016. During that inspection, the home was rated 'requires improvement' overall and we found that legal requirements were not being met in relation to safe care and treatment and good governance and we issued warning notices in relation to these areas. We issued a requirement notice regarding protecting people from abuse and improper treatment as this legal requirement was not being met. After the last inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breaches. This inspection was planned to check whether the provider had made necessary improvements to ensure they are meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating under the Care Act 2014.

Prior to this inspection we had received concerns relating to staffing levels and poor quality of care and we reviewed these areas as part of our inspection.

This inspection took place on 18 and 19 October 2016 and was unannounced. The inspection team included two adult social care inspectors, a pharmacist inspector, a specialist advisor whose specialist area was nursing 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.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, quality manager, regional director, the maintenance person, chef, an activity coordinator, 12 members of the care staff, a trainer, an admiral nurse (dementia specialist), 17 people living in the home, nine relatives and a visiting health professional.

We looked at the care files of 12 people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

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.

Inadequate

Is the service safe?

Our findings

When we carried out a focused inspection of Rowan Garth in April 2016, we identified a breach of regulation in relation to keeping people safe. The 'safe' domain was judged as 'requires improvement'. This inspection checked the action the provider had taken to address the breach in regulation. The breach was in relation to medicines management.

At our previous inspections of Rowan Garth in September 2015 and April 2016 we had concerns about the way medicines were managed throughout the home. After our last inspection in April 2016, we issued a warning notice telling the provider that improvements must be made by May 2016 as they were in breach of legal requirements. During this inspection, a pharmacist inspector visited three of the four units in the home specifically to check that improvements had been made and people were not at risk of harm due to poor medicines management and that the regulations were being met. We found however, that medicines continued not to be managed safely and legal requirements were still not being met.

We looked at medicines and associated records for 5 people receiving residential care and found on the whole that medicines were handled safely. However, when we reviewed the medicines and associated records for 26 people receiving nursing care, we found there were concerns about how medicines were handled for 23 of those people living in Oak House and Heather House.

We found that medicines were not always administered safely. Records showed that one person had the dose of one of their medicines decreased by a consultant, but nursing staff continued to administer the higher dose for almost four weeks. Two people had medicines and liquids administered via a percutaneous endoscopic gastrostomy (PEG) tube in their stomachs. A PEG tube is a flexible tube placed through the abdominal wall and into a person's stomach. This allows for medicines, nutrition and fluids to be provided to a person when they are unable to swallow. We found that nurses did not follow company policy or good practice guidance for the safe administration of medicines through a PEG tube. For example, records showed that when flushing a person's PEG tube with water during administration of medicines, staff did not always adhere to the company's policy as to when to flush the tube. This meant the tubes could become blocked.

The time of administration of paracetamol was recorded to ensure a safe time interval was left between doses. However, we saw that four out of five people whose records we looked at were given doses of paracetamol with an unsafe time interval between doses.

Suitable arrangements had been made to give most medicines that needed to be given at specific times with regard to food. However we saw that one person was prescribed an antibiotic which needed to be given on an empty stomach, nurses gave it with food or with other medicines which needed to be taken with food. This placed them at risk of the antibiotic not working properly.

When people were prescribed medicines to be given when required, such as pain relief, laxatives or medication for anxiety, we saw that there were protocol sheets in place to guide staff when people were

unable to verbalise their need for the medicine. However we saw the information was generic and did not fully explain how to assess people's individual signs that the medication should be given. This meant that people may not receive their medicines when they need them.

We saw that when people should be monitored to establish whether specific medicines were required, there were no monitoring systems in place. Some people were prescribed medicines with variable doses, however there was no information recorded for nurses to guide them as to the dose to select. This meant people were at risk of not being given their medicines safely and consistently.

Two people needed to be given their medicines covertly, hidden in food or drink. However there was no information to show that the pharmacy had been consulted to make sure it was safe to crush tablets. This information was obtained for one person on the second day of the inspection but not for the other person. There was information recorded for one person to tell nurses how to disguise the medication but one nurse we spoke with told us they did not administer it that way, they gave it a different way. There was no such guidance in place for the second person. The efficacy of some medicines can be affected if they are not administered correctly.

Records about medicines were not always accurate. We checked the stock levels against the records belonging to seven people and found that the stock levels for two of those people showed that medicines had been signed for, but had not been given. Nurses had recorded the stock levels, but had not recognised that they were inaccurate and showed that some medication had not been given. The records about the administration of creams and prescribed fluid thickening agents may not have been accurate because they were not made at the time the creams were applied. In some instances the records were made several hours later. When some staff thickened drinks for people they did not make any record of this.

This is a breach of Regulation 12(1) (2) of the health and Social care Act 2008 (Regulated Activities) 2014

Staff completed medicines training and had their competency assessed each year.

Care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition and mobility. One person's file contained a falls risk assessment that identified the person as being at high risk and measures had been put in place to try to minimise this risk. For instance, an assessment had identified that it was not safe for the person to use bed rails, so the person had a bed low to the floor and a mattress next to the bed in case they should fall. A referral had been made to the falls prevention service for advice.

We found however, that not all identified risks were managed safely. For example, on Heather House we observed the kitchen door to be open with no staff inside. This meant that vulnerable people had access to an instant hot water dispenser which could lead to injury. This had been raised an previous inspections and measures had been put in place to reduce the risks, such as signs on the door reminding staff that it should be kept closed at all times. These measures were ineffective and people remained at risk of scalds.

Care files we viewed on Oak House and Heather House contained completed risk assessments regarding people's skin integrity. Those we saw identified that people were at high risk of developing pressure ulcers; however there were no specific plans in place to guide staff as to how this risk should be managed.

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

We looked at how the home was staffed. Most staff we spoke with told us there were usually enough staff on duty to meet people's needs. People living in the home had mixed views on staffing levels. Comments included, "Sometimes [staff] can talk with you, ask if I am alright, but they do not talk for long as they are always busy" and "There is always staff around."

Most relatives we spoke with did not feel there was always enough staff on duty. Comments included, "There is not enough staff here but they do their best", "There does not seem to be a replacement when someone goes on sick", "They need more staff on duty, they have to do a lot", "More staff are needed" and "Staff are good but could do with more of them."

Our observations showed us there was not always enough staff on duty to meet people's needs in a timely way. For instance, in Oak House, one person asked for assistance to leave the dining table after eating and had to wait over an hour before staff were available to support them. Another person was heard to be shouting out for 15 minutes saying they needed the toilet before staff assisted them. A third person was shouting out for long periods throughout the day due to their confusion and staff on Heather House were unavailable to offer reassurance regularly, however we observed that when staff attended to the person, sitting and chatting with them, they immediately became less distressed.

We completed a SOFI on two units and this showed that there were minimal interactions with people during that period of time as staff were busy. The registered manager told us they completed an assessment of people's needs to help determine how many staff were required to ensure people's needs could be met and that this assessment was reviewed regularly. The registered manager told us that based on the number of staff the tool suggested were necessary, the home was overstaffed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they felt safe living in Rowan Garth. One person said, "Yes I feel safe, [staff] give me my medication and they come in to my room when I press for them." Another person told us, "[Staff] always say hello and sometimes have a chat with me when they pass by in the corridor. Yes this makes me feel safe." Relatives we spoke with agreed that people were safe in the home. One visitor told us, "[Relative] is in safe hands. This place was recommended to me by a friend."

We spoke with staff about adult safeguarding and how to report concerns should they arise. All staff we spoke with told us they had completed safeguarding training and knew how to report any issues. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available to enable referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made. A system was in place to monitor any safeguarding referrals and their outcomes.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. One file did not contain photographic identification of the employee as required to comply with legislation. The registered manager told us they would request the staff member provide this when they were next on duty.

We looked at accident and incident reporting within the home and found that incidents were reported and

acted upon appropriately. Incidents were monitored by the regional director and a monthly log was in place to enable all incidents to be reviewed to look for trends or themes. This would enable risk reduction measures to be implemented. Records showed that individual falls diaries were completed for people, equipment put in place to reduce risks and referrals made to the falls prevention team when needed.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. Regular checks of fire alarms were undertaken and staff participated in fire drills. Internal checks were completed in relation to window restrictors, wheelchairs, bedrails, water temperatures and PAT testing. External contractors were utilised to ensure regular checks were completed for; gas, electricity, call bells, fire alarms, legionella checks, fire fighting equipment and lifting equipment such as hoists. We viewed certificates for these checks and they were in date.

There were systems in place regarding cleanliness within the home. There were some malodours noted on one unit and this was discussed with the registered manager. On the second day of inspection domestic staff completed an intensive clean of the area and the malodour had improved. There were no concerns raised by people living in the home or their relatives regarding cleanliness of the home. One person told us, "Oh yes they keep it clean" and another said, "Everywhere I see [domestic staff], she always has a mop in her hand."
There was hand gel available at set points throughout the home; however we observed staff move from one unit to another without using any hand gel.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in April 2016, we identified breaches of regulation in relation to the implementation of the Mental Capacity Act 2005 (MCA). The 'effective' domain was rated as 'requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation.

At the last inspection we looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We previously found that DoLS applications were not always submitted when required and people were being deprived of their liberty unlawfully. During this inspection in October 2016, we found that improvements had been made.

The registered manager told us eight DoLS authorisations were in place and a further 55 applications had been made to the local authority. A system was in place to monitor these applications with regards to their progress as well as monitoring the expiry dates of those that had been authorised. Systems were implemented within the units to help ensure staff were aware of who had a DoLS application or authorisation, although we did find that this was not consistently implemented across all units. Staff we spoke with had a good understanding of DoLS and told us they had completed training around this. Most care records we viewed clearly recorded when a DoLS application had been made.

When people were unable to provide consent, most care records showed that mental capacity assessments were completed and decisions made in people's best interest through consultation with the relevant people in line with the MCA.

We found however, that the appropriate assessment processes were not always evident in people's file when restrictions were in place. For example, we saw one person in Heather House sitting in a chair with an incline which made it difficult to stand from. The person was continuously attempting to get up from the chair but was unable due to the incline. This meant that there was a restriction imposed on the person as they were unable to freely mobilise. Staff we spoke with told us the person was at risk of falls and needed the chair to help maintain their safety. We looked at the person's care records which reflected that a specialist chair was needed for safety, but did not evidence any assessment for this chair, whether the person was able to consent to its use, whether any specialist advice was sought as to the most suitable chair, or what impact this chair had on the person due to the restriction.

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

We looked at on-going support provided to staff and found that although staff told us they felt well supported, supervisions and appraisals were not always provided regularly to help support staff in their roles. The registered manager told us that all appraisals were completed in December, however no records were available to support this. The registered manager also told us that they completed supervisions for each head of department and the unit managers, though there were no records available to evidence this. Unit managers were responsible for providing supervision to staff on each unit. On one unit we observed a supervision matrix that evidenced almost all staff had received supervision in September 2016, however most staff we spoke with told us they had not received an appraisal and did not receive supervision regularly. Staff told us, "I'm not getting regular supervision. We don't get an annual appraisal" and, "I don't get regular supervision."

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff personnel files to establish how staff were inducted into their job role and saw that staff new to care completed an induction in line with the principles of the care certificate. The care certificate requires staff to complete appropriate training and be observed in practice by a senior colleague or manager before being signed-off as competent. All staff completed training that the provider considered mandatory as part of the induction process.

We spoke with a trainer within the home who told us they were completing personal development plans for staff and that training had improved over the past few months. They had undertaken training to enable them to provide training to staff in areas such as moving and handling and managing behaviours that challenge. An electronic overview of training was maintained to enable the trainers to monitor when staff were due to attend refresher training. We viewed this system and it showed that most staff were up to date with mandatory training courses such as safeguarding, fire safety, infection control, nutrition, medicines, moving and handling and pressure ulcer management. Staff told us, "The training keeps you updated. We do some every three to six months" and, "Training is good. They do the training well, but I have to go on my days off."

People living in the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the G.P, district nurse, mental health teams, speech and language therapist, dietician and optician. A visiting health professional told us, "I've no concerns at the moment. All of the patients are well looked after. Carers are straight on the phone if there's an issue."

We observed the lunch time meal in two of the dining rooms during the inspection. We found that meal time experiences varied greatly between the units. For example, we found that on one unit staff did not interact with people when providing meals, tables were bare and there was little atmosphere throughout lunch. In another unit however, tables were set with tablecloths and napkins, staff were attentive, asking people whether they had had enough to eat, they gave encouragement and offered alternatives to people who struggled to eat their meals and there was a nice atmosphere during the lunch.

We spoke with the chef who told us there was a main menu within the company but regional changes were made. A nutritionist was involved in the development of the menu to help ensure it provided people with a

variety and choice of nutritious meals. The chef told us fresh soups and cakes were made daily and an alternatives menu was available at all times and included foods such as omelettes, sandwiches and jacket potatoes. The chef explained that they catered for people's specific dietary needs, such as pureed or diabetic diets and always tried to accommodate people's requests.

Feedback regarding meals was positive. One relative told us, "[Relative] can get drinks anytime and can decide where [relative] wishes to eat. [Relative] can have cereal or toast in the night if [relative] gets hungry." Staff we spoke with told us people were always offered a choice of meal. One staff member said, "The menu is displayed, but if there's nothing a person likes, we can go to the kitchen." Another staff member told us, "People get two options for their meals. You get to know what people want, but we can ring the kitchen for other things." Although people were generally asked the day before what meal they wanted from the menu, staff on one unit told us people often forgot what they had chosen due to confusion, so they had changed the way they offered meals. Staff held both meals in front of the person at lunchtime and asked which they would like. This helped to ensure people received their choice of meal.

Records showed that staff had completed training in meeting people's nutrition and hydration needs.

We observed the environment of the home and found that the registered manager had taken steps some within the units for people living with dementia, towards the environment being appropriate to assist people with orientation and safety. For instance, pictorial signage was displayed for key areas within the units, such as toilets and dining rooms. On one unit a bus stop had been created on the corridor and doors were colour coded. Individual memory boxes had been installed outside people's bedrooms to enable people to have familiar or meaningful memories within them. We found however, that many of these were empty. There was memorabilia displayed along the corridor walls in some units as a point of stimulation and discussion.

We spoke with the admiral nurse who was working with staff on two of the units to improve support provided to people living with dementia. They shared an action plan with us that they were working on and this included changes to the environment, staff training and reviews of people's care plans. These improvements were due to be completed within a few months.

Requires Improvement

Is the service caring?

Our findings

We found that people were not always treated with dignity and respect and their privacy was not always maintained. In Heather House we observed a person sitting in the lounge with a letter and numbers written across their sock in black pen. We asked a staff member what this meant and they told us this is how clothes were marked to ensure laundry staff knew who the items belonged to. The letters and numbers related to the initial of the unit and the person's room number. When we asked the staff member whether the person resided in the room number recorded on the sock, we were told they did not, so they were not the person's own socks.

Some relatives we spoke with expressed their concerns about clothing going missing within the home and this had led to them taking their relatives clothes home to be washed and ironed. The registered manager told us clothes should be marked discreetly and that they would discuss this with staff to ensure all clothes were marked appropriately.

We observed one person in Moss House walking in the corridor very distressed and crying. A staff member walked passed and ignored the person, not offering any reassurance or enquiring why the person was upset. We spoke with the person and tried to offer reassurance until a second staff member arrived and immediately offered comfort and reassurance to the person.

We found that there were no locks available on communal use bathroom doors. This meant that there was a possibility people's privacy would not be maintained as other people could access the bathroom when it was in use by another person. On the second day of inspection the regional director told us they had discussed this with the estates team who would identify and order appropriate locks for the doors.

We observed a number of occasions when people had to wait significant amounts of time to receive the support they had requested. People became distressed and their dignity was not maintained during these times.

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

However we did observe a number of interactions between staff and people living in the home that were warm and caring. For example, one person in Beech House was in pain and staff explained to the person that they were unable to administer their pain relief for another hour due to minimum time needed between doses. The staff member reassured the person and supported them to get into a more comfortable position using a cushion until the pain relief was due. We also seen a member of staff spend time sitting with one person, talking with them about a doll they were holding. "The staff member spoke in a gentle, reassuring way and the person responded with a smile.

People living at the home told us staff were kind and caring and relatives we spoke with agreed. People told us, "The staff are caring", "The staff have been great" and, "They're very good the staff."

Care plans we viewed showed that when able, people or their families had been involved in the care planning process. This was evident through signed consent forms, records of discussions with family members and completion of a document which discussed choices and decisions regarding care. Care plans were specific to the individual and there was information available regarding people's life histories and preferences in relation to their care and treatment in areas such as activities and meals.

Care files were stored within a staff office on each unit and doors had locks on to ensure records would be secure when no staff were in the office. This helped to ensure people's confidentiality was maintained.

The registered manager told us there was nobody living in the home at the time of inspection that had any specific needs in relation to their culture or religion. They had in the past provided specific diets based on people's cultural needs and would be able to do so again should this be required.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with and their relatives told us they could visit at any time.

For people who had no family or friends to represent them, contact details for local advocacy services were available within the home for people to access and the registered manager told us they would support people to make these arrangements if it was necessary.

Requires Improvement

Is the service responsive?

Our findings

Care plans were viewed in areas such as communication, choices, safety, moving around, lifestyle and skin care. The detail within plans was inconsistent. For example, one person's file contained a care plan regarding pain; it guided staff to observe the person to see if they required pain relief. It did not advise what staff should look for to know whether or not the person was in pain. Their continence plan however, provided further guidance in how the person's behaviours changed when they needed to use the bathroom, which enabled staff to respond and provide support when the person needed it.

Care files we viewed showed that not all identified needs were reflected within people's plans of care. For instance, there were a number of people who were assessed as being at high risk of developing a pressure ulcer, however there were no care plans in place to guide staff how to manage and reduce this risk. In Oak House, a person's file recorded that they became agitated at times and was prescribed medication to help reduce their agitation during these times. We found however, that there was no care plan to guide staff how to support the person, what helped to relieve their anxiety or when to administer the prescribed medicines. We raised this with the registered manager and by the second day of inspection, a new care plan had been created and was available within the person's file. We observed another person in Heather House shouting out regularly during the inspection and staff told us this was not unusual behaviour for this person. We looked at their care file and although it reflected that the person could be vocal due to their confusion, there was no plan to inform staff how to manage this to support the person effectively.

Care files showed that planned care was not always recorded as provided in a timely way. For instance, one person on Oak House who required support to reposition every three to four hours had not had this care recorded for over nine hours. Staff told us they had provided this support and the person had been assisted to reposition a number of times, but they had not completed the records. Another person's care plan in Heather House advised they required hourly checks overnight, yet there were no records to show this had been completed. We found that care staff who applied prescribed creams did not complete records at the time creams were applied, but recorded it later in the day when all records were being updated. This meant there was a risk that errors could be made and records may not be accurate.

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

We found that locks were available on bedroom doors on some units within the home but not on others. We spoke with one person who would prefer to have a lock on their door as other people often went into their room due to their confusion. We discussed this with the registered manager who agreed to speak with people living in the home regarding this and ensure that when safe to do so, people had locks fitted to their door to help protect their privacy.

Due to the recent closure of one of the units within the home, staff had been moved onto other units and some staff were supporting people they did not know well. Staff based on units that had not closed were also moved to other units and the registered manager told us this was done after a review of staff skill mix.

Relatives told us they felt this was detrimental to the care and welfare of their family members, particularly for those people living with dementia as they were unable to tell staff what they needed and staff were not familiar with their needs. During the inspection we spoke with staff about people they were supporting and some staff were not aware of people's names or care needs, but did tell us that there was always a staff member on duty with them that did know people well. We were told staff had not had an induction to the new units or any time to get to know people before they began providing care. We discussed this with the registered manager and they agreed to look at ways that staff could get to know people, their needs and their preferences, as soon as possible.

Care plans we viewed contained information regarding people's physical needs, such as mobility and nutritional needs. There were also plans in place regarding specific health conditions. For example, in Oak House one person's file indicated that the person had a medical condition that could result is seizures and there was a care plan in place to guide staff what actions to take should the person have a seizure. We found however, that there was limited information regarding people's background, lifestyle and preferences in relation to their care and support. This meant that it would be difficult to provide person centred care based on people's preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care files we viewed contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission. The care plans had been reviewed regularly, however relatives we spoke with told us that although they had been involved in the development of the care plans, they not been involved in any reviews.

We looked at the social aspects of the home and found that four staff had been employed to provide activities to people each day. The registered manager told us there was usually two activity staff on duty each day.

There were weekly activity schedules in place, including activities such as reminiscence, reading aloud, bingo, crafts, manicures, quiz and games. We found however, that activities were only provided on one unit each day but staff told us that people from other units could go to the unit where the activity was taking place. Our observations showed us that this arrangement was not always effective. For example, we asked staff on a unit whether any people from that unit were going to participate in the bingo that was available in another unit. By the time staff were available to ask people and support one person who did want to join in to the other unit, the activity was almost over and the person was back on the unit within 15 minutes. We did not see any other activities taking place during the inspection.

On one unit a board was on display which advertised activities available that week. For four of the days there were no activities advertised, crafts were available one day, bingo on another day and one day's activity was buying raffle tickets.

Relatives we spoke with told us, "I feel residents need more activity and the TV being on less and more music instead. They have activity staff but last year they made Christmas decorations, but none of the residents joined in, they just did it themselves" and, "It would be nice for [relative] to get out more though, I have asked staff about this but nothing has been done."

The registered manager told us that based on previous feedback received from people regarding activities, some additional resources had been provided. On one unit, people had said they enjoyed old music so the

provider purchased a record player and vinyl records. There was a notice within the unit stating that this had been provided, however we found the record player was stored in a quiet lounge and was not used. On another unit relatives had requested more activity and stimulation be provided to people. The registered manager had purchased everyday activity sets with themes such as washing up and sorting laundry. Reminiscence suitcases had also been provided. We asked staff on this unit about these resources and they did not know where they were. They were later observed to be stored under a table in a corner of the lounge and were not in use. We discussed this with the registered manager who told us they would speak with all staff to ensure they understood it was their role to utilise these resources and provide activities based on people's preferences on a daily basis.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing. One relative told us, "When I come the staff always tell me how [relative] has been."

We looked at processes in place to gather feedback from people and listen to their views. The service had developed a residents' committee and records showed these meetings included discussions such as what had been good recently and what had not been good recently. Regular relative and resident meetings were advertised, however records showed that there was often poor attendance at these meetings. Relatives we spoke with told us they raised any issues at the time. One relative told us, "I get invited to meetings but do not come because I come in to see [relative] every day."

Feedback was also sought through the use of quality assurance surveys. They had last been distributed in August 2016, though only seven responses had been received. Comments within the survey were mainly positive.

People had access to a complaints procedure and this was available to people within the home. People we spoke with told us they knew how to raise concerns and relatives agreed. One relative told us, "If me or my family had a complaint we would tell staff but the staff have been great." Another relative told us about a time they had raised a concern and told us improvements had been made based on this. A system was in place to record and monitor complaints and those we viewed had been responded to appropriately in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

During our last inspection in April 2016, we identified breaches of regulation in relation to the effectiveness of systems in place to identify, assess and manage the quality and safety of the service. The 'well-led' domain was rated as 'requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation.

In April 2016 we found that the quality monitoring systems in place were not always effective and that they had not highlighted the concerns identified during the inspection. We issued a warning notice telling the provider that improvements must be made by May 2016 as they were in breach of legal requirements. During this most recent inspection, we found that sufficient improvements had not been made and the provider was still not meeting legal requirements.

During the visit we looked at how the registered manager and provider ensured the quality and safety of the service provided. We viewed completed internal audits which included areas such as care planning, medicines, nutrition and catering and accidents. As well as the registered manager, the provider had a team of staff who visited the service to undertake further checks, such as the regional quality manager, regional director and visiting clinical support managers (CSM). The registered manager was in the process of recruiting a CSM who would be based in the home and whose responsibility it would be to complete audits on a regular basis.

Audits completed did not all highlight the issues we identified during the inspection, such as the significant risks regarding medicines management, the issues regarding provision of person centred care and concerns identified in relation to maintaining people's dignity.

We found that when areas for improvement had been identified through the completion of audits, actions were not always taken to improve the service. For example, the regional quality manager completed a visit in October 2016 and it was identified that one person was calling out for support for half an hour. This was also observed during our inspection, however the management team told us the tool used to assess staffing levels, showed that the home is actually overstaffed. The area director visited the home each month and completed checks. These checks included a review of the governance systems in place and recorded whether internal checks had been completed, whether staff training was up to date and a review of nurse registration dates. The last review undertaken in October 2016 identified issues such as lack of activities observed and staff not wearing name badges. During the inspection we found that these issues were on-going. Checks of the service made in August 2016 identified that audits had not been completed as regularly as they should have been and that there were no staff meeting minutes available. We also identified these issues during the inspection, which indicates no improvements had been made in these areas.

We found that checks completed in August, September and October 2016 all identified similar issues, such as staff not wearing name badges, lack of activities and personal protective equipment not used appropriately by all staff. We also observed a care file which had been audited by a CSM on 7 October and rated as 'red' level of compliance and actions were identified to help ensure staff could update the plan to

improve the level of compliance. Records showed that the care plan was again reviewed by a CSM a week later and although minor improvements had been made, it was still rated as 'red' level of compliance. This showed that even when concerns were identified, measures were not always implemented to ensure adequate improvements were made.

Measures put in place to help ensure the management team had a full understanding of the quality of the service provided were not consistently completed. For instance, the daily clinical walk which should have been completed daily on each unit, looked at areas such as medicines, supplementary charts, safeguarding concerns, wounds and any hospital admissions. Records showed however, that this had not been completed daily and had only been completed four times during October 2016.

When changes were made in order to improve the quality of the service, they were not maintained. For instance, resources provided by the registered manager based on feedback from people, were not utilised by staff, such as the reminiscence boxes and music therapy. This meant that there was no improvement in the quality of the service experienced by people living in the home.

As well as audit systems, processes to support staff had not been consistently completed, such as supervisions, appraisals and team meetings.

The warning notices issued after the last inspection had not been met and many of the same issues were identified during this inspection, particularly in relation to medicines and monitoring the quality of the service. We found that there was inconsistency in the quality and safety of care between the units within the home. There were more significant concerns identified on the units that provided nursing care, such as those relating to medicines. This meant that systems in place to monitor the quality and safety of the service were not effective and people were placed at avoidable risk.

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

We found however, that some actions identified that were required to improve the quality and safety of the service had been completed. For example, one review identified that bathrooms were not clean and cleaning cupboards were not locked and we found that improvements had been made in these areas during our inspection. Another check identified that a nurse's registration date had expired. We discussed this with the registered manager who told us that the identified registration had not expired, but that the nurse had not provided the registered manager with the updated details, but these were now in place. The registered manager also showed us that a full audit had been undertaken following this and a system was now in place to monitor nurse's registration.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was mixed. Staff and relatives we spoke with told us the registered manager was, "Approachable." Staff told us they enjoyed their job and felt able to share their views.

Other staff however, were not as satisfied with how the home was managed. Some staff agreed that they could raise any issues and have their views heard, however staff told us that no changes were made following suggestions they had made. One staff member told us they did not feel motivated as there was a lot of pressure put on them, another said that communication was not always good and a third person told us that they did not get to know what was happening outside of the unit they worked on.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue

they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff we spoke with were aware of their roles and responsibilities. One staff member told us, "We're here to promote the resident's quality of life and give them the best that we can."

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Rowan Garth Care Home.