Veatreey Development Ltd

Rowan Tree Lodge

Inspection report

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23 October 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection of Rowan Tree Lodge took place on 19 and 23 October 2018 and was unannounced.

Rowan Tree Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection nine people were living at Rowan Tree Lodge. The care home is a large detached house converted into a nursing and care home for 16 older people.

At the time of the inspection there was a new manager in post, but they had not yet registered with CQC. We returned to Rowan Tree Lodge for a second day of inspection to meet the new manager who had started their role in August 2018.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 24 April 2018. Breaches of legal requirements were found regarding the governance of the service. This was because people's care plans lacked guidance around care and support. Governance arrangements were not always robust to ensure a safe, well managed service.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report covers our findings in relation to those requirements and additional concerns we found at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rowan Tree Lodge on our website at www.cqc.org.uk.

At this inspection we still found issues with the governance of Rowan Tree Lodge, which meant the service remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, we found breaches of Regulation 12, regarding the safe care and treatment of people who lived at the home.

You can read what actions we told the provider to take at the end of this report.

Whilst we found that some improvements had been made to the safety of the service and to how it was led, we have not revised the rating for the service. We will check this during our next planned comprehensive inspection.

At this inspection we found that information in people's care plans was still not always consistent. Record keeping processes had not always ensured that information was up to date and reliable for staff. Staff had not always taken timely action in line with care plans.

We found that although the service had addressed some cleanliness issues, we had concerns about other aspects of the service's safety. This included the day-to-day management of fire risk and water hygiene.

We found that checks and monitoring processes did not always ensure robustly the safe care and treatment of people who lived at the home. This included checks to protect people from pressure sores.

The area manager had looked to improve protocols for people's 'as required' medicines. They made further significant improvements between the two days of our visit. The area manager was also liaising with GPs to get clearer directions for people's prescribed creams. The service managed other medicines safely.

There were enough staff to meet people's needs. People who lived at the home, relatives and staff confirmed this. The area manager had carried out checks to recruit new staff, although some references needed clarification.

Staff were aware of their responsibilities to safeguard people from abuse and avoidable harm. Staff had confidence that managers would deal with any concerns.

People who lived at the home told us care staff were wonderful. However, we also found that the service needed to improve on how they listened to people's needs and wishes.

Staff were knowledgeable about people's needs, but some aspects of person-centred care needed to improve. The service was developing their activity offer.

We observed staff engaging with people and heard good examples of how the responsiveness of care to individual's needs had made a big difference.

The area manager had developed their own and the service's audit checks. These needed further improvement, as they had not picked up on significant issues we found.

The staff, manager and area manager at the service were warm and welcoming. They were helpful, engaging and acted on any concerns we had. The area manager worked hard between the two days of our visit to make further improvements.

As the manager was new, not everyone knew who they were. However, the manager and area manager held regular meetings with relatives to keep them up to date with changes. We heard positive feedback about the new manager.

There were regular team meetings and staff we spoke with felt well supported.

There had been no notifications to CQC since we last inspected the service, the area manager confirmed to us no notifiable events had occurred. The service had displayed ratings from our last inspection as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We could not improve the rating for "safe", as we found additional concerns. We will check this during our next planned comprehensive inspection.

Aspects of the service's fire safety and preventative care needed to be more robust to protect people.

Further development of people's "as required" and "as directed" medicines care plans was required to guide staff clearly and ensure timely administration. The service recorded and checked medicines appropriately.

Cleanliness of the laundry had improved, some communal spaces and carpets needed attention. The provider had carried out repairs to the building.

There were enough staff and those we checked had been recruited appropriately, although references needed clarification. Staff knew about safeguarding procedures and were confident to whistle-blow to other bodies if needed.

Is the service responsive?

Requires Improvement

We could not improve the rating for 'responsive'. We will check this during our next planned comprehensive inspection

Information in people's care plans was still not always consistent with the actual care staff provided. Information recorded in care plans did not always lead to timely intervention to meet the person's needs.

People told us about times when care was not person-specific and they did not always feel listened to. However, we also observed some good person-centred care and knowledge by staff.

Listening to people and involving them in decisions over their care needed to become more natural and regular. Activities were still being developed.

The service had arrangements in place to care for people at the

end of their life.

Is the service well-led?

Requires Improvement

We could not improve the rating for 'well-led'. We will check this during our next planned comprehensive inspection.

There was a new manager in post who was in the process of applying to register with CQC. People and relatives were still getting to know the new manager.

Recording and monitoring tools were not always used effectively to ensure safe, quality care. This included checking of the environment, as well as the care people received and the planning of it.

The area manager had improved care plan audits, however these had not always led to corrective action and needed further development.

Regular meetings took place for residents, relatives and staff.

Rowan Tree Lodge

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Rowan Tree Lodge on 19 and 23 October 2018.

This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 24 April 2018 had been made. The team inspected the service against three of the five questions we ask about services: is the service well led, is the service responsive to people's needs and is the service safe? This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection was undertaken by one adult social care inspector. During our inspection we spoke with the manager of the service, the area manager, two care staff members and one nurse employed by the service.

We spoke with four people using the service and one relative.

As part of our inspection we undertook general observations and walked around the service. We viewed the care plans belonging to four people, as well as different daily records and documents relating to people's medicines. We viewed complaints, accidents and incidents and other records relating to the management of the service. This included different kinds of checks the manager, area manager and provider used regularly.

Before our inspection we reviewed the information we held about Rowan Tree Lodge. This included whether we had received any notifications from the provider. A notification is information about important events which the service is required to send to us by law.

We looked at this information to plan our inspection at Rowan Tree Lodge, as well as the provider's previous action plans and information they gave us in their last Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had submitted this before our last comprehensive

inspection.

We contacted the local authority for feedback regarding the service and they provided us with insight of their ongoing monitoring.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we gave a rating of 'requires improvement' with regards to the question whether the service was safe. We recommended that the provider considered current guidance for 'as required' medicines, topical preparations and self-administration of medicines and takes action to update their practice accordingly.

We found at this inspection this needed to improve further, but the service made progress during our visit. These changes needed to be consistent and sustained. We discussed protocols for people's 'as required' medicines with the area manager on the first day of our visit, as they were still lacking detail. On the second day of our visit, the area manager had reviewed protocols, so they now gave a clearer description of why and when the person needed the medicine.

When we walked around the service on the first day of our visit, we found that three internal doors had been wedged open inappropriately. This included the bedroom door of a person who lived at the home who could not move independently. We found this door had been wedged open with a folded-over slipper. Doors in place to prevent fire from spreading had therefore not been operated effectively to protect people. The area manager did not know why this was and none of the staff they spoke with could explain it.

We found that the pressure relief mattress of a person at risk of developing pressure sores was on a substantially incorrect setting. The person remained in bed at all times and the correct setting was important to protect their skin. Staff needed to set the dial to the person's weight to make the mattress effective, yet we found it set at double the person's weight. Staff had not identified this in their regular checks.

We found that another person's care plan stated that they needed to be referred to a dietician if their Body Mass Index (BMI) fell below 20. We found staff had recorded a BMI of 19 in June 2018, and a further drop to 18 in August 2018. However, staff did not refer this person to the dietician until September 2018 and the dietician visited the person in October 2018.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our visit we found all doors either opened appropriately with door guards or closed and pressure relief mattresses were at the correct setting.

The area manager following the first day of our inspection also liaised with GPs to review all 'as required' medicines, if the prescription was not clear or no longer needed. They also asked for clarification around people's prescribed creams. The "as directed" instructions and descriptions such as "apply twice to [area of the body]" were not clear enough to guide staff. The service had added a 'body map' to cream, or 'topical', administration charts, to show where staff needed to apply this.

Nurses gave people their medicines, but other care staff at times applied prescribed creams. We discussed with the area manager and manager the need for checking care staff competency around this. The nurses and the manager did regular stock checks of people's medicines. We did a count of four medicines with the manager, including controlled drugs that needed particular protection. We found these to be correct. Recording of medicines administration was appropriate.

At our last inspection we found that the service's laundry room was dirty and cluttered. At this inspection, the service had rectified this. We found the service was generally clean. However, we discussed with the area manager that some communal walls and carpets needed additional attention as they were stained.

The provider had completed previously outstanding repairs to the service's roof and the affected rooms had been redecorated. The service's maintenance person and external contractors carried out regular checks of the environment and safety equipment of the service. We discussed with the area manager that there was no current water hygiene risk assessment and related checks were missing. We considered this further under the question whether the service was well-led.

People who lived at the home, a relative and staff we spoke with had no concerns about the service at the moment. Staff we spoke with were knowledgeable about safeguarding procedures and their responsibility to protect people from avoidable harm. There were no ongoing safeguarding investigations and none had taken place since our last visit.

A staff member told us, "I would speak to the manager or the nurse in charge [if I had any concerns]. If I was not happy, I would speak to [the local authority] Safeguarding team. I would be confident to speak to the local authority or CQC if my concerns were not dealt with."

Staff told us they had confidence that their concerns would be listened to by the manager or area manager and dealt with appropriately. Staff's safeguarding training was up-to-date and there was a current policy for safeguarding and whistle-blowing that staff had signed.

We saw that following incidents or accidents, staff had written appropriate care plans and updated risk assessments for people. For example, where a person had had a fall or was at risk of choking, additional measures were put into place to protect people.

People we spoke with and a relative told us there were enough staff. Staff were nevertheless busy and needed to be mindful on occasion of how their working arrangements affected person-centred care. We considered this further under the question whether the service was responsive. People who lived at the home told us about a couple of examples, but said generally this was not a problem and care staff were very helpful.

A staff member told us, "There is enough staff, but I do not 'sit around'." While we visited, we observed staff interacting with people in a calm way, that was not rushed.

The provider had carried out appropriate checks for new staff before they started working at the service. These checks helped to protect people who lived at the home by assessing whether applicants were suitable to work with adults who are vulnerable as a result of their circumstances. We discussed some questions we had about staff's references as they needed to be more robust. The area manager explained their recruitment decisions and reasons to us.

The area manager showed us examples of checking that nurses' Personal Identification Numbers were valid,

to ensure they were competent to practice

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection on 24 April 2018 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because information in people's care plans was not clear and consistent to guide staff.

At this inspection we found that staff had added more detail to people's care plans, but this was still not always consistent with the actual care people received. For example, we saw that further support was needed for a person following an incident of choking. The care plan stated that the person needed supervision at mealtimes. We asked the nurse in charge about this, who told us the person was actually receiving full assistance to eat now. This was not included in the person's nutrition care plan.

We also discussed with the manager and area manager that where care plans did give more detail, this was not always evidenced as followed in practice.

We found that reviews of a person's nutritional care plan had not picked up on the changed needs of the person. A referral to the dietician had been required in line with care plans since June 2018, but care plan reviews including in August 2018, had not identified this delay in staff response.

We found that a person had a care plan and record in place of how staff supported them to turn regularly to prevent pressure sores, as the person remained in bed. We found that on occasion staff recorded the person lying in the same position for three entries in a row during an eight-hour period. The area manager explained staff had ensured the person had moved slightly, but this was not evident in their record.

This meant systems and record keeping in place to protect people had not been operated in a timely and effective manner.

The examples above show a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The area manager had made further improvements to the detail in people's care plans by the second day of our visit. These improvements needed to be consistent and sustained.

Listening to people who lived at the home needed to become a more natural and regular part of care. A person we spoke with did not "wish to make a formal complaint", but clearly had things on their mind they needed to be addressed. One of the concerns the person we spoke with had was around person-centred approaches. We found that the service needed to ensure that person-centred care was not affected by staff's work procedures. For example, a person had been asked to come inside the service to have their medicines, when they wished to enjoy the garden. They told us, "Usually it is not a problem, but I do not know why I had to come in when it was such a lovely day outside."

Following our discussion with the area manager, they spoke with the person, recorded their concerns and

addressed them appropriately.

There were no other recorded complaints since April 2018. The service carried out annual surveys for people who lived at the home. We discussed with the area manager and manager their approaches to more naturally and frequently 'checking in' with people who may have wishes and needs, but would not like to raise "official complaints".

One person we spoke with told us, "The care staff are wonderful and brilliant." We heard from this person that a long-standing wish of theirs was finally being fulfilled by the service and they praised the new manager for this.

We heard some good examples of how the responsiveness of the service had made a difference to people's lives. A relative told us, "The way they ensure good routines has really helped [my relative]. At first, we were concerned, but through those routines, a few months later it was great."

We discussed with the area manager people's wishes to be more involved in their care planning. A person told us, "I wish they would let me do more for myself." The area manager explained how they were working to keep the person safe, but responded to this wish by arranging a review with professionals and involving the person.

The service was still developing activities on offer for people. The area manager showed us pictures of a trip out to a restaurant, which had received mixed feedback from people using the service. We observed staff engaging with people sitting in the lounge by knitting, doing puzzles or chatting. A relative told us these activities helped to create a routine for their loved one.

We found that engaging with people who remained in their bedrooms needed review. In people's activities records, we saw that staff had noted, "listening to music" or "watching TV", but not how they had engaged with the person. We discussed with the manager and area manager how this was important to support people's emotional wellbeing and prevent isolation.

A person we spoke with told us they felt lonely sometimes. We asked the person if staff ever popped in to have a chat. They said, "They do, but I know they are busy". Staff showed us person-centred knowledge of when people were happiest to chat with them and when they preferred to be left alone. We considered that evidencing such support to people living at the service needed to be stronger.

We observed some good examples of person-centred approaches and it was clear that staff knew people who lived at the home well. This was evident in the way staff engaged with people. Staff also told us about how they understood people who might not use words to communicate. Staff explained people's gestures and sounds.

We found that a former 'registered mental nurse' working at the service had provided good information in people's care plans around behaviours that challenge. We discussed with the manager and area manager how information from incident records and charts could help to personalise such care plans further.

The service had a service user guide, however this was only available in a standard-print format. As this informed people on how to make a complaint for example, the provider needed to make the information more accessible.

The area manager explained to us their arrangements to care for people at the end of their life. We saw that

plans were in place to provide this, however we heard examples of where people's health had improved so they were not receiving 'end of life' care now. One of the service's nurses was their 'end of life' champion. They were completing their 'six steps' training. This is a dedicated course to promote dignified care to people at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection on 24 April 2018 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service's governance arrangements to assess and monitor standards were not always robust to ensure a safe well managed service.

At this inspection we still found issues. Daily checks, audits and monitoring had not picked up on the concerns we found. Records and systems in place to protect people had not always been operated effectively to ensure safe, quality care. This included the inappropriate wedging open of doors, the incorrect setting of a person's pressure relief mattress and inconsistency in the planning and carrying out of care. The delay in referral to a professional had not been picked up in care plan audits, which meant they were not always effective.

The above examples show a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that although the provider had an overview of checks required to ensure the safety of the service, not all of these had been completed. There was no current water hygiene risk assessment to describe measures to prevent the build-up of harmful legionella bacteria. Checks of the safe temperature of stored hot water, to prevent the growth of bacteria, were not taking place. A recent test found there were currently no such bacteria present in the service's water supply. However, this needed to be maintained through appropriate measures. The area manager informed us they would employ an external contractor to carry out a water hygiene risk assessment as soon as possible.

The service had invested in the training of staff and review around good record keeping processes. The area manager and manager had developed checks of the environment for example, to be less of a 'tick-list' but more action driven. This meant if something was not right, an action needed to be recorded to rectify it. These checks were an improvement, but did not always lead to timely corrective actions. We discussed with the area manager and manager how their checks could 'ask the right questions', to help improve areas in need of development.

For example, following our input the area manager reviewed the daily nursing charts with respect to people's pressure relief mattresses. Instead of just asking staff to check the mattress was working, the improved record clearly instructed staff to check the mattress setting was correct. The area manager had also re-introduced more effective records they had previously used, such as more detailed wound care plans.

We found staff at the service, the area manager and new manager to be warm and welcoming. Both the area manager and manager were responsive to our feedback and addressed any immediate concerns.

The new manager had started at the service in August 2018. They showed us their application to register as a

manager with CQC, which they had sent off in September. People who lived at the service and their relatives were still getting to know the new manager.

However, one person we spoke with said, "She is finally getting me my shelter in the garden, so I like her already. She comes in and speaks with me."

A relative told us, "They have regular meetings every few months and always invite us." The area manager showed us an invitation letter about the latest residents' and relatives' meeting at the end of September 2018. They had called this a "cheese and wine afternoon", to make the meeting more inviting and less formal.

Team meetings took place regularly. We saw that there had been a team meeting in June 2018 following our last inspection report, for example. Managers had updated staff on our findings and improvements required. The provider arranged training to develop staff's record keeping and this was reviewed at a team meeting in August 2018. The service kept minutes of meetings to show what had been discussed. The manager and area manager had clearly put development measures in place to improve the quality of the service. However, as is shown by the examples above, the effectiveness of these measures needed to be reviewed.

A staff member told us, "The teamwork is alright, I feel well supported by the managers. I can talk to them about any problems." Another staff member also gave us examples of the good support they received from managers.

Staff had access to a range of policies to guide them in their role. We saw the area manager developed these regularly and ensured staff signed for policy awareness when they had read them. This included policies on Safeguarding, the Mental Capacity Act, Infection Control and Equality and Diversity.

The provider had a policy on Equal Opportunities, as well as a Diversity policy. These particularly described the diversity of staff, but made a general statement against discrimination of anyone based on things such as age, disability, gender or gender reassignment, marriage or civil partnership, maternity, race, religion or sexual orientation.

We saw in pre-admission assessments that there was space to explore the diverse needs of people who lived at the home. Assessments asked particularly around the person's spiritual needs, their way of expressing sexuality and relationships. The area manager explained that they supported people to access different spiritual services. They stated currently none of the people who lived at the home wished for such services.

We found the service had displayed ratings from our last inspection prominently at the entrance to the building, in line with requirements.

We had received no statutory notifications from the service since the comprehensive inspection in April 2018. The area manager confirmed there had been no incidents they had been legally obliged to inform CQC of and we checked records, such as any potential safeguarding investigations or incidents, to confirm this. Only one accident had been recorded for one person who lived at the home and this resulted in minor injury.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The safety of premises in relation to fire prevention was not always ensured. Fire preventing doors had been inappropriately wedged open. Preventative care to mitigate risks to people had not always been carried out in a timely and effective manner in line with care plans. The operation of care equipment to prevent pressure sores had not always been checked appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were inconsistencies between planned and actual care. Care plans did not always include consistent information. Recording and review systems were not always operated effectively to lead to timely care interventions for people. The service's governance arrangements to assess and monitor standards were not always robust to ensure a safe, well managed service.