

Rowena House Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inspected but not rated

Is the service well-led?

Inspected but not rated

Summary of findings

Overall summary

About the service

Rowena House Limited is a residential care home providing personal care for up to 22 people aged 65 and over. Seventeen people were living at the home at the time of the inspection.

People's experience of using this service and what we found

Staff did not always follow current national guidelines to reduce the risk of the spread of infection during the COVID19 pandemic. Risks associated with the spread of infection were not always safely managed. Risks to people had been assessed but assessment tools had not always been used correctly and did not always help identify when risk levels had increased. Products containing substances hazardous to health were not always stored securely.

The provider had systems in place for monitoring the quality and safety of the service through the use of routine checks and audits. However, audits had not always been effective in identifying issues or driving improvements. The provider's Nominated Individual (NI) and the home's manager confirmed they were aware of current guidelines relating to the use of personal protective equipment (PPE) in the home during the COVID19 pandemic. However, they did not pick up on staff shortfalls in this area unless prompted to do so during the inspection.

We have made a recommendation about following national guidelines regarding ventilation in care homes.

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

Rating at last inspection

The last rating for this service was requires improvement (published 30 May 2019).

Why we inspected

We undertook this targeted inspection to check on specific concerns we had about the way in which risks to people were managed at the home. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches of regulations at this inspection because the provider and staff were not always managing risks to people safely. The provider's systems for monitoring the safety of the service had not always been effective in identifying issues or driving service improvements.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Inspected but not rated

Is the service well-led?

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Inspected but not rated

Rowena House Limited

Detailed findings

Background to this inspection

The inspection

This was a targeted inspection to check on specific concerns about the way in which risks to people were managed at the home.

Inspection team

The inspection team was made up of two inspectors.

Service and service type

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

The service did not have had a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We contacted the provider to announce our arrival directly before carrying out the inspection. This enabled us to discuss how best to carry out the inspection safely during the COVID19 pandemic.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We also sought feedback from partner agencies and healthcare professionals. These included the local authority's contract monitoring team, the local clinical commissioning group, the home's GP and the local community nursing team.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people living at the home. Where people were not always able to express their views about the support they received, we spent a brief amount of time observing the support provided to them by staff. We spoke with a member of the domestic staff, the provider's nominated individual and the manager of home. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We carried out checks on the environment and equipment. We reviewed a range of records including three people's care plans and audits carried out by senior staff.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at records relating to the safety of the environment. We spoke with two relatives and four staff by telephone to gain their views of the service.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check on specific concerns about the way in which risks to people were being managed at the home. We will assess all of the key question at the next comprehensive inspection of the service.

Preventing and controlling infection

- Staff did not always follow safe infection control practices. We observed staff failing to follow current guidelines from Public Health England on the correct use of personal protective equipment (PPE) in care homes. One staff member wasn't wearing a face mask whilst supporting a person with an activity. The provider's nominated individual wore a face mask which did not comply with the recommended safety standards and we observed them pulling the mask down when speaking with nearby people. Two staff sought to reuse face masks which should have been disposed of and replaced, in line with the current guidelines.
- People were not always supported to socially distance whilst in communal areas of the home. Whilst some furniture had been removed to give more space in the ground floor lounge, the remaining seating arrangements did not enable people to maintain the minimum distance from each other when sitting down, in line with Public Health England's current guidelines. This placed people at risk from the spread of COVID19.
- Additional hand washing facilities had been put in place near the entrance to the home to help reduce the risk of the spread of infection. However, we also noted that hand drying facilities were not always in place where needed across the home and that bins for disposing of paper towels did not always have lids. These issues increased the risk of the spread of infection.
- Whilst it was evident that areas of the home had been cleaned recently, the cleaning that had taken place was not always comprehensive and shortfalls increased the risk of the spread of infection. One person's bedroom had a strong odour when we first checked it at the beginning of our inspection and this continued to be the case after domestic staff had finished working for the day.
- We found evidence of dust and built up grime in some areas, for example on the pump attached to one person's pressure relieving mattress. A high-backed chair in one person's room did not appear to have an impermeable cover and remained stained where efforts to clean it had not been effective. The failure to clean the home and equipment used by people effectively placed people at risk of the spread of infection.

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

- One person's bedroom had no external facing windows with the only window opening onto a corridor within the home. We noted that a recent fire risk assessment of the home had identified that this window

needed to be a sealed unit to comply with fire safety regulations. The manager confirmed they were in the process of addressing the issues identified in the fire risk assessment. Whilst the bedroom also had an extractor fan in place, sealing the window to comply with the fire regulations will have an impact on the ventilation of the room, potentially increasing the risk of the spread of a virus such as COVID19.

We recommend the provider considers nationally recognised guidance for ensuring the adequate ventilation of rooms in care homes.

Assessing risk, safety monitoring and management

- Risks associated with the environment had not always been managed safely. Regular checks on fire safety equipment, including the home's fire alarm had not been carried out since the end of February 2020. We tested the home's call bell system but staff were not able to locate us during the five minutes that we waited. They told us they had responded to the alarm from the call bell, but the system had directed them to the wrong room. This placed people at risk of not receiving support when needed.
- Risks to people had been assessed in a range of areas including the risk of malnutrition, risks to their skin integrity and risks associated with their behaviour. However, we noted that the risk assessment tool used to assess the risk of malnutrition had not always been used correctly and had not identified increased risks to two people who had lost weight over a six-month period.
- We also noted that completed risk assessments had not always taken into account other changes in people's conditions. For example, one person had recently been diagnosed as being anaemic which was a scoring risk factor on the provider's skin integrity risk assessment, but this had not been identified by staff carrying out the assessment. While we found no evidence that either the people who had lost weight or the person with anaemia had suffered harm from these errors, people remained at risk of unsafe care where risk assessments were not carried out correctly.
- Products containing substances hazardous to health were not always stored securely, in line with regulatory requirements. We saw signage in place in a downstairs toilet reminding staff to ensure these products were securely stored. However, in the adjacent room we found a bottle of eau de toilette and a bottle of cleaning product had been left out and were accessible to people living with dementia. This placed them at risk of harm.

This was a further breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check on specific concerns about the way in which risks to people were being managed at the home. We will assess all of the key question at the next comprehensive inspection of the service.

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

- The provider's Nominated Individual (NI) and the manager of the home were not always clear in their understanding of the risks associated with managing a care home during the COVID19 pandemic. The NI told us they were aware of the Public Health England guidelines on the use of personal protective equipment (PPE) in care homes, but we observed them failing to follow this guidance during our inspection. We also observed other staff failing to follow these guidelines in front of both the NI and manager, but neither picked up on these issues until we brought them to their attention.
- The manager told us domestic staff worked to a cleaning schedule each day to minimise the risk of infection. We requested a domestic staff member show us their cleaning schedule towards the end of their shift on the day of our inspection and noted that it had not been updated at any point that day. This meant we were unable to identify what cleaning had been carried out on that day.
- We asked the domestic staff member whether they had carried out each of the tasks identified on the schedule and they told us there was not enough time for them to complete all of the tasks assigned to them each day. However, the cleaning schedule from the week prior to our inspection had been completed to show that all of the tasks had been carried out each day. This meant the provider's system for monitoring the cleaning of the home was not effective.
- The NI and manager told us senior staff carried out a range of checks and audits to monitor the quality and safety of the service people received. However, these checks were not always effective at identifying issues or driving improvements. For example, health and safety audits carried out over the previous quarter had failed to identify that fire safety checks had not been carried out. An infection control audit carried out a week prior to our inspection did not identify any concerns regarding the cleanliness of the home or equipment despite the issues we identified during our inspection.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always safely managed. The provider had not always acted to prevent, detect and control the spread of infection.

The enforcement action we took:

We served an urgent notice on the provider imposing conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems for monitoring and improving the quality and safety of the service were not always effective.

The enforcement action we took:

We served an urgent notice on the provider imposing conditions on their registration.