Rowley Care Ltd

Rowley House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Rowley House Nursing Home is a residential care home providing personal and nursing care to people aged 65 and over. The service can support up to 35 people in one adapted building. At the time of our inspection there were 31 people using the service.

People's experience of using this service and what we found
People were not supported in a safe way by enough skilled staff who understood their needs and risks. People were not supported by staff who understood safeguarding and had raised concerns with the local safeguarding team as required. Action was not taken in response to accidents and incidents to reduce the future risk of harm to people.

People were not supported by staff who understood infection control and COVID-19 government guidance and were adhering to this. People were not supported to receive their medicines safely. People did not have access to external professionals in a timely way.

The registered manager and provider had not ensured there were effective oversight at the service to identify where improvements were required and to implement these. People did not feel listened to and their feedback was not acted upon. The provider and registered manager had not notified CQC of all potential incidents and safeguarding concerns at the service.

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 27 July 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection .

Why we inspected
The inspection was prompted in part due to concerns received about people's safe care and treatment, medicines management, safeguarding, staffing and the oversight of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence that the provider needs to make improvements.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to people's safe care and treatment, safeguarding, staffing staff training and competency and the oversight of the home at this inspection. This is the home's fifth consecutive rating of less than good and fifth consecutive breach of regulations in relation to people's safe care and treatment and the oversight of the service.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Rowley House Nursing Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Rowley House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rowley House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with eight people and three relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, deputy managers, nurse on duty, care workers and a cook.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to review the information sent to us by the provider. This included staff training records and staff rotas. We also spoke with multiple professionals that work with the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the safety and welfare of people. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns and the provider was still in breach of regulation 12.

● The provider and registered manager had failed to ensure people had risk assessments which gave staff guidance to follow to meet people's health needs safely. For example, four people had diabetes however, had no diabetes care plans or risk assessments in place to ensure their care met their diabetes needs. Staff were not clear on how to support people with diabetes and we saw staff had had to be prompted by external professionals to take action were a person's blood sugars were very high. This placed people at significant risk of harm.
● The provider and registered manager had failed to ensure people had care plans and risk assessments in place which reflected their needs. For example, one person had an episode of choking due to having anxiety. However, they had no care plans or risk assessments in place for their choking risk and anxiety needs. No referrals had been made to professionals to review this person's needs. This placed them at prolonged risk of harm.
● Staff were unclear around people's needs and risks. Staff not having clear guidance to enable them to understand and support people safely placed people at significant risk of harm.
● Lessons were not learned where things went wrong and we found multiple examples of accidents and incidents were no action had been taken to reduce future risk to people.
● A person living with dementia had drunk hand sanitiser and no action had been taken to seek medical advice or reduce future risk. During our inspection we saw eleven bottles of hand sanitiser around the area this person was spending their time unsupervised by staff. We raised this with the provider and registered manager who told us they were not able to move the hand sanitiser as staff required access to this. It was only on our insistence that this was removed. This meant it took 18 days for action to be taken to keep this person safe.

These issues constitute a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
At our last inspection the provider had failed to robustly assess the risks relating to people's medicines not being managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns

and the provider was still in breach of regulation 12.

● People were not receiving their medicines as prescribed as we found staff had administered two people's medicines outside of their prescription. For example, one person was prescribed their medicine every other day. However, staff had administered this medicine every day for five days. Staff had failed to recognise this or seek medical attention for this person.
● Medicines were not managed safely as people prescribed topical medicines did not have these administered by the staff who had recorded they had administered them. This placed people at risk of not receiving their topical medicines as prescribed, placing them at risk of harm.
● We found multiple missed signatures on people's medicines records. One person's medicines records had missed signatures on 21 occasions. Staff had failed to recognise this or seek medical attention for this person.
● Medicines were not stored safely as staff had not always recorded open dates on people's liquid and topical medicines and had not stored a medicine in the fridge as per the instructions. This placed people at risk of harm from using medicines that were not as effective at treating their medical conditions.
● A person prescribed their medicines in patch form was not receiving this safely as staff were not alternating where they were placing the patch as per the medicine's instructions. This placed the person at risk of skin irritation and breakdown.

These issues constitute a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● At our last inspection we raised concerns around the sluice room being unlocked and containing substances harmful to people's health. At this inspection we found this continued to be unlocked with no facility to secure the door. There were people living with dementia at the home and an incident where one person had drunk hand sanitiser. Not securing harmful substances placed people at significant risk of harm.
● The provider and registered manager did not understand and were adhering to government guidance in relation to COVID-19. During our inspection a person was readmitted to the service following an emergency admission to hospital. The registered manager was not aware of this person returning to the home or that the hospital had contacted the home to inform them this person was COVID-19 positive. The person was supported by staff who were not wearing enhanced personal protective equipment (PPE) and their door was left open. Staff were also not aware this person was COVID-19. This placed people at significant risk of harm from transmission of COVID-19.
● Staff were not wearing PPE in line with government guidance. For example, during our inspection we saw staff taking down their masks to speak to one another and wearing their masks below their chins.
● The registered manager told us they were not adhering to government guidance on staff testing as they only asked staff to take lateral flow tests rather than the required weekly PCR tests. This placed staff and people at risk of increased transmission of COVID-19.

Systems were not in place to ensure government guidance around COVID-19 was understood and adhered to. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

Visiting in care homes
● The registered manager had failed to ensure people were supported to have visitors. Relatives we spoke with told us they had been unable to visit their relative prior to their death as the registered manager told them there was a COVID-19 outbreak in the home. The registered manager had failed to inform relatives of

their right to visit as an essential care giver. The relatives we spoke with told us they would have liked to have seen their loved one prior to their death.

Not ensuring people could make decisions around their care and visitors placed people at risk of not receiving person centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

We have signposted the provider to resources to develop their approach.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Systems and processes to safeguard people from the risk of abuse
● The provider and registered manager had failed to ensure people were supported by staff who understood safeguarding and how to report concerns. For example, one person had an unexplained black eye. No investigation had been completed by the provider or registered manager and no referral had been made to the local safeguarding team to understand how this had happened and to reduce potential future risk. This placed people at prolonged risk of harm.
● Another person with dementia had left the service unsupported, placing them at high risk of harm. However, no actions were taken to investigate how this occurred to reduce future risk. No referral was made to the local safeguarding team for investigation and review also. This person did not have a care plan or risk assessment in place following this incident which identified the risks associated with this and gave staff clear guidance to mitigate future risk.

The provider and registered manager had not ensured they and staff had enough understanding of safeguarding and effective and processes in place to ensure safeguarding concerns were investigated and action was taken to reduce future risk. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities).

Staffing and recruitment
● The registered manager had not completed effective assessments for people to ensure they were supported by enough staff. The dependency tool completed by the registered manager did not contain details of all people at the home. This meant the amount of staff the tool suggested would be required to support people safely was inaccurate.
● During our inspection we observed there were not always sufficient staff to support people safely. For example, one person was allocated one to one staff following a safety incident. However, we saw this person was left unattended on two occasions. This placed the person and those around them at increased risk of harm.
● Staff did not have skills to meet people's individual needs and risks. For example, staff we spoke with did not have sufficient understanding of the Mental Capacity Act, safeguarding or diabetes care.

There were not sufficient number of skilled staff to meet people's needs safely. Staff had not had effective training to ensure they understood and could meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities).

● Staff were recruited safely and the provider had completed checks on employment and criminal records history prior to their employment.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection the governance systems in place were not effective to continually assess, monitor and improve the quality of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found significant concerns in relation to the quality and oversight at the home and the provider was still in breach of regulation 17.

● The registered manager and provider had failed to take timely action to make improvements at the service to ensure people received consistently good care. The service has been rated less than good for the fifth consecutive inspection. This is also the fifth consecutive breach of Regulations 17 and 12 which demonstrates there is not consistent safe care and treatment. At this inspection we also identified breaches in regulations around staffing and training, safeguarding, duty of candour and failure to notify.
● The provider and registered manager had failed to ensure there were effective quality assurance tools in place to identify where improvements were required and to drive improvements at the home. None of the concerns raised at this inspection had been identified by the management team prior to our visit. This placed people at prolonged risk of harm.
● Whilst the registered manager was reviewing people's care plans, these reviews had failed to identify gaps in people's records and where they contained conflicting information about their care needs. This placed people at risk of harm.
● Checks on medicines records had failed to identify significant concerns around people's medicines and where staff had failed to seek medical attention for people who had not received their medicines as prescribed.
● Following significant accidents and incidents the registered manager had failed to ensure people's future risks were assessed and reduced. For example, where a person living with dementia had left the home unsupported, placing them at risk. No action had been taken to reduce future risk to this person. This person also had no care plan or risk assessment completed in relation to these risks.
● The provider and registered manager had failed to recognise and report potential safeguarding incidents to the local safeguarding time. This placed people at prolonged risk of harm.
● The provider and registered manager failed to ensure there were enough trained staff to support people safely.

These issues constitute a continued breach of Regulation 17 (Good governance) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to notify us of safeguarding concerns and police incidents at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People we spoke with did not feel involved in the service or that their views were heard and acted upon. One person told us, "It's terrible here. I get meals but it's usually the opposite to what I asked for." Another person told us, "It's very lonely here, it's the same day in day out. I used to like football but there is nothing going on here."

● People's protected characteristics were not considered within their care planning and risk assessments.

● The provider told us they engaged with people at the service regularly to gain their feedback. However, they were not aware of any of the concerns people raised with us during the inspection.

● Staff had access to supervisions however these were not effective at ensuring staff were suitable comfortable and understood the importance of sharing concerns about the home. The registered manager and provider had not been made aware of concerns the staff shared with us during the inspection.

These issues constitute a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● There was a closed culture within the home. The registered manager and staff were not communicating effectively as they were not aware of multiple incidents that had occurred within the home or of concerns we identified at our inspection. For example, the registered manager was not aware of multiple occasions where people had not received their medicines as prescribed and that staff had not taken action to seek medical attention.

● Staff we spoke with raised concerns around the registered manager not being approachable or responsive when they raised concerns.

These issues constitute a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager had failed to ensure people's needs and wishes were considered during COVID-19 and at the end of their lives. People had COVID-19 visiting care plans in place and people did not always have end of life care plans in place. This meant person centred care was not championed within the service, placing people at risk of not receiving care in line with their preferences.

● People did not have access to healthcare professionals in a timely way when they required these. For example, a person who was at high risk of falls had multiple falls prevention equipment by their bed which were not effective. No referral had been made to external professionals to review what equipment this person required.

● Professionals we spoke with raised concerns around the communication within the home. For example, it took staff three weeks and multiple prompts to provide the GP surgery with a person's urine sample they had requested to review a person's deteriorating health.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● We could not be assured the registered manager understood or was adhering to the duty of candour as records did not reflect they had had communication with people and their families when things went wrong

● At this inspection we found incidences of people not receiving their medicines as prescribed. These had not been identified by the registered manager and therefore no conversations had happened with people and their families to apologise and discuss how improvements would be made.

The provider and registered manager had failed to meet the duty of candour. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities).

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure they had sufficient understanding and knowledge of COVID-19 visiting and end of life guidance to ensure people were offered informed choices around this and their care could be centred around these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Potential safeguarding concerns had not been identified or reported to the local safeguarding team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider and registered manager failed to identify all incidents within the home and be open and honest with people about improvements that were required to their care.