Rowena House Limited

Rowena House Limited

Inspection report

28 Oakwood Avenue
Beckenham
Kent
BR3 6PJ

Tel: 02086503603

Date of inspection visit:
18 August 2021
20 August 2021
23 August 2021

Date of publication:
07 October 2021

Ratings

Overall rating for this service	Requires Improvement

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

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 in one adapted building. There were thirteen people living at the home at the time of this inspection.

People's experience of using this service and what we found
People were not always protected from improper treatment as inappropriate restraint was used on some occasions to ensure some people remained seated during a meal. People were not always treated with dignity and respect or their equality characteristics considered.

Risks to people in relation to their health or care needs were not always identified or assessed. The provider's policies and current government guidance was not consistently followed in respect of visiting or discharge from hospital. Some risks in respect of some equipment and premises risks were not identified.

The provider's quality monitoring system was not effective in identifying or addressing risks to people's health and safety. The culture of the service was not always empowering or inclusive.

We observed that people were relaxed in the presence of staff and each other. Staff understood how to raise any safeguarding concerns and where to go if they felt these were not acted on by the provider. Relatives were positive about the care provided and told us it was a warm friendly service.

Improvements had been made to the cleanliness and hygiene measures to prevent and control infection risks. Regular infection control audits were completed to ensure these remained effective.

Staff were positive about the way the registered manager led the staff team and managed the home. They said he had made a number of improvements.

Safe recruitment processes were followed. There were enough staff to meet people's needs. We have made a recommendation for the provider to review their domestic staffing levels to ensure people's needs are met at all times.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 14 January 2021).

At this inspection we found some improvements had been made but enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We carried out an unannounced focused inspection of this service on July 2020. Breaches of legal requirements were found. We imposed urgent conditions on the provider's registration in respect of infection prevention and control.

We undertook this focused inspection to check they met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains requires improvement. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rowena House on our website at www.cqc.org.uk.

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

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

We have identified breaches in relation to safeguarding people from abuse, assessing risks, treating people with dignity and respect and the quality monitoring of the home.

Please see the action we have told the provider to take at the end of this report in relation to some of the breaches found.

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 request an action plan and meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rowena House Limited

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection team was made up of two inspectors 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. The site visit was carried out by two inspectors on the first day and a single inspector returned on the second day. The Expert by Experience made phone calls to relatives following the first inspection day.

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 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority's contract monitoring team and safeguarding 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
Most people were unable to verbally express their views about their care, so we made observations of the care provided and 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. We spoke with two relatives visiting the home to understand their experiences.

Across both inspection days we spoke with the registered manager, the deputy manager, two team leaders, a senior care worker two care workers, an activity coordinator, a chef and the housekeeper and the provider. Following the site visit the Expert by Experience and inspector spoke with six relatives by phone.

We reviewed a range of records. This included five people's care records and four 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 risk assessments and monitoring checks were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
● People were not consistently safe from abuse or improper treatment. There was evidence that on occasions staff used a form of restraint on people strapping a tabletop to the chair which prevented anyone sitting in the chair from getting up when they wished. We did not observe this practice at the inspection, but staff and the provider told us this was used when people did not wish to remain seated for their meal. This practice was therefore a restraint against a person's wishes.

People were not always protected from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action during the inspection and removed the chair from use.

● We observed that people felt relaxed in the presence of staff and each other. People's relatives told us they thought their family members were safe from abuse or harm. One relative commented, "Absolutely, as [my family member] is always clean and well cared for and I have watched their interactions with staff and other residents."
● Staff received regular safeguarding training. They were aware of the different types of abuse and the signs to look for that may indicate abuse may have occurred. Staff confirmed they would report any concerns they had to the registered manager. They were aware of the providers whistleblowing policy and where to go if they thought they needed to raise concerns outside the service.
● The provider had safeguarding policies and procedures in place for reporting any allegations to the local authority. The registered manager understood these procedures and knew to notify CQC of any abuse allegations.
● There had been no safeguarding concerns since the last inspection. While action had been taken following accidents and incidents. Some improvements were needed to evidence that any learning was identified, and trends and patterns looked for to improve the quality and safety of the service.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to assess some risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks to people were not always adequately assessed or reviewed, and risk management plans were not always followed or available to support staff to provide safe care. Where one person was at high risk of skin integrity breakdown, staff were not following the risk management plan which guided them to use a pressure cushion. Diabetic risk assessments did not include signs for staff to be alert to that might indicate signs of concern and a full risk management plan was not in place to mitigate the risks.

●Where people's needs had changed, their risk assessments had not been updated to guide staff on how to manage these risks safely. Most relatives said they had not been invited to discuss or review the plan of care for their family member; and they told us they were aware their needs had changed. One relative said, "Risk assessments and a care plan may have been written initially but we have had no reviews of her care plan for over two years and she has most definitely deteriorated in this period of time."
● We observed a staff member carry out an unsafe transfer from a chair to a wheelchair for one person who was in discomfort placing them at some risk of injury. This was not in line with their mobility care plan or risk assessment. There was no pain risk assessment or risk management plan in place for their health condition which had associated pain.
● We identified some concerns about the assessment of equipment risks. The registered manager had identified a possible risk in relation to some new beds recently purchased, but there was no risk assessment completed to asses and mitigate any risks where these were in use.

Care and treatment was not always provided in a safe way. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the registered manager who told us they would organise refresher moving and positioning training for staff members and address the other concerns.

Using medicines safely
● Medicines were not always safely managed. The medicines fridge which was used to store medicines did not conform to current guidance as there was no display of maximum and minimum temperatures to ensure medicines were always stored at safe temperatures. Fridge thermometer readings varied at different times of the day and were not always within safe levels. We were not assured therefore that medicines were always safely stored. These risks had not been assessed or mitigated.
● For one person prescribed a controlled drug, we found a discrepancy between the recorded and actual balance of remaining stock, which meant they had not received their medicines as prescribed.

Medicines were not always safely managed; this placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were some other areas for improvement. Staff did not always record dates of opening of some medicines on opened bottles to ensure they were used within safe limits. Medicines competency assessments were not detailed to show what areas of competency staff had been assessed, or evidence areas for possible development.
● People's relatives said they thought their family members received their medicines when they should. We observed staff to administer medicines safely. Medicines administration records we viewed were completed

with no gaps. There were medicines risk assessments in place and guidance for staff on how to administer as required medicines.

Preventing and controlling infection
At our inspection in July 2020 we had found the provider had failed to assess some risks relating to infection prevention and control. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had imposed urgent conditions on the provider in relation to the prevention and control of infection.

At this inspection we found improvements had been made and overall these conditions were being met. However, there were other areas where the provider remained in breach of regulation12.

● People were not always protected from the risk of infection. Staff were not always following the provider's policy or government guidance, 'Guidance on Care Home Visiting,' updated 16 August 2021. There was no assessment of visiting risks in relation people's vaccination status or health conditions that would increase their vulnerability. Relatives told us and we observed that they were not always asked to carry out a temperature test or asked for proof of testing when they visited, to reduce risks.
●The designated visitors' room was unventilated, and no risk assessment had been completed to guide staff on how to mitigate infection risks to service users, visitors and staff.
● Staff did not always follow the provider's policy or government guidance when people were discharged from hospital and we found people were not isolating or taking part in regular post discharge testing. Where the guidance was not followed there was no assessment of the risks and how to safely manage them.

Care and treatment was not always provided in a safe way. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been considerable progress in the cleanliness at the home since the last inspection. There were suitable handwashing facilities throughout the home. Care staff supported the housekeeper with enhanced cleaning of high-risk areas such as door handles. Staff wore appropriate PPE and had all received infection prevention and control training. They told us there was a good supply of PPE. Two staff had been nominated as health protection champions and they attended local meetings to keep informed about infection prevention. People and staff took part in routine Covid-19 testing.
● Relatives confirmed the home was clean and odour free when they visited, and that staff wore personal protective equipment (PPE). One relative remarked " It's always spotless when I visit no smells either." The registered manager carried out checks on the cleaning carried out to ensure it was done satisfactorily.

Staffing and recruitment
● Our observations were there were enough staff to support people safely. However, we had mixed views from relatives, one relative commented," I haven't done a head count of staff when visiting, but there seems to be sufficient staff available." Another relative said, "They really could do with more staff."
● Staff mostly told us there were enough of them to meet people's needs. We tried a call bell which was answered promptly. The registered manager told us they would flex staffing levels to respond to people's needs.
● On both days. we observed that staff were very busy with the additional tasks including the enhanced cleaning as well as laundry and bed making took them away from their care and support to people who occasionally looked for reassurance. There were no kitchen staff after lunch so care staff were involved in serving and clearing up after the evening meal. There was no housekeeper at weekends and so these tasks

were then was the responsibility of the care staff in addition to their care roles.

We recommend the provider reviews the domestic staffing levels across the home to ensure there are sufficient staff at all times.

● Safe recruitment processes were in place. We checked the recruitment records for two new staff members. We found all appropriate recruitment checks in place to ensure they were suitable for their roles.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

At our last inspection the provider's systems for monitoring the quality and safety of the service had not been effective in identifying issues or driving improvements. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made to address the issues we had previously identified. However, there remained shortfalls with the quality monitoring system and the provider remained in breach of Regulation 17.

- Systems to assess, monitor and improve the quality and safety of the service and address risks to improve care were not effectively managed. The registered manager had not addressed people's changing needs and associated risks in relation to two people's care or updated guidance given to staff to ensure their needs were met safely. The provider's quality monitoring had not identified that staff were not always following their policy in relation to visiting or admission to the home from hospital.
- The quality monitoring checks had not identified risks we found in relation to the premises. Full legionella checks were not being carried out in accordance with the legionella risk assessment. Hot water temperature checks were also not being accurately recorded. Night staff had not all taken part in a fire drill to understand how to evacuate people safely at night.
- The provider's oversight of food hygiene was not effective. There was no recorded monitoring of the daily and weekly cleaning records in the kitchen and some checks had not been recorded. Freezer temperatures were only recorded for one of two freezers in the kitchen which meant there was a risk of unsafe food storage. Food was not always stored safely wrapped in the fridge. We have referred our findings in relation to food hygiene to the Food Standards Agency.
- The provider's quality monitoring system had not recognised that the visitors' room was not ventilated. The registered manager had not carried out a risk assessment to identify how to manage this risk. Cleaning records and cleaning monitoring checks did not include records for the cleaning of the visitors' room to verify how frequently and effectively the room was cleaned adequately to reduce infection control risks.
- Medicines audits had not assessed the risk in relation to the medicines fridge we identified or that staff were not recording controlled drugs in a bound book in line with government guidance.
- The registered manager had not acted on feedback from the local authority in a timely way to improve the

running of the service. A local authority monitoring report and action plan dated 14 May 2021 recommended individual visitor risk assessments completed in relation to Covid-19. Personalised risk assessments were not evident at this inspection, although the action was marked as completed.

Systems to monitor the quality and safety of the service were not effectively operated. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager took action to address the issues we found with visiting arrangements, the medicines fridge and with freezer temperature checks following the inspection.
●Regular audits of aspects of the management of the home were completed by the registered manager. These included health and safety infection control and medicines. Some issues had been identified and action taken to address these.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not always treated in a person centred, dignified way or their equality characteristics sufficiently considered. Staff addressed one person by their surname multiple times during the inspection, rather than their chosen name, which showed a lack of respect. The person concerned or their family had not been consulted about this. They also referred to this person by their surname in their care records.
● For another person their cultural needs in respect of their diet were not fully considered. Their care plan stated they liked the food traditional to their culture. However, there was no guidance on how to meet this need for the chef. They were observed to have the same menu as other people on both days of the inspection. The registered manager said they had arranged that the family would bring food into the home. No evidence was provided to confirm this or to show the home had considered how best to address people's cultural needs in respect of their diet.

We found no evidence that people had been harmed however, people were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was mixed feedback from relatives about communication with the home. Three relatives commented that they received little contact or updates from the home and had not been asked for their views about the running of the home. One relative said, "I have always thought communication between relatives and management is lacking. If I didn't make the effort I know they would not." The registered manager showed us feedback from three relatives he had asked for about the home. He told us they had not had any relatives' meetings in the last 18 months due to the pandemic, but he produced a regular monthly newsletter which was on display at the service for relatives that visited.
● Where relatives had needed to complain they told us these had been acted on by the registered manager. The activities coordinator held regular residents' meetings at the home for people to contribute to.

Working in partnership with others
● The home worked with a range of professionals such as the GP, district nurses and the hospitals to meet people's needs. Care records included the advice received from health professionals.
● The registered manager attended the local authority provider forums and had followed advice from the local authority and the CCG in order to address infection control issues we had identified at the inspection in July 2020.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: 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

● The registered manager understood their role, the requirements of Care Quality Commission (CQC) to be notified of significant events and their responsibilities under the duty of candour.

● Staff told us they felt well supported by the registered manager. They commented he was approachable, supportive and made themselves available for staff when he was away from the home. One staff member said, "He has made our roles clear to us and we know what we need to do."

● Regular staff meetings were held to share information with staff and ensure there was effective communication among the staff team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and due regard was not always paid to their relevant protected characteristics. Regulation 10 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse or improper treatment as acts of restraint or control were sometimes used. Regulation13 (1)(2)(4)

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 People did not always receive safe care and treatment as risks to people were not always identified assessed or mitigated. Regulation 12 (1)(2)(a)(b)(d)(e)(g)(h)

The enforcement action we took:

We served a Warning Notice against the provider and registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess monitor and improve the quality and safety of the service and to assess monitor and mitigate risks were not effectively operated. Regulation 17(1)(2)(a)(b)(e)

The enforcement action we took:

We served a Warning Notice against the provider and registered manager.