Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Rowan Garth Nursing Home

Inspection report

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Anfield,
Liverpool.
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 23 and 24 September 2015 and was unannounced.

Rowan Garth Nursing Home is a large facility located in the north of Liverpool. The provider is BUPA Care homes (CFC) Limited. The location provides accommodation for up to 150 people across 5 separate units set within extensive grounds. Each of the units is single-storey and can accommodate 30 people. The service supports people with a range of care needs from nursing to end of life care. The units within the home are as follows;

Heather Unit (Dementia and Nursing Care)

Moss Unit (Dementia and Residential Care)

Oak Unit (Nursing Care)

Beech Unit (Residential Care)

Clover Unit (Intermediate Care)

The service is registered to provide nursing and personal care, diagnostic and screening procedures and treatment of disease, disorder or injury for older people and people living with dementia.

Summary of findings

A registered manager was in place. 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.

Prior to the inspection we received information of concern regarding altercations between people living at the home, staffing levels, poor standards of care and security of the units. We included a review of these areas in our inspection.

We saw that staffing levels were not always adequate to attend to the needs of people living at the home. This was particularly evident in the units caring for people with dementia.

Access to some buildings was not secure. This meant that people may have left the building without staff being aware. This also meant that people living at the home were not always protected from the risk presented by intruders. We also saw that a door to one of the units had been damaged and part of the locking system removed.

We observed that the kitchens in each unit had their doors open on a regular basis. These doors were marked as fire doors to be kept closed. This presented an additional risk in the event of fire and also gave people living at the home access to water at very high temperatures.

Care was not regularly reviewed. We saw examples where care plans associated with weight loss and pressure area care were not regularly reviewed. We also found that the risk of cross-infection was not adequately managed.

Accidents and incidents were reviewed and assessed by staff and changes were recommended as a result. These recommendations were not applied consistently across the location.

We looked at the storage and administration of medicines in four of the five units. We saw that medicines were not always stored and administered safely. Some records relating to the administration of medicines were not completed correctly.

Staff were appropriately recruited and trained to meet the needs of the people living at the home.

The service operated in accordance with the principles of the Mental Capacity Act 2005 and the deprivation of Liberty Safeguards. We saw that staff sought the consent of people before providing care in an appropriate manner. When people refused care this was documented and reviewed.

The kitchens were well-equipped and provided a varied menu in accordance with provider' guidance. The menu had been adjusted slightly to ensure that people living at the home had access to familiar meals. People on specialised diets were accommodated for. Each meal had a detailed recipe and a list of its nutritional content.

We found variations in the quality of care and support provided in relation to people's health needs. We saw that some care files had important information missing which would help to inform care plans and support engagement with external healthcare services. This was particularly true of pre-admission information meaning that people were exposed to unnecessary risk on admission.

Staff were sometimes task-focused during the inspection, but were seen to provide care and support with kindness and compassion when engaging with people. Staff were observed speaking to people with respect. Staff took time to talk to people and demonstrated that they knew the person by the nature of the conversation.

Staff promoted the dignity of people living at the home through observation and early intervention when people required support. Staff were seen to encourage independence at lunchtime through careful prompting in accordance with care plans.

People's privacy was not always protected. We saw that the bedroom doors of some people were kept open for the purposes of observation, but that this sometimes compromised their privacy and dignity.

We observed significant delays in supporting people with personal care which was a task-orientated process lacking the flexibility to meet peoples individual care needs.

We saw evidence that people's preferences were recorded and reflected in the decoration and furnishing of their rooms.

Summary of findings

The review of people's care needs was not consistent. People's care plans lacked personalisation, were generic and did not include regular reviews.

The home had systems in place to record compliments and complaints. The complaints procedure was displayed throughout the home. There was a schedule of resident and relative meetings, but some of the meetings were not minuted or had not taken place. Other meetings were poorly attended.

We saw that some staff were not motivated in their roles and had notified the provider of their intention to leave.

The registered manager and senior staff demonstrated an understanding of their roles in leading the team and developing the location. Where areas for improvement were identified during the inspection they responded in a positive, professional and timely manner.

During the transition between registered managers at the location we found that the procedure for submitting notifications of important events was not being followed consistently.

The provider showed us evidence of extensive quality and safety audit processes which had been completed on a regular basis. The review schedule for some of these audits had been missed. Issues identified during quality audits had not always resulted in action.

Summary of findings

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.

People were not protected against the risks associated with the administration of medicines because safe procedures were not consistently followed.

We saw that staffing levels were not always adequate to attend to the needs of people living at the home.

The security of some buildings was inadequate and people were not protected from the risk posed by leaving the service unnoticed.

Care plans were not regularly reviewed which meant that people were at risk of receiving care which was inappropriate to their needs.

Accidents and incidents were reviewed and assessed and changes were recommended as a result. These recommendations were not applied consistently across the location.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were appropriately recruited and trained to meet the needs of the people living at the home.

Staff sought the consent of people before providing care in an appropriate manner. When people refused care this was documented and reviewed.

We found variations in the quality of care and support provided in relation to people's health needs. We saw that some care files had important information missing which would help to inform care plans and support engagement with external healthcare services.

The kitchens were well-equipped and provided a varied menu in accordance with provider' guidance.

Is the service caring?

Good

The service was caring.

Staff were seen to provide care and support with kindness and compassion when engaging with people.

Staff were observed speaking to people with respect. Staff took time to talk to people and demonstrated that they knew the person by the nature of the conversation.

Staff were seen to encourage independence through careful prompting in accordance with care plans.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

We observed significant delays in supporting people with personal care which was a task-orientated process lacking the flexibility to meet peoples individual care needs.

We saw evidence that people's preferences were recorded and reflected in the decoration and furnishing of their rooms.

The review of care needs was not consistent. Care plans were not personalised and did not include a schedule for review.

The home had systems in place to record compliments and complaints. The complaints procedure was displayed throughout the home.

Is the service well-led?

Requires improvement

The service was not always well-led.

The registered manager and senior staff demonstrated an understanding of their roles in leading the team and developing the service. Where areas for improvement were identified during the inspection they responded in a positive, professional and timely manner.

During the transition between registered managers at the service we found that the procedure for submitting notifications of important events was not being followed consistently.

The provider showed us evidence of extensive quality and safety audit processes which had been completed on a regular basis. The review schedule for some of these audits had been missed. Issues identified during quality audits had not always resulted in action and they had also failed to identify concerns found by us on this inspection.

Rowan Garth Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 24 September 2015 and was unannounced. We had also received concerns in relation to the safety of people prior to this inspection.

The inspection team consisted of three adult social care inspectors, an inspection manager, two pharmacy inspectors, a specialist advisor in nursing and dementia care and an expert by experience in residential and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We were not able to review a Provider Information Return (PIR) before the inspection. The 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. We had not requested this prior to the inspection.

We reviewed other information we held about the home and spoke with service commissioners and social workers.

We spoke with 21 people who lived at the home, 13 relatives, 20 staff and two visiting professionals. We viewed nine care files and nine staff records and observed staff interacting with people living at the home across all five units. We checked procedures for the storage and administration of medicines. We also checked medicine records for 17 people living at the home.

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 looked at the location's policies and procedures with a specific emphasis on safety and quality auditing systems.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information of concern regarding staffing levels and the security of buildings. We reviewed this as part of the inspection.

We saw that staffing levels were not always adequate to attend to the needs of people living at the home. This was particularly evident in the Heather and Moss units which cared for people living with dementia. We asked the provider about the assessment of need process. The provider told us that a dependency tool was used at a regional and national level, but not locally. A dependency tool is used to establish appropriate staffing levels based on the needs of the people living at the home. This meant that the provider could not accurately assess if staffing numbers were sufficient to meet the needs of people living in each of the units. A visiting professional told us, "There's sometimes an issue when residents need the toilet if the person needs two staff."

We saw that people were not always protected from the risk of abuse or neglect because staffing levels in Clover, Heather and Moss units was insufficient at the busiest times. One person living at the home told us, "At certain points of the day, they [Staff] are pushed." Another person said, "Staff are busy all the time." Five people living at the home also told us about delays in responding to the call-bell. One person said, "I was waiting this morning. No one came for about an hour." A member of staff told us that they were looking for another job partly because of, "Short staffing."

We observed significant delays in supporting people with personal care which was a task-orientated process based on the routine of the service rather than people's individual care needs or preferences. One person reported that they had been waiting all morning to be supported with personal care. While it is unclear exactly how long this person had been waiting, we observed that they were left for a period in excess of thirty minutes before staff attended to them. A member of staff told us, "The mornings are busy. In the afternoons we spend time with people." Another member of staff said, "We generally do baths in the afternoon because there's more time and we're not rushed." This approach does not provide sufficient flexibility to take account of people's individual preferences. People's preference for a specific time to bathe or shower was not recorded in the care files that we saw.

The registered manager was asked to supply a representative sample of staffing information for 2015. From this information we identified that nursing cover regularly fell to one nurse during the am and pm shifts from the usual level of two. On one occasion, staff cover for the general (non-nursing) dementia unit overnight was recorded as one carer. The information supplied by the provider (Staff on-duty records) indicated that three carers were on duty on other night shifts. The registered manager told us that this was an error on the form and did not accurately reflect the provision of staff. The records showed that the number of care staff deployed was similar in each of the five units. The provider was not able to demonstrate that the needs of individuals had been taken into account when determining staffing levels because a dependency tool had not been used to establish safe staffing levels. The staffing levels reported and observed impacted on the home's ability to respond appropriately and safely to the needs of people living at the home.

This is a breach of Regulation 18(1) Staffing; of the HSCA 2008 (Regulated Activities) Regulations 2014.

We had been notified by the provider that people living at the home had left the units unobserved. Prior to the inspection we received information of concern that the security of one of the units had been compromised. We saw that access to some buildings was not secure. During the inspection a relative did not receive an answer when ringing a door bell so entered the building through the garden. They told us that they had done this before. This meant that people may have left the building without staff being aware and that they and their property were not always protected from the risk presented by intruders. We also saw that a door to one of the units had been damaged and part of the locking system removed. This meant that it was not as secure as it should have been. We told the provider about this and they agreed to ensure that the door was made safe.

We saw that the kitchens in each building had their fire doors open on a regular basis during this inspection. This presented an additional risk in the event of fire and also gave people living at the home access to water at very high temperatures. For people living with dementia the ability to recognise and respond safely to risk is sometimes compromised which meant that access the kitchen compromised their safety. We asked the provider to address this as a priority. We were assured that instructions

regarding access to the kitchens were clear and that the risk posed by open doors would be relayed to staff. We also saw that the doors to the sluice rooms in Moss Unit and Clover Unit were unlocked giving access to a hazardous environment. In one of the sluice rooms a bottle of cleaning fluid was easily accessible. We advised the staff of these hazards and the rooms were locked in each case.

We saw that the maintenance checks for the units did not identify all potential hazards. A bath panel was found to be in a dangerous state of repair leaving a sharp edge exposed. We asked the provider to address this during the inspection and a remedial repair was completed. We also saw that some door handles were broken or had been removed leaving access to sharp edges. The provider assured us that these matters would be addressed as a priority.

This is a breach of Regulation 15 (1) (b) & (2) Premises & equipment; of the HSCA 2008 (Regulated Activities) Regulations 2014.

We saw evidence that accidents and incidents were reviewed and assessed and changes were recommended as a result. This information was shared with staff at their daily meetings, but not consistently entered into people's care files. The recommendations were not consistently applied across the service which meant that opportunities were missed to improve safety across the service.

Not all staff were sufficiently familiar with the needs of people living at the home to provide safe and meaningful support. On one occasion a member of staff was seen giving a person with diabetes high-sugar foods which was not in accordance with their care plan. We saw that another person who was diabetic was being served biscuits. This was not in accordance with their care plan. This presented a risk to the health, safety and welfare of this person.

We found that care planning was not consistently assessed and reviewed. Of the care files that were viewed we saw examples where risks associated with weight loss and pressure area care contained contradictory information and had not been regularly reviewed. We saw that one person had experienced significant weight loss since their admission to the service. A member of staff told us that a referral had been made to a specialist, but no evidence of this was present in the care file and no evidence of review. In another care file we saw instructions that a person was to receive positional changes every hour. In the same care file we saw instructions to move the person every four hours. The records indicated that the person had been moved every four hours. The lack of clarity and consistency regarding the planning care put people's health and wellbeing at risk.

The service used the Waterlow Assessment Tool to identify actual or potential risk to people's skin integrity. We saw the records of one person with significant pressure ulcers was not being completed correctly. Each section of the tool was not completed as required. This generated a false score which placed the person at risk of inappropriate or inadequate treatment.

This is a breach of Regulation 12(2) (a) and (b) Safe care and treatment; of the HSCA 2008 (Regulated Activities) Regulations 2014.

We also found that the risks associated with cross-infection were not adequately managed by an effective cleaning regime. We found that cleaning in Moss, Clover and Beech Units was not always effective in eliminating odours. Some bathrooms had strong odours which were evident in corridors at various points during the inspection. There was equipment to hold soiled linen in communal areas. These findings have implications for the management of infection control on each of the units. We alerted the registered manager to these issues during the course of the inspection.

This is a breach of Regulation 12(2) (h) Safe care and treatment; of the HSCA 2008 (Regulated Activities) Regulations 2014.

We visited four out of the five units in the home to check the medicines and viewed records for 17 people. We spoke with the registered manager, clinical services manager and a regional services manager for the home as well as two registered general nurses, two registered mental health nurses and two senior carers in the four houses.

Two people did not have photographs and three people did not have their allergies recorded on their medicines record, which is not in line with current guidance. Having a photograph and allergies recorded can reduce the risk of medicines being given to the wrong person or to someone with an allergy. One person had an allergic reaction to

some antibiotics; however the staff member carrying out medicines administration was unaware of which antibiotics the person was allergic to, even though the person had recently been on a course of antibiotics.

The units have four medicine rounds at breakfast, lunch, teatime and at night. When we visited, there was no time documented for when paracetamol had been given in three of the houses and therefore it would be difficult to ensure a minimum of four hours' time interval had passed between paracetamol doses to ensure safe administration. One person was taking a medicine to relieve dizziness to be taken when required with variable doses (one or two tablets), the Medicines Administration Record (MAR) chart did not have the number of tablets administered recorded to make it clear what the person had taken. It was therefore not clear how much medicine the person had taken.

Medicines were not always given as directed by the doctor, for example one person was given a medicine after their breakfast when it should have been given before food. One person was on a variable dose of medicine to thin their blood; the incorrect dose was given nine times over 18 days. Another person who had been discharged from hospital was wrongly given three medicines that had been stopped by the hospital. During our visit we contacted the doctor who confirmed that they should have been stopped.

We checked the stock levels recorded by three of the houses for medicines belonging to nine people. The quantities recorded for medicines belonging to five people were different to what was in the home; this meant that these medicines could not be fully accounted for.

Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were not stored securely as per legislation as at one point the controlled drugs keys were given (as part of a bunch of keys) to one of the workmen on-site. We made the provider aware of this and the keys were returned. Fluid thickeners and creams were not always locked away securely, which was not in-keeping with current guidance and best practice.

This is a breach of Regulation 12(2) (g) Safe care and treatment; of the HSCA 2008 (Regulated Activities) Regulations 2014.

Medicines audits had been completed and the home had learned from a medicine incident when a patch to relieve pain had not been applied. The home now reviews all people on pain relief patches every week to reduce the risk of the error happening again. The home also reviews people with dementia who are taking medicines to reduce behavioural and psychological symptoms, which is considered good practice.

People living at the home and their relatives told us that they felt safe. A person living at the home said, "[I feel] safe, very much so." Another person told us, "I'm safe and secure here." A visiting relative told us, "Residents are safe here. I've got no concerns." These views were contradictory to those expressed by people living at the home and their relatives following recent incidents prior to the inspection.

Staff had been recruited in accordance with organisational procedure subject to two satisfactory reference's and a Disclosure and Barring Service (DBS) check. A DBS check is used to confirm that an applicant is suitable to work with vulnerable adults. Each of the nine files that we checked contained a record of their interview, two references, a DBS number, photographic identification and proof of address. Nurse registration (PIN) numbers were in date and a record kept on file.

Fire risk assessments had not been reviewed since December 2013. This meant that changes in the physical environment and people's needs may not have been reflected associated plans. External organisations were used to check the safety and compliance of emergency equipment. This meant that the location was not wholly reliant on internal resources and had responded to some findings from both internal and external audits.

Requires improvement

Is the service effective?

Our findings

We found variations in the quality of care and support provided in relation to people's health needs. We saw that some care files had important information missing which would help to inform care plans and support engagement with external healthcare services. This was particularly true of pre-admission information meaning that people were exposed to unnecessary risk on admission. Clover Unit specialises in the provision of intermediate care and has accepted people being discharged from hospital at short notice. A member of staff told us that pre-admission information was provided via telephone calls and fax meaning that staff were only able to assess referrals on arrival. We were told that this had led to some people being returned to hospital as the unit could not meet their needs. They told us that they had escalated their concerns regarding the referral process many times during management meetings. The provision of detailed and accurate pre-admission information and a schedule for the regular review of care plans is essential if people's care needs are to be met in an appropriate manner.

This is a breach under Reg. 9 (3)(a) Person-centred care; of the HSCA 2008 (Regulated Activities) Regulations 2014

Staff were trained to meet the needs of the people living at the home. One member of staff told us that their induction was a mix of classroom-based study and shadowing more experienced members of staff. One person living at the home told us, "They [Staff] are well trained." Another person said, "Most of them [Staff] are well trained. I can tell by the way they give me a bath or a shower." We looked at nine staff files and spoke with the training manager. We saw a copy of the provider's training matrix which detailed the courses that care staff had completed and gave scope for development through access to additional training. All training was completed or booked.

Induction training was managed by an on-site trainer and consisted of four days which were classroom-based, followed by time working under the supervision of an experienced member of staff. Staff were required to complete knowledge checks as proof of learning. Staff spoke positively about their induction and subsequent training and said that they felt supported to do their jobs. The skills mix was appropriate to meet the needs of the people living at the home. The views of the nurses that we spoke with regarding training were not as positive as those provided by care staff. One nurse outlined the recent training that they had completed but added, "The training for nurses is not good." Another nurse told us, "There needs to be more professional development for nurses." The location had a generic development programme for all nurses. The registered manager told us that development was also addressed on an individual basis. The records that we saw demonstrated that nurses were trained in the same topics as care staff. This training was appropriate to meet the needs of people living at the home.

The atmosphere in the dining areas was friendly and relaxed. Tables were laid-out with cutlery, condiments, napkins and a pot of tea. People had chosen their meals the previous day, but were offered alternatives before and after serving. Staff encouraged those who were not eating in a gentle and supportive manner. Feedback on the quality of food was generally positive. One person living at the home said, "The food's very nice. If I don't like something, they bring me something else." Another person told us, "The food's marvellous; I don't eat this well at home." A relative told us, "The food seems good. Nice roast dinners. There's plenty to drink, especially when it's hot." We identified that some people required prompting and support at mealtimes to ensure that they consumed their food. However, staff were not always available to provide this prompting and support. We asked the registered manager about this. They told us that staff numbers were not determined at a local level but that they would be reviewed in light of our discussion.

This is a breach of Regulation 18(1) Staffing; of the HSCA 2008 (Regulated Activities) Regulations 2014.

When asked, staff demonstrated that they understood the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). They also understood their role in relation to MCA and DoLS. The MCA is a piece of legislation which covers England and Wales. It provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. DoLS provides legal protection for vulnerable people who are, or may become, deprived of their liberty in a hospital or care home. 11 people were subject to a DoLS

Requires improvement

Is the service effective?

authorisation. People's capacity had been assessed and recorded on their care file. Where people did not have capacity, representatives had been involved and best-interests decision made.

We saw that staff sought the consent of people before providing care in an appropriate manner. When people refused care this was documented and reviewed.

We looked at the kitchens and spoke to staff regarding the provision of food and drinks. We ate a meal with people living at the home and observed that staff supported people with their meals. The kitchens were well-equipped and had prepared a varied menu in accordance with provider' guidance. The menu had been adjusted slightly to ensure that people living at the home had access to familiar meals. People on specialised diets were accommodated for. Each meal had a detailed recipe and a list of its nutritional content. This meant that people with special dietary requirements could be catered for within the standard menu or through the production of additional meals. One person living at the home had low-sugar desserts prepared and served to assist in the management of a health condition.

Because of the communication needs of some of the people living at the home we were unable to gather detailed information from them regarding their health needs and the options available to them. Those who did express a view were satisfied with the input from visiting healthcare professionals and the way this had been organised. One person living at the home said, "The doctor comes to see me." Another person told us, "I saw the doctor yesterday. The nurse arranged it." We spoke with a visiting healthcare professional who told us, "Staff are very cooperative."

The service caters for the needs of older people requiring different models of care and support. The environment was similar in each of the five buildings with the exception of the Heather and Moss units where it had been adapted to meet the needs of people living with dementia. These adaptations included the use of different door colours, pictures, photographs and memory boxes to help people locate their own rooms. Some of the walls featured colourful sensory objects and information about activities and events. This approach was not as evident in the lounge areas which were plainly decorated.

Good

Is the service caring?

Our findings

Staff were noticeably busy at mealtimes and when providing personal care, but they were seen to provide care and support with kindness and compassion when engaging with people. One person living at the home said, “Staff are so attentive.” Another person told us, “Nothing seems too much trouble for them [Staff].” A different person said, “Nurses and staff are marvellous. They’re kind. Out of this world, all of them.”

Staff were observed speaking to people with respect. Staff took time to talk to people and demonstrated that they knew the person by the nature of the conversation. There were periods during the inspection when staff did not have time to converse, but they explained to people what they were doing and when they would return. One member of staff said, “It’s more than a job.” Another told us, “It’s like a family.”

The ability of people living at the home to be meaningfully involved in the planning and review of their care differed across the units. Where people lacked capacity we saw evidence that relatives had been involved although this was not consistently recorded in care files. A relative told us, “They [staff] involve me in [relative’s] care.” A member of staff said, “We involve families in care planning. We phone them if they don’t come in.” Where people did have the capacity to be involved we found similar inconsistencies. It was not evident in care records that people were routinely involved in the planning and review of their care or that reviews took place regularly. The manager said this would be addressed more consistently in the future.

Information about the service, activities and events was displayed in each of the buildings. We saw that people had choices regarding their care and were able to exercise their right to refuse care if they chose. Accessible information was available for some people which made use of plain English and images to support understanding. Other people had information relayed to them verbally by the staff.

Throughout the inspection we saw that relatives and friends were able to visit without any restriction. Visitors were known to staff and made use of communal areas. Privacy was facilitated by access to individual rooms where required. Relatives spoke positively about the service and the staff. One relative told us, “The staff are lovely. I can only visit once a week, but staff will always call me if there are any problems.”

Staff promoted the dignity of people living at the home through observation and early intervention when people required support. Some staff were seen to encourage independence at lunchtime through careful prompting in accordance with care plans. One unit specialised in intermediate care and aimed to return people to live in their own homes as quickly as possible following a hospital admission.

Prior to the inspection we were given information of concern regarding people’s privacy and dignity. The bedroom doors of some people were kept open for the purposes of observation, but this sometimes compromised their privacy and dignity. This was demonstrated when people were visible from the corridors while lying in bed. The registered manager told us that this was because staff had to balance the right to privacy with the need to monitor the health and safety of people who were confined to their rooms. They added that they would remind staff to ensure that people’s dignity was preserved where this arrangement was in place.

Requires improvement

Is the service responsive?

Our findings

People's views on the ability of the service to respond to their needs were inconsistent. We observed that the ability to respond in a timely manner was severely affected by the nature of the request and the availability of staff. One person living at the home told us, "Everything was ready for me when I came here." A relative said, "There are nice things going on. When the staff get time they do manicures."

The review of care needs was not consistent. Care plans were 'generic' [they lacked reference to people's individual care needs and preferences] and did not include a schedule for review. The absence of a person-centred approach to the development and review of care plans limited the ability of the service to respond to people's current and emerging needs and is not in-line with best-practice. However, we saw some examples, at the time of the inspection that the regular staff had an understanding of people's needs and responded appropriately. For example, we saw that on one occasion a person was without their glasses and was pointing to their eyes. Without further prompting, a member of staff collected the glasses and passed them to the person. This demonstrated that they understood the needs of the person and were attentive to them. The absence of a person-centred approach to care planning and regular review meant that the quality of care might be compromised if unfamiliar staff were deployed.

This is a breach of Regulation 9 (1) (b) & (c) Person-centred care; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw evidence that people's preferences were reflected in the environment. One person living at the home had strong preferences regarding sport and music. These preferences were evident in the personal belongings present in their room.

Views regarding the availability and suitability of activities were mixed. We saw staff engaging in activities with people, but saw others who were left without significant staff interaction. The service employed a team of activities coordinators although at the time of the inspection this team was depleted. We saw the promotion of a range of activities but little evidence that individual preferences were accommodated within the schedule. The activities team made sure that they visited each of the five units every day even if this limited the time that they could spend in each and the activities available. Details of activities were displayed on notice boards in each unit. One person living at the home told us, "They don't do much here." Another person said, "There's a good atmosphere, we have a laugh at times."

The location had systems in place to record compliments and complaints. The complaints procedure was displayed throughout the service. One relative that we spoke with said that they, "Would go to the office and complain if there was an issue." There was a schedule of resident and relative meetings, but some of the meetings were not minuted or had not taken place. Other meetings were poorly attended. We saw that there was a lack of consistency regarding these meetings across each of the units. None of the people that we spoke with said that they had been asked for their opinions about the service.

We were told that accidents and incidents were monitored by senior staff and that important findings were communicated to care staff and nurses at daily meetings. We found that these meetings were not recorded consistently or may not have taken place. In one case only five daily meetings were recorded for August. This limits the impact of these meetings with regards to communication and accountability.

Requires improvement

Is the service well-led?

Our findings

The registered manager had a range of quality audit processes at their disposal which had identified issues and priorities at the service. We discussed one audit where issues relating to an unlocked sluice room had been identified, but not actioned. In addition to this, the service had also failed to pick up on some of the concerns we found on this inspection. The registered manager told us that they would make better use of audits to establish priorities and monitor actions. The provider showed us evidence of extensive quality and safety audit processes which had been completed at a local and regional level. We saw a number of examples where review schedules for local audits had been missed. We had recently inspected other care home services managed by the provider during which significant concerns were identified. Some of these concerns were of a similar nature to those identified at this location. We found that the issues identified in other homes had not generated learning which might lead to improvement at Rowan Garth. The quality systems in use did not require that quality was benchmarked against current guidance or best-practice approaches.

This is a breach of Regulation 17 (1)(2)(a)(b) & (f) Good governance; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager had recently become registered with the CQC. We discussed the requirements of the role with the registered manager. During the transition between registered managers at the service we found that the procedure for submitting notifications of important events was not being followed consistently. These notifications help us to monitor significant events and identify concerns. A significant number of recent notifications had not been submitted without delay as required. We also discussed that some notifications were sent from the email address of a previous manager which created confusion and delay in subsequent communications. We asked the registered manager about this requirement and were given assurances that all notifications would be submitted in a timely manner from the correct email address. The registered manager was able to explain other responsibilities in relation to registration with CQC and the management of the service.

Discussions with the registered manager and other staff regarding issues within the service were open and transparent. The registered manager was aware of the day to day culture and had identified issues requiring their attention. They were supported by senior managers and other registered managers within the organisation.

People living at the home and the staff on duty were open and engaged in conversation with the inspection team. Their views were honestly and fairly expressed and were free from any obvious influence. This demonstrated that the culture within the service allowed questioning and challenge. One member of staff told us, “[We need to] stop staff getting burnt-out.” Another member of staff said, “Everyone gets on. Everyone works as part of a team.”

We were shown evidence of engagement with the local community and the registered manager told us that this was a priority to promote local networking. They explained that they were working with local partners to bring activities into the location and to provide education on dementia to local schools. We were shown photographic evidence of this engagement.

The registered manager and senior staff demonstrated an understanding of their roles in leading the team and developing the service. Where areas for improvement were identified during the inspection they responded in a positive, professional and timely manner.

We discussed the inconsistencies that we had identified during the course of the inspection and asked what measures would be taken to improve performance in this area. The registered manager acknowledged that there was a lack of consistency in safety and quality and told us that they would, “Find out what is done well and cascade it across each unit. It’s not for [Unit] managers to dictate.”

Observations of staff and discussions with them indicated that the service was fairly managed and that transparency and open communication were encouraged. Staff offered conflicting views regarding the management of individual units. We saw that each operated differently. One member of staff told us, “I did enjoy working here. This place is getting worse week by week.” A member of staff from a different unit said, “It’s a lovely unit here. The staff work hard, but it’s a good team.”

We saw that the visions and values of the service were not clearly communicated to people living at the home, their relatives or staff. Each unit displayed a generic poster which outlined expectations but there was no evidence in care files of other documentation that this information had

Requires improvement

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been discussed or made available in different formats or followed through. Staff were unsure about visions and values when questioned. People living at the home and their relatives did not have a clear understanding of what they could expect from the service.

The registered manager and other senior staff remained highly visible throughout the inspection. Staff approached them on a regular basis for advice and to share information. On each occasion the response given was appropriate and professional.

We saw that some staff were not motivated in their roles and had notified the provider of their intention to leave. We discussed the turnover of staff and the difficulties in recruiting and retaining nursing staff with the registered manager. The registered manager outlined a range of approaches developed by the organisation and told us that recruitment of replacement nursing staff was at an advanced stage.

The location had a set of policies and procedures in place. The policies that were provided had review dates for 2013. An electronic version was available on-line which had been reviewed more recently but it was unclear how easy it would be for staff to access this resource. This meant that they may be working in accordance with policies and procedures which were out of date. We looked in detail at the latest versions of policies relating to recruitment, the management of complaints and quality assurance. We saw evidence that staff and management actions were undertaken in accordance with these policies.