Wellington Healthcare (Arden) Ltd

Rowan Garth Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rowan Garth Care Home is a residential care home providing nursing and personal care to 95 people aged 65 and over at the time of the inspection. The service is registered to support up to 150 people over 5 single storey units. Each unit specialised in different types of support. These included residential or nursing care for people with a variety of health and care needs, including those living with advanced dementia.

People's experience of using this service and what we found
There was a repeated failure from the provider to make and sustain improvements to the quality of care delivered. This is the third consecutive time the provider has been in breach of regulations.

People were at risk of harm because risks were not always assessed, recorded or manged effectively. Staff did not always effectively safeguard people or act on recommendations made by safeguarding professionals to reduce risks identified. Accidents and incidents were not effectively managed to prevent further incidents and lessons were not always learnt.

People were at risk of receiving inadequate care that did not meet their needs because some assessments and care plans were poorly completed and not person-centred. Records were either incomplete, inaccurate or lacked detail to provide staff with guidance on how to support people in line with their needs and preferences. People were not always supported to make informed decisions about their care in a person-centred or timely way.

The service was not well-led. The manager and provider failed to carry out their regulatory responsibilities. Quality assurance processes were ineffective. During the inspection the senior management team and nominated individual ensured immediate actions were taken to mitigate the failures highlighted in this report. However, we are not yet assured that these actions are effective or embedded to ensure that the quality and safety of the service is consistently monitored and improved to keep people safe.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We made a recommendation about this.

Infection control procedures were in place and followed by staff. Staff wore appropriate PPE and the home was clean throughout. Visiting was safe and followed current guidance. People were supported by staff who were kind and considerate in their approach.

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 12 February 2022) and there were

breaches of regulation. 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.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service was a victim of alleged abuse. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of disinhibited behaviours and concerns with aspects of dementia care. This inspection examined those risks. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse and governance.

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.

During the last inspection we recognised that the provider had failed to notify CQC of incidents. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Rowan Garth Care 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 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
This inspection was carried out by two inspectors and one inspection manager.

Service and service type
Rowan Garth Care 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. Rowan Garth is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. However, there was a home manager in place who was in the process of registering with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before 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. We used all of this information to plan our inspection.

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 2 people who used the service and 5 relatives about their experience of the care provided. We spoke with 10 members of staff including the manager, director of care and quality, regional manager, clinical support manager, senior care workers and care workers.

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 reviewed a range of records. This included 10 people's care records, and 4 people's medication records. We looked at staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

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 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

- People were exposed to serious risk of harm due to a lack of person-centred risk assessment. Risk assessments were either not completed, not accurate or reflective of people's current needs, or detailed enough to guide staff on safely supporting people.
- People were at an increased risk of harm as risk assessments were not always followed. For example, one person was assessed as needing a floor sensor and chair sensor due to being assessed as a high risk of falls. Our observations and checks on the bedroom showed these were not in place. Staff gave us mixed responses when we asked if they should be in place.
- People were at increased risk of pressure sores as care plans did not always reflect the support they required. Where people were supported with repositioning to prevent pressure sores, records showed this did not always happen in line with their assessed needs.
- There was a process in place to record accidents and incidents, but this wasn't always followed. There were incidents that had not been recorded or investigated.
- Accident and incident analysis was not robust enough to prevent further incidents. We found repeated incidents had occurred with no appropriate risk mitigation put in place.

Systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service were not effective. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the concerns raised during the inspection and reviewed risk assessments and plans for people. However, we are not yet assured that effective systems are in place to ensure new or changing risks will be promptly identified and mitigated to consistently promote peoples safety.

- Plans were in place to ensure people's needs would continue to be met in the event of an emergency.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is

usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● People's ability to consent to care and treatment had been assessed and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. However, there was failure to consistently review this and consider people's ability to consent when people's needs changed.

We recommend the provider seeks advice from a reputable source and update their practice accordingly.

Systems and processes to safeguard people from the risk of abuse
● People were placed at an increased risk of abuse as processes to prevent abuse were not always followed.
● Multiple safeguarding incidents had not been referred to the local authority for investigation to ensure people were protected from abuse.
● Safeguarding incidents that had been recorded had not always been investigated appropriately by the manager or provider.
● Not all staff were aware of their responsibilities regarding safeguarding.

Systems and processes to safeguard people form the risk of abuse were not established and operated effectively. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to concerns raised and reviewed local safeguarding processes and arranged for enhanced safeguarding training for staff. However, we are not yet assured that these processes are effective, embedded and used consistently by all staff to protect people from the risk of abuse.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had been made and the provider was no longer in breach of this part of regulation 12.

● Medicines were managed safely and administered as prescribed.
● Staff were trained to administer medicines and had their competency checked to ensure they were safe to do so.
● Medicines records were audited regularly by the management team to ensure that people received their medicines safely.

Preventing and controlling infection
● The home was clean. However, there were strong malodours present on some of the units on both days of the inspection. Some relatives told us they also noticed strong malodours when visiting.
● Measures were in place to ensure the risks of the spread of infection were reduced. Staff had access to appropriate PPE and wore this as outlined in national guidance.
● We were assured effective infection prevention and control (IPC) policies and procedures were in place at the home.

Staffing and recruitment
● There were enough suitably qualified staff to support people. However, we received mixed feedback about

staffing levels from staff and relatives. We raised these concerns with the provider to monitor.
● A dependency tool was in place and used to ensure people's needs could be met.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Records of care delivered were inconsistently completed and did not always show people had been supported with their needs or preferences.
- Where people expressed distressed behaviours there was a lack of appropriate person-centred management plans to guide staff in supporting people in a dignified and respectful manner.
- People were not always supported to be involved with decisions about their care. One person, who had capacity to make decisions about their care, had plans that showed restrictions on how they lived their life were in place. This had been assessed as needed to keep the person safe, but no discussions had taken place with the person to ensure they agreed to this.
- Relatives with the appropriate legal authority were not always included in discussions about people's care. Most relatives told us they had never seen a care plan or had a discussion about care needs or preferences. One relative said, "I worry [person] doesn't get much attention. [Person] is bed bound and I don't know how they support that. I've never seen notes or a care plan. I've never been involved in those discussions."

Systems had not been established to ensure people received person-centred care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection to review people's social and health needs and preferences. However, we are not yet assured that effective systems are in place to ensure these systems are consistently used for all people who received care at the service.

- Staff were kind in their response to people and their approach was observed to be patient.
- Staff encouraged people to express their day to day wishes, such as which food they wanted to eat.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not always promoted consistently. On one unit all bedroom doors had been locked without consideration to people's independence and freedom to access their bedrooms. This practice was immediately reviewed and changed when we raised concerns.
- People told us staff were respectful and protected their dignity and privacy. One person said, "Staff are respectful. They always explain to me what they are doing".

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

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure systems and processes were in place to consistently monitor and improve the quality and safety of the service and failed to ensure records were completed accurately and in full. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation.

- This is the third consecutive time the provider has been in breach of regulations. This demonstrated a continued failure to make and sustain improvements to the quality of the care provided.
- Systems were not robust enough to ensure learning from incidents was implemented to further reduce risk to people.
- Governance arrangements did not consistently promote the provision of high-quality, person-centred care which fully protected people's human rights.
- Systems to monitor the quality and safety of the service were not used consistently or effectively.
- People were at risk of receiving poor care because risks to their safety and well-being were not consistently assessed and managed appropriately to protect them from harm.
- Records were not always of good enough quality to guide staff on how to meet people's needs safely in a person-centred way. This meant there was a risk care and support provided may be unsafe.
- The provider had failed to notify CQC of significant events as legally required under the regulations. Governance checks had not identified all of these missing notifications.

The provider failed to ensure governance procedures were always effective to monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection to address the immediate risks to safety that we identified. However, we are not yet assured that any changes to governance systems are effective or embedded to ensure the quality and safety of the service is consistently monitored and improved.

● There was a manager in place. They had applied to CQC to register shortly before the inspection started.
● Ratings form the last inspection were displayed in the home as required.

Working in partnership with others
● Staff made referrals to other services, such as dieticians, for additional input, advice and support when necessary to support people's health and well-being.
● The provider worked closely with other professionals, including the local authority, to improve the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were systems in place to obtain feedback from people and their representatives about the running of the service. However, some relatives told us they had not been asked to provide feedback on their experiences of the care provided.
● Most relatives said they had not been involved in care planning or reviews of care plan information.
● Staff told us they were supported and felt the management team were approachable.

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 provider understood their duty to share information in an open, honest and timely manner. There was a policy in place regarding this.
● We found the provider receptive to feedback about the shortfalls found during the inspection.