Rowena House Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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 ten people living at the home on the first day of the inspection and fifteen people on the second day of this inspection.

People's experience of using this service and what we found
Risks to people were not always assessed and managed. Staff were not always aware of the risks to people they supported. Suitably qualified, competent, skilled and experienced persons were not deployed to meet people's needs at night. Appropriate checks were not always carried out before staff started to work at the service. People's medicines were not always safely managed.

The providers systems for assessing, monitoring, and improving the quality and safety of the service were not operating effectively. They failed to identify issues we found at this inspection. There were safeguarding vulnerable adults' procedures in place however the registered manager failed to notify the CQC about safeguarding allegations and police visit in respect of these concerns.

People had individual emergency evacuation plans which highlighted the level of support they required to evacuate the building safely. The provider and staff were following government guidance in relation to infection prevention and control. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff said they received good support from the registered manager. The provider took people's and their relatives' views into account through meetings and feedback was used to improve the service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 7 October 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which contain those requirements. The second day of the inspection was prompted in part due to concerns received about potential risks relating to people's night-time care. A decision was made for us to inspect the home during the night and examine those risks.

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 and Recommendations
We have identified breaches in relation to assessing and planning for peoples care needs and managing people's identified risks, managing people's medicines safely, protecting people from abuse, recruitment records, training and inducting staff and the overall management of the home.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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 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
Three inspectors carried out this inspection over two days. One of these was a night-time inspection.

Service and service type
Rowena House 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. Rowena House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

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. 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. We used all this information to plan our inspection.

During the inspection
This inspection was carried out over two days. After the first day of the inspection we received information about potential risks relating to people's night-time care. A decision was made for us to inspect the home during the night and examine those risks. Across both inspection days we spoke with three people using the service, seven care staff, the registered manager, and the registered provider. We reviewed a range of records. This included seven people's care records and four medication records. We looked at three 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.

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 the rating has changed to Inadequate: This meant people were not safe and were at risk of avoidable harm.

At our last two inspections (Published 7 October 2021 and 13 August 2020) we found that care and treatment was not always provided in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- At this inspection we found that risks to people were not always assessed and managed. Staff were not always aware of the risks to people they supported. Following the first day of our inspection the registered provider admitted seven new residents into the home. We saw referral information from the local authority for these people that described their care and support needs. However, we found that preadmission assessments and risks assessments had not been completed and care plans were not put into place to ensure their needs were safely met.
- During our night-time visit we observed a person walking along the corridors on their own and using the stairs. We saw a new resident file for this person that included the local authority's referral information and where the registered manager had highlighted areas for staff to be aware of. The highlights referred to the person being at high risk of falls, and that they required supervised mobility. A staff member told us they were not aware that the person was at risk of falls.
- Another person's records referred to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order being in place. However, these records were inaccurate as the person did not have DNACPR orders in place. This meant there was a risk that staff would not attempt to resuscitate the person who if they wished to be resuscitated.
- A third person's local authority referral information recorded they were unsteady on their feet and they used a walking stick. However, there was no falls risk assessment or mobility care plan in place for this person.
- The registered manager told us they had not had any time to complete people's needs assessments or care plans. A staff member told us, "We are not always sure on what people's needs are.'
- People were not always protected from the risks that can arise in the event of a fire. During our night-time visit we observed a person's bedroom door was wedged open with a chair. We saw another person's door was wedged open with a box of music CD's. When we pointed this out to the registered manager, they removed the chair and closed the door. The registered manager told us these people did not have risk assessments in place for holding their bedroom doors open. We made a referral to the London Fire Brigade after the inspection.

Risks to people were not always assessed and managed. This placed people at risk of receiving poor care. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014.

At our last inspection we found medicines were not always safely managed, this placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were not always safely managed. Medicines administration records (MAR) were not always accurately completed. We found discrepancies with medicines administered for two people. One person's stock of blood thinning medicine (Warfarin) did not tally with what was recorded in the MAR, so we were unable to determine whether this person was receiving the correct dose each day. Another person on a 'as required' medicine was prescribed one or two tablets daily. Their MAR recorded they had been administered one tablet each day however the remaining stock did not tally with this, so it was unclear what dosages had been administered. This placed people at risk of not receiving their medicines as prescribed by health professionals to maintain their health.

● During our night-time visit we found there was no competency check in place for the staff member who had administered medicines to people the previous night. We found a medicine for one person had not been signed by this staff member as administered. We pointed this out to the registered manager. They told us they had asked the staff member and they had said the medicine had been administered but they had not signed for it. However no further check took place, such as checking the stock of medicine to make sure the medicine had been administered.

People did not always receive appropriate support to take their medicines. This placed people at risk of receiving poor care. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014.

We raised these issues with the registered manager who accepted they could not always be sure MAR records were accurate. They told us they would contact the GP to discuss the person's blood thinning medicine (Warfarin).

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection we found that people were not always protected from abuse and improper treatment. 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.

● People were not always protected from the risk of abuse. There were safeguarding adults' procedures in place and staff had received training on safeguarding adults. However, during our night-time visit we a staff member was not able to provide examples of what might be considered as safeguarding, they suggested it was about "safety and doors closing."

● On the first day of our inspection the registered manager told us they understood their responsibilities in relation to safeguarding and told us they would report any concerns immediately to the local authority and CQC. However, we found they had not notified the CQC of a recent safeguarding allegation they were made aware of or a visit from the police in relation to the allegation.

● The provider had systems in place for monitoring incidents and accidents however we saw nothing had been recorded in the system since June 2022 and it was ineffective. There was an incident report from 25th September 2022 where a person sustained a facial injury. The providers accident and incident audit did not include any information about the incident, or any actions taken by the provider or lessons learned.

Safeguarding adults' procedures were not being followed This placed people at risk of receiving poor care. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● On the first day of our inspection staff told us they would report any concerns about abuse to the registered manager. They also told us they had access to a safeguarding adult's helpline where they could report abuse if they needed to.

Staffing and recruitment
● Appropriate checks were not always carried out before staff started to work at the service. A staff member told us they had worked on and off at the home for many years. However, there were no records of this person's employment history, interview notes or evidence of health checks in their staff file.
● Agency staff did not always have appropriate checklists or profiles in place despite some staff working at the service since 26 September 2022. Following the inspection, the registered manager sent us evidence that DBS checks had been completed for these staff. They provided us with agency staff profiles that included the staff names, addresses and telephone numbers. However there was nothing on the checklists to assure the provider that the agency staff had received training relevant to supporting people with their care needs and nothing to confirm that the agency had carried out all the necessary recruitment checks for these staff.

People were at risk of receiving care and support from suitable staff. This placed people at risk of receiving poor care. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Suitably competent, skilled and experienced persons were not deployed to meet people's needs at night. Staff did not check on people at night to ensure they were safe. Two people using the service were up when we arrived at 5am. One person told us, "I was kept up all night by a resident singing and clapping. I never saw any staff. I went to bed at 10pm and no one checked on me. Normally staff come to see if I am ok, but I didn't see anyone last night." Another person was asked if they saw any staff during the night, they said, "I didn't see any staff, I came down to watch TV for a while."
● An agency member of staff told us this was her first time working at the home. They said they had not been provided with a handover or any information about people's needs. A staff member told us they had shown the agency worker around the home and told them people using the services names. This meant service users were at risk of not receiving appropriate support from staff who had not been given the information they needed to perform their roles.
● The agency worker told us they had not been provided with the code to unlock the kitchen, so they were unable to make people drinks or snacks if they needed them.

People did not always receive care and support from staff when they needed it. This placed people at risk of receiving poor care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they used a dependency tool to assess the number of staff that was appropriate to meet peoples care needs safely. A staff member told us, "We have enough staff to meet people's needs. If people's needs changed the registered manager would make sure we have more staff."

Ensuring consent to care and treatment in line with law and guidance
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)

● The provider was working within the principles of the MCA and DoLS. We saw applications had been made to the local authority DoLS team where required, to deprive a people of their liberty.

Preventing and controlling infection
● The provider was taking appropriate measures to prevent people and staff catching and spreading infections.
● Staff had received training on COVID-19, and infection control and they had access to personal protective equipment (PPE). Throughout the inspection we observed staff wearing appropriate PPE and abiding by social distancing rules.
● The registered manager told us they had received good support from the local authority public health lead and infection control team. The home had received a certificate of excellence from the local authority in recognition that all of the people using the service and staff had been vaccinated
● There were no restrictions placed on people's relatives visiting them at the home.

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 the rating has changed to Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found that despite some improvements to the provider's systems for monitoring the quality and safety, there remained shortfalls with their quality monitoring and governance systems. This was a breach of regulation 17 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 17

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

- The providers systems for assessing, monitoring, and improving the quality and safety of the service were not operating effectively. The provider failed to identify issues we found at this inspection.
- The provider did not ensure that appropriate procedures were followed when admitting new people to the home to ensure the process was safe. Seven new people had moved into the home following the first day of our inspection however their needs had not been assessed, risk assessments had not been carried out and there were no care plans in place for staff to follow to meet their needs.
- The provider's systems to make sure medicines were managed safely were not effective.
- The management team were not working together to make sure the service was meeting people's individual needs. We observed that the working relationship between the registered provider and registered manager was not a supportive one or conducive to the effective running of the home. They disagreed with each other about recent admissions to the home. The registered manager told us they felt overwhelmed and they hadn't had time to carry out preadmissions, risk assessments or draw up care plans for the new admissions to the home. The registered provider openly challenged the registered manager on his performance and attendance at the home.
- There was an organisational structure in place, but staff were not always supported to carry out their roles effectively. A staff member told us "We have some new residents, the registered manager is trying very hard, but the provider doesn't help."

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- A person using the service who did not understand or speak English did not have any key words for staff to use to communicate with them. A staff member told us, "The lady can't speak English, I can't understand

her, I know she doesn't have a care plan, I use my experience and go along with her." This person had moved into the home almost week prior to our night-time visit. The registered manager told us a preadmission assessment had been completed for this person, but they were unable to produce this upon request.

● People's needs had not been assessed and staff did not have any guidance about how to support them in a person-centred way. Due to the lack of needs assessment people did not have goals or outcomes to achieve. People had not been asked about their preferences and staff did not know what people's preferences were.

Staff were not made aware of peoples care and support needs. This placed people at risk of receiving poor care. This was also a breach of regulation 9 HSCA RA Regulations 2014 Person-centred care

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

● On the first day of our inspection we saw that people and their relatives' views were sought through meetings. Minutes of meetings showed people had made positive comments about food, activities and the support they received from staff. Where issues were raised, action was taken to address them. For example, at the last relatives meeting, relatives discussed taking family members out for trips and setting up a group on a telephone application to help with. communication. The registered manager told us relatives had been taking their loved ones out and the communication group had been set up. Relatives also commented they enjoyed a coffee morning held at the home.

● We saw no evidence on the second day of our inspection that people using the service, or their relatives had been involved in planning for their care and support needs.

● Staff views were gathered to improve on the quality of the service. Staff told us regular staff meetings were held to discuss the running of the home and to discuss areas of good practice. A staff member told us, "We talk a lot about people's needs, staff training needs and the latest COVID-19 guidelines. Staff can voice their opinions at the meetings. I feel that I am listened to."

● Some staff told us they felt supported in their role. A staff member told us, "The registered manager's door is always open, I get on well with him. He is a good manager and things here have been much better since he came along." However other staff told us, "We had a deputy manager before, but the provider took them away. The new deputy isn't always here. We are not always sure on what people's needs are, the provider puts pressure on the registered manager to get people.

● The provider did not always act in line with the duty of candour. We saw an incident report from 25th September 2022 where a person sustained a facial injury however there was no evidence that the injury had been discussed with the person's family.

Working in partnership with others

● The registered manager told us they worked closely with health professionals such as the GP and district nurse. They said they were working closely with the local authorities commissioning team who they said had helped them make improvements at the home. They also had positive working relationships with the public health lead and infection control team and the Clinical Commissioning Group.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to assess the needs of people using the service and devise with them a plan for how those needs should be met.

The enforcement action we took:

We served a notice of proposal to cancel the registered manager and registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks faced by people using the service had been properly assessed and mitigated.

The enforcement action we took:

We served a notice of proposal to cancel the registered manager and registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems and process had failed to identify and address issues with the quality and safety of the service.

The enforcement action we took:

We served a notice of proposal to cancel the registered manager and registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure appropriate checks had been carried out on staff to ensure they were suitable to work in a care settings.

The enforcement action we took:

We served a notice of proposal to cancel the registered manager and registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received the support and training required to perform their roles.

The enforcement action we took:

We served a notice of proposal to cancel the registered manager and registered providers registration.