Care Quality Commission

Avery Homes (Nelson) Limited

Rowan Court

Inspection report

Silverdale Road
Newcastle under Lyme
Staffordshire
ST5 2TA

Date of inspection visit:
25 October 2016

Date of publication:
08 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 October 2016 and was unannounced. At our previous inspection in November 2015 we had concerns that care being delivered was not safe and there were insufficient staff to meet people's needs in a timely manner. We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in Regulation 12 (Safe Care and Treatment) and Regulation 18 (Staffing). At this inspection we found that there had been some improvement, however the provider continued to be in breach of these Regulations. We also found further concerns and three further breaches of regulations in safeguarding people from abuse, people consenting to their care and the overall governance of the service. The overall rating for this service is Inadequate which means it will be placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Rowan Court provides care and support, including nursing care, for up to 76 people, some of whom may require dementia care. At the time of the inspection there were 67 people living in the home.

The home was divided into three separate units. These were the Nursing Unit which accommodated up to 42 people requiring nursing care. The Memory Unit which accommodated up to 19 people requiring dementia care and the Residential Unit which accommodated up to 15people requiring personal care. We visited all three units and found some areas of concern in all three units.

There were still insufficient suitably trained staff to safely meet the needs of people in a timely manner throughout the service. People did not always feel safe with the availability of staff.

Care being delivered was not always safe. Risks of harm to people had not been minimised through the effective use of risk assessments. Action was not always taken to keep people safe.

Staff we spoke with all knew what constituted abuse and told us they would report it if they suspected abuse had taken place. However allegations of neglect were not always investigated.

People's medicines were not always managed safely. People were at risk of not receiving their prescribed topical creams.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the DoLS ensures that people are not unlawfully restricted. We found that people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves and some people were at risk of being unlawfully restricted.

Staff felt supported however they did not have all the training and support they needed to be effective in their roles. Staff performance was not always monitored to ensure good quality care was delivered.

People had a choice of food and were supported to maintain a nutritional diet. However some people required their food and fluid intake monitoring and this was not always completed. This could put people at risk of malnutrition.

People had access to health care support, however professional advice was not always followed to meet people's assessed needs.

People told us that they were treated with dignity and respect. However we saw some practises that did not always uphold people's right to privacy.

People did not always receive personalised care due to a lack of available staff. Staff were not always made aware of incidents that may affect the way they cared for and responded to people.

There were a range of activities and hobbies available for people to participate in. Activity staff did what they could do to involve as many people as they were able to throughout the service.

The provider had a complaints procedure and people felt able to complain if they needed to. Staff were employed using safe recruitment procedures.

Systems the provider had in place to monitor and improve the service had not been effective in ensuring the quality of care being delivered was safe.

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 did not always receive care and treatment that was safe. Risks to people were not always assessed and minimised.

People were not always safeguarded from abuse or the risk of abuse as potential abuse was not always investigated.

There were insufficient suitably trained staff to safely meet people's needs in a timely manner.

People's medication was not always managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was not following the principles of the MCA and ensuring that people were consenting to or being supported to consent to their care.

Staff were not always supported to fulfil their role effectively.

People's nutritional needs were met, however food and fluid monitoring was not always in place when required.

People had access to health care, however appropriate advice and support was not always gained or followed.

Is the service caring?

Requires Improvement

The service was not consistency caring.

People's right to privacy was not always respected.

People did not always have quality time spent with them due to a lack of staff.

Staff were kind and caring when interacting with people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their individual needs.

A lack of available staff compromised people's choices.

The provider had a complaints procedure and people told us they were able to complain if they needed to.

Is the service well-led?

Inadequate

The service was not well led.

The provider's systems to monitor and improve the quality of the service were ineffective.

No improvements had been made since our last inspection and we found further breaches of Regulations.

People liked the registered manager and told us they were approachable.

CareQuality Commission

Rowan Court

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 had made improvements since our last inspection and was 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 25 October 2016 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners. We used the provider's action plan to inform the inspection.

We spoke with 10 people who used the service, four relatives, eight members of staff, two nurses, the registered manager and operational manager. We observed people's care in the communal areas.

We looked at the care records for nine people who used the service. We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incident, accident and complaints records and minutes of meetings.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment being delivered was not always safe. At this inspection we found that some improvement had been made in the management of medicines and the deployment of staff. However we found further concerns and continuing risks to people as they were still not receiving care and treatment that was safe.

We saw one person had been assessed by a speech and language therapist as requiring their fluids thickening as they were at risk of choking. We saw the thickening powder with the prescribing details on it in the person's room. However we saw they had a drink of unthickened cordial within reach of them, which if they had drank would have put them at risk of aspiration. We were informed that it had been identified that family members had been giving the person unthickened drinks when visiting and they had been spoken to about this. However, this continued to occur as it did on the day of the inspection. We spoke to the nurse on the unit who told us they were unaware that this person had been given an unthickened drink. We had observed this as at previous inspection. This meant that this person was at continued risk as their assessed needs were not being met.

We found that risks to people were not always assessed and minimised. Some people experienced periods of challenging behaviour. A person's behaviour can be defined as "challenging" if it puts them or those around them at risk, or leads to a poorer quality of life. The risk assessments and care plans did not inform staff comprehensively how to care for people. We saw one person had been regularly assaulting other people, including people who used the service, their visitors and staff. The person had been referred to a health professional for advice and support and was awaiting an appointment. However, the risk of these incidents occurring again had not been reduced and no precautions had been put in place to minimise the risks to people. This put people at continued risk of being physically assaulted and of being injured whilst at the service.

Another person became anxious and aggressive when being supported with personal care. We looked at the person's care plan and it stated that staff should verbally reassure the person when they were anxious or walk away and return when the person was calm. One member of staff told us it could take up to three members of staff to support the person at these times and another member of staff told us it took two. Staff described different ways they supported the person at these times and it was unclear how the person was being supported and whether it was safe as there was no clear risk assessment. We saw records that showed the person regularly received unexplained bruises and staff were regularly receiving injuries whilst supporting the person at these times. This meant that this person and the staff were at risk due to ineffective risk management.

We saw one person had an increase in falls which had resulted in injuries. We were told that the person refused to use the equipment made available to them to help them with their mobility. We saw the person's risk assessment stated that the person required a sensor mat when sitting. However it did not assess the risk associated to them not using their equipment and no control measures had been put in place. We observed

the person walking around the service unsupervised on several occasions with an injury which would have increased the risk of them falling again. The unit manager on duty told us that they referred the person to the 'falls team' on the day of our inspection.

We found following the previous inspection that some areas of improvement were noted with the management of medicines. However, we looked at the way that medication was stored and administered and found that several people had 'topical' creams in their bedrooms which did not have prescribing labels on. There were no instructions to staff as to where and when the creams should be applied and we found that staff were not signing to say the creams had been administered. This meant that the provider could not be sure that people were having their prescribed medication applied where and when they needed it. This put people at risk of harm.

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

At our previous inspection we found the provider was in breach on Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient staff to meet people's needs in a safe and timely manner. At this inspection we found that no improvements had been made as staffing levels had not been assessed and there had been no increase in staff numbers.

At our previous inspection people told us that there were not enough staff to meet their needs. A relative had told us that people were often left unsupervised in the lounge areas which left people at risk of falls and assaults from other people who used the service. At this inspection we observed that there were still times within the Memory and Residential units that people who were at high risk of falling and unpredictable behaviour from other people were left alone in the lounges. A relative told us: "I think sometimes they are short staffed for all the residents they have and sometimes I've been in the lounge and there's no one there and people are left by themselves". People told us they didn't always feel safe. A person who used the service told us: "There isn't enough staff they could certainly do with more, especially at night if there was an emergency they wouldn't manage".

There were four members of staff available on the Memory unit and this included the member of staff who was responsible for administering the medication .Staff on the unit told us that there were times when it took three members of staff to support one person who used the service as they became anxious and resistive to personal care. This would only leave the member of staff administering medicines to care for the other 18 people. On the Residential unit there were only three staff available and it took two staff to deal with some people's personal care and this would leave the person responsible for administering the medication care for the other people within the unit, this left people at risk of not receiving the support they needed in a timely manner. On the Nursing unit we saw some people were only just being served their lunch at 14.15 as there were not enough staff to facilitate this in a timelier manner. A member of staff told us: "We could do with another pair of hands as it sometimes impacts on care". On the Nursing unit a member of staff told us: "There are not enough staff, we are constantly rushing between people and we don't have any time to spend with people. Some people are cared for in bed all day and we are the only people they see and some people want to talk and it's not possible".

Some staff told us they didn't have time to read people's care plans. One staff member told us: "It's hard sometimes; the unit manager doesn't have time to do the paperwork as we are all rushed off our feet". We saw that people's care plans and risk assessments were not always up to date with the relevant information to be able to care for people safely.

Staff told us that they had not been trained in how to safely support people whose behaviour may challenge; although a two day course on how to care for people living with dementia had been arranged. We found that staff and people who used the service were being regularly assaulted. Staff were receiving injuries when supporting some people with personal care and at other times when people became anxious and aggressive. We saw records that confirmed some people who used the service had assaulted other people who used the service on a regular basis. However staff had not been trained to intervene safely to protect people from further harm.

The above issues constitute a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to knew what to do if they suspected someone had been abused or was at risk of potential abuse. However we saw records that showed one person had been regularly assaulting other people who used the service and although some of the incidents had been reported to the local safeguarding team for further investigation not all had. We saw that staff had recorded that one person was found with bruising which was unexplained on several occasions. No investigation into the bruising or referral for further investigation had been made. This meant that the registered manager and staff were not following the safeguarding procedures by reporting incidents of suspected abuse. This meant that people were not always being safeguarded from abuse or the risk of abuse.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a staff recruitment procedure in place including carrying out relevant checks such as Disclosure and Barring Service (DBS) to ensure that staff were suitable to work with people who used the service. The provider obtained suitable references, employment history and DBS checks for each person before they were offered employment.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had concerns that care being delivered was not always effective. At this inspection we had further concerns. We found the provider was not following the principles of The Mental Capacity Act 2005 (MCA). The 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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. We saw that some people had a 'Do Not Attempt Resuscitation order'. We could not see that people's capacity to consent to the DNAR's had been assessed and that they or their representative had been involved in the decision for this DNAR order. For example, we were told by a nurse that one person had fluctuating capacity which meant there may be times that they were able to discuss the implementation of a DNAR. We saw that this person's DNAR had been signed by the clinician and it was recorded the person did not have capacity. The person or their representative had not been involved in the decision.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some people had been referred for a Deprivation of Liberty authorisation. A relative told us how the needs of their relative had changed in relation to their mobility. They told us: "Because of frequent falls the staff have now decided for safety to put my relative into a sling and wheelchair all the time'. We saw this person ask a member of staff for help to stand up and they were told they couldn't. The person's care records confirmed that the person could walk with assistance however was at risk of falling. The decision to restrict the person to a wheelchair had not been discussed and agreed as the least restrictive. The provider had not followed the MCA and DoLS process to ensure that this restriction was lawful.This meant this person was being unlawfully restricted of their liberty.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

People we spoke with told us they felt that staff were competent in their role. One person said: "I would think the staff are trained they seem capable". A relative told us: "I'm not told what qualifications these carers should have, what I can say is they are kind, talk to people and seem to care". Staff we spoke with gave us mixed responses as to whether they felt supported to fulfil their role. Some staff told us there were not enough staff to be able to fulfil their role effectively. Other staff told us they had not received training to be able to fulfil their role competently. For example staff had not been trained to support people safely who may become anxious and aggressive and inconsequence were getting regularly assaulted. The registered manager told us that some dementia training was being sourced later that week and they were hopeful that this training would support staff to care for people when they were anxious.

If people lost weight we saw that this was acted upon, however some people required their food and fluid intake monitoring. However on the nursing unit records were not always in place. This meant that the provider could not be sure that people received adequate food and fluids. People were offered choices of

food and if required special diets were catered for. Some people required soft food to prevent the risk of choking and we saw this was available to them. People generally told us they were happy with the quality of the food and they had enough to eat and drink. One person told us: "I have enough to eat and the food is nice and hot and I can have a drink anytime I want". Some people required support and encouragement to eat and we saw that staff spent time with people ensuring they had adequate nutrition. We observed that people were offered more food when they finished their meal to make sure they had sufficient to eat.

People had access to a range of health care professional and generally referrals for professional advice were sought. However health care guidance was not always followed, for example people who had been assessed as requiring thickened fluids did not always get them and care plans in relation to catheter care were not always followed. We saw three visiting GP's on the day of the inspection. A relative told us: "A Dr comes in once a week and a district nurse every other day to see my relative; I've just put their name down to see the visiting chiropodist".

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had concerns that some people who were being cared for in bed experienced isolation and staff did not always have the time to spend with them. At this inspection although people themselves did not tell us this, staff told us they didn't feel there was enough staff to spend quality time with people and that care was rushed. We observed that staff had little time to spend quality time with people who were in bed as they were busy competing tasks . A relative told us: "On the whole, it's ok here. It's just the shortage of staff".

People told us and we saw that they could get up and go to bed when they liked. One member of staff told us: "Yes people can get up when they like, it's called natural waking". However a member of staff told us they felt the night staff should be getting people up to help the day staff. This did not demonstrate a caring attitude and when we discussed it with the registered manager they knew which member of staff this was but it had not been addressed.

Mostly people's privacy was respected. However we saw in the Nursing unit that some people were being cared for in bed and so they didn't feel isolated their doors were kept open. However some people required a catheter and we saw several catheter bags in full view of the corridor which were full of urine. The registered manager and operations manager agreed that this did not promote people's dignity.

People we spoke with told us they felt that the staff were kind and caring and we observed caring interactions throughout the inspection. One person who used the service told us: "Me and the staff get along well, they tell me I'm the best thing since sliced bread". We observed staff talking with people and telling them what they were going to do before doing it. We saw one staff member bend down to a person in a wheelchair and gently put their feet on the foot rest whilst talking with them. We saw staff and people liked to have a laugh and some banter with each other. One person who had been talking about dancing asked a member of staff to rub their back as it was aching and the staff member obliged whilst asking them, "Where did you used to go dancing"?. They continued to laugh and chat about the old days and ballroom dancing which they enjoyed.

Relative and resident meetings took place to encourage people to have a say in how the service was run. One person told us: "They do have meetings, I don't know how often but I do go and you can vent your feelings there can't you"? Relatives were free to visit and we saw several visiting relatives on the day of the inspection. The registered manager told us how if their relative was unwell, relatives were able to stay overnight. They told us: "We have a put you up bed and recently a relative spent five nights with their relative until they unfortunately passed away".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had concerns that care was not always personalised and met people's individual needs. At this inspection we found that some people had little or no individual time spent with them. On the Nursing unit a large proportion of people were being cared for in bed and staff told us they did not have time to spend with them and this meant they were at risk of isolation.

People's care plans were regularly reviewed by the managers however they did not always reflect people's current care needs. We saw examples of where staff did not always follow care plans to ensure people received care that reflected their needs. For example, the management of one person's challenging behaviour. We could not see how people or their representatives were involved in the reviewing of their care as it was not clear in people's care records. Some people told us they were involved and others told us they were not. A relative told us: "I was involved in the care planning at the beginning of my relatives stay but we haven't discussed it since, but they seem much improved since being here".

When people's care needs changed the staff and managers responded however, this was not always done in a safe manner. We saw people who experienced periods of anxiety and unease and who were putting themselves and others at risk had not had their changing needs responded to, to minimise risk and keep people safe. We saw people who were at high risk of falls had received some support when a change in their mobility had been noted. However this was not always appropriate or to the person's preferences or in the least restrictive for the person.

We saw and people told us that there was range of activities that were available to people. One person told us: "The activity girl comes round and says what we're having today. I don't always go. They've got a singer coming you know and we all sing together". The afternoon entertainment arrived at 14.00 and was arranged to take place in the dining room on the Nursing floor. Some people were still receiving their lunch on the nursing unit so were disturbed. The activity coordinators planned activities and entertainment and rotated around the units to try and involve as many people as they could and who wished to join in.

The provider had a complaints procedure and we saw it was visible in the reception area. The registered manager told us there had been no recent complaints. People told us they felt they were able to complain if they needed to. One person said: 'I've no complaints, some might think I don't get enough care but I'm all right being where I am now. It isn't perfect but there are people a lot worse off".

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had concerns that the service was not consistently well led. We had found two breaches of Regulations and asked the provider to improve. Following the inspection the provider sent us an action plan telling us how they planned to improve. At this inspection we found that minor improvements in relation to the management of people's medicines and the deployment of staff. However we found further concerns in medicines management and in the staffing levels and a further three breaches of Regulations.

The provider's action plan told us that the staff availability would be reviewed rather than the staffing levels in relation to the breach of Regulation 18 (staffing). We had found that there were insufficient staff to keep people safe. At this inspection we found the only change that had been made since the last inspection was that one member of staff was starting earlier on the Nursing unit. The staffing levels across all three units had not been assessed and increased and we found that people were still not receiving care in a safe and timely manner. The registered manager told us they were able to increase the staffing levels when they needed to. However the levels had not been increased to meet people's needs. Even though one person had been assessed as requiring more support than the service could give, staffing had not been increased to keep people safe and minimise risk of harm. We discussed this with the registered manager who was unable to tell us why this had not been done.

The units lacked clear leadership and management. We saw that a person who required thickened fluids had a drink that was not thickened. Staff were not able to tell us who had given the person the unthickened drink. Following the inspection we were informed that the person's relatives had been seen on several occasions to give this person a thickened drink. This had not been managed effectively to ensure did not happen. We saw records that confirmed that a serious incident had occurred which may affect the safety and wellbeing of people, staff and visitors in one unit. The unit manager and staff we spoke with on the unit were not aware of the incident. The information had not been passed on and the risk of the incident occurring again had not been minimised. On another unit the nurse was not aware until alerted by an inspector that staff gave one person unthickened fluids which put them at risk of choking. Care plans were not being followed in relation to people's catheter care. There were three nurses on duty and it was not clear who was responsible for the day to day management of the Nursing unit.

There was a medication audit completed however it did not check people's prescribed topical creams were being managed safely and effectively. We found and identified concerns with the use of topical creams, some did not have with prescribing labels and there were no clear instructions for care staff. This showed that the medication audit was ineffective and left people at risk of not having their prescribed creams and becoming unwell.

Policy and procedures were not always being followed to ensure that people were safe and were consenting to their care, treatment and support. We saw incidents of suspected abuse had not been referred to the local authority and some people were not being supported to consent to the care. This meant that people were not always being safeguarded from abuse and the principles of the MCA were not being followed to ensure care being delivered was safe and appropriate.

Not all care records were up to date and some did not contain the information to be able to care for people safely. Some records were not in place such as food and fluid monitoring records for people who were at risk of malnutrition. Risk assessments in relation to supporting people with challenging behaviour lacked comprehensive information. Staff had not received training to support people who experienced challenging behaviour. Accurate records ensure that the provider can monitor and plan to improve the quality of care for people when issues are identified. The registered manager told us they thought staff exaggerated incidents, however staff told us and records confirmed that staff were being regularly assaulted by some people who used the service. This meant that staff were not being supported to ensure they delivered a high quality service that was safe.

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

Without exception people told us they liked the registered manager and found them approachable. However most people, their relatives and staff we spoke with told us they felt the home needed more staff. One person told us: "I know who the manager is and yes it's good here, there is just not enough staff".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from the risk of abuse.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care that was safe.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor and improve the quality of the service were not always effective.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient, suitably trained staff to keep people safe.

The enforcement action we took:

We served a warning notice.