Runwood Homes Limited

Rowena House

Inspection report

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26 February 2021
23 March 2021
01 April 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Rowena House is a care home providing accommodation for up to 40 people, including people living with dementia. The home is purpose built and accommodation is provided on one level. At the time of the inspection there were 33 people living at the home.

People's experience of using this service and what we found.
We found the service had not always responded to risks related to people's deteriorating health in a timely way. There were systems in place to monitor the quality of service. However, there was room to improve these as they had not picked up the shortfalls we identified during the inspection process.

The provider had effective systems in place to safeguard people from the risks associated with abuse. Staff were trained and deployed effectively to ensure people's needs were met and people's medicines were managed safely overall. We found people were protected from the risk and spread of infection.

There was a real emphasis on learning lessons and improving the service. There was also evidence that feedback from people who used the service and their relatives had been sought and acted upon.

People's care plans and risk assessments were being improved. There was also evidence of staff working in partnership with other agencies. This helped deliver individualised care and supported people's access to healthcare services.

Rating at last inspection
The last rating for this service was good (published 8 January 2020).

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rowena House on our website at www.cqc.org.uk

Why we inspected
Initially, we undertook this targeted inspection in part to follow up on specific concerns which we had received about staffing levels, medicines management and infection control. Following the visit, we received further concerns and a decision was made to extend the inspection to a focussed inspection, in order to review the two key questions of Safe and Well led only. We completed a second site visit in order to review these two key questions.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the

findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well led sections of this full report.

The provider has taken action to mitigate the risks during and after the inspection and this has been effective.

We have made a recommendation about the provider's system of audit and monitoring.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well led.	**Requires Improvement**

Rowena House

Detailed findings

Background to this inspection

The 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.

As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure the infection prevention and control (IPC) practice in the home was safe and the service was compliant with IPC measures. This was a targeted inspection looking at the IPC practices the provider has in place.

Additionally, in part this inspection was undertaken to review areas of concern we had received.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Rowena House is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Inspection site visits took place on 26 February and 23 March 2021 and were unannounced.

What we did before the 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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
The inspection activity started on 26 February and was completed on 1 April 2021.

During inspection site visits on 26 February and 23 March we spoke with seven people who used the service about their experience of the care provided. We spoke with nine members of staff including the, registered manager, deputy manager, care team leaders, care workers and ancillary staff. The regional quality director attended during both inspection site visits providing information and support.

We observed staff interacting with people in all areas of the home and reviewed a range of records. This included four people's risk assessments, care plans and care records. We saw records related to medicines for five people. We also reviewed monitoring records regarding people's weight and the record of complaints kept in the home.

We also conducted telephone interviews with six staff members on 1 March.

We requested and reviewed a range of records which were provided to us remotely. These were in relation to the management of the home. This included quality and safety records and audits, meeting minutes and staff training and supervision. We undertook remote meeting with the registered manager and members of the provider's senior management team on 1 April.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
We received concerns about poor management of the risks associated with people's care in areas such as weight loss and dehydration.
● We found risks associated with people's care and treatment had been identified but not always managed to keep people safe. For example, one person's records showed they had lost weight and another person had not had enough to drink for a significant period. However, action was not taken in a timely way to address these issues. This put people at risk of harm.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to act upon and mitigate risks relating to people's health, safety and welfare.

● There was evidence of the team working to improve people's care plans and risk assessments.
● Environmental risks had been assessed and monitored and environmental safety checks were carried out.

Using medicines safely
Prior to the inspection we received concerns about how people's medicines were managed.
● We found this was an area of practice that was well managed and monitored overall. Although, there had been a brief period during a recent COVID-19 outbreak when oversight had not been as effective.
● Where there were errors in administration or recording of medicines these were identified and addressed by the weekly and monthly audit system. However, we saw one instance when a person did not receive a medicine they were talking once a week. This omission was not noted in a timely way. We discussed this with the registered manager, who took immediate action to address this. This ensured any gaps in medicines administration records would be noted more quickly.
● Clear protocols were in place to guide staff where people were prescribed medicines to be given as and when required.
● Staff who administered medicines received competency checks to ensure training effective and medicines were administered following policies and procedures.

Staffing and recruitment
Prior to the inspection we received concerns about staffing levels. This included that staff were pressured to work unreasonably long hours during a recent COVID-19 outbreak. Therefore, staff tiredness increased the risk of people receiving poor and unsafe care.
● We found there were enough staff to keep people safe. We looked at the staffing provision, including the

period of the COVID outbreak and found there were enough staff available to meet people's needs safely.
● We observed adequate staffing levels during the two inspection visits and no-one we spoke with said there were issues with staffing levels. Although staff said they had to work very hard during the COVID outbreak, they also told us there were enough staff to make sure people were kept safe and their needs met during that period.
● There were staff who felt there would be more time to spend with people if the system of care planning and record keeping was less time consuming. This was discussed with the registered manager who agreed to review, to ensure staff were not duplicating records and had more time to support people.
● All staff, we spoke with who had worked additional hours were clear they had not been put under undue pressure to do so.
● As part of the response to the pandemic the provider had recruited extra bank staff, this is a pool of staff an employer can call on as and when work becomes available. This had helped build resilience in their services. Several bank staff had been recruited for Rowan House and the staff rota showed they helped provide cover, in preference to bringing in agency staff unfamiliar with the home.
● We did not review staff recruitment at this inspection. No concerns had been identified in this area at previous inspections.

Preventing and controlling infection
Prior to the inspection we received concerns about how infection control was managed.
● We looked at how infection prevention and control was implemented and found people were protected from the risk and spread of infection. We saw the following examples of good practice:
● Although the décor was a little tired in places, the home was clean and fresh throughout.
● There were communal spaces designated for people who would not benefit from isolating in their rooms for long periods. This allowed people to move around more freely, while minimising the risk of spread of infection.
● Best practice feedback had recently been provided by a visiting infection control specialist nurse and as a result, changes had been implemented quickly and effectively.

Systems and processes to safeguard people from the risk of abuse
● The provider's system for safeguarding people was effective overall. Although, we asked the registered manager to report two incidents to the safeguarding authority as safeguarding concerns, following evidence identified at inspection. The registered manager responded appropriately and assured us lessons would be learnt to identify any future issues immediately.
● People we spoke with told us they felt safe living in the home.
● Staff told us they completed training in safeguarding people and knew what action to take if they needed to.

Learning lessons when things go wrong
● Accidents and incidents were recorded and analysed. Therefore, themes or trends were identified to mitigate risk.
● The registered manager was keen to ensure lessons were learned when things went wrong. They used learning positively, communicating this to staff in a clear and timely way. This helped to improve the service.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The quality and safety audits completed in the home were effective in identifying and addressing most shortfalls and concerns. However, they had not picked up all issues we identified during this inspection.
- While staff's responsibilities were clear in most areas, we found instances when this was not the case. This had led to risks associated with people's care not being addressed in a timely way. (As reported in the safe section of this report.)

We recommend the provider reviews the home's audit and monitoring systems to prevent duplication of records and clarify staff's responsibilities for acting in response to identified risks.

- There was a relatively new registered manager, who had been in post around six months. They told us they were well supported by their line manager, who was also quite new to the service. The registered manager also had the support of a mentor, who managed another of the provider's services.
- Where we discussed areas where there was room for improvement, the registered manager acted to address issues in a very positive way.

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

- We found the registered manager was keen to promote a person-centred culture. it was also clear they encouraged learning lessons to support improvements in the service.
- The service had seen several staff and management changes, and a challenging period related to the Coronavirus pandemic. However, staff we spoke with were positive and optimistic. They felt they had jelled as a team, supported each other and were working well together.
- The clear majority of staff said they found the registered manager helpful, fair and supportive.
- Several staff were 'champions' in areas such as dignity, dementia and medicines and were enthusiastic in promoting good practice in the service in their areas of special responsibility.
- The atmosphere was welcoming and inclusive of people's diversity. People, and those close to them were regularly asked about their satisfaction with the service, in day to day conversation and via annual surveys.
- We saw people were encouraged to make decisions and speak for themselves. Where staff were called upon to make decisions about people's care, this was undertaken thoughtfully, and in people's best interests.

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

● During the Coronavirus pandemic communication with people's relatives had often been by telephone or online. To help keep relatives updated about was happening for people in the home colourful newsletters had also been sent out.

● However, some people's relatives did not feel enough information was shared with them about their loved one's health and welfare.

● Feedback from people, their relatives, professionals and staff had been documented and there was evidence to show the actions taken to improve the service based on this feedback.

● The members of the management team we spoke with were aware of their responsibilities in relation to the duty of candour.

Working in partnership with others

● We received concerns about the way the service communicated with some health partners during the outbreak. However, we were reassured because, when made aware, the registered manager addressed the issues in an open and positive way.

● We received positive feedback from the local authority regarding the registered manager and care team's management of the COVID outbreak.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to act upon and mitigate risks relating to people's health, safety and welfare.