Ideal Carehomes (Number One) Limited

Bowbridge Court

Inspection report

Bowbridge Road
Newark on Trent
Nottinghamshire
NG24 4DF

Tel: 01636614821
Website: www.idealcarehomes.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 18 December 2017. The inspection was unannounced. Bowbridge Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bowbridge Court accommodates up to 54 people in one purpose built building, which is split across three floors. On the day of our inspection 50 people were using the service.

At the last inspection in April 2017, we asked the provider to take action to make improvements to the safety of the service, consent, staffing, leadership and quality assurance. During this inspection we found the required improvements had not been made.

There was no registered manager in place at the time of our inspection. The previous registered manager had left Bowbridge Court at the start of December 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager in post at the time of our inspection who had been in post for a period of approximately two weeks at the time of our inspection visit. They informed us they would be submitting an application to register with CQC. We will monitor this.

During this inspection we found ongoing concerns about the safety of people living at the home. Action had not been taken to protect people from the behaviour of others living at the home, this placed people at risk of serious harm. Systems to review and learn from accidents and incidents were not consistently effective. Action was not always taken to protect people from improper treatment or abuse, and referrals were not consistently made to the local authority safeguarding adults team. People were not always protected from risks associated with their care and support, such as pressure ulcers. Medicines were not always managed safely. Equipment was not clean and hygienic.

There were not enough, adequately trained staff available to provide care and support to people at all times. Staff did not always have the necessary training to enable them to provide safe and effective support. Staff were not provided with regular supervision, this meant opportunities to monitor and improve staff practice may have been missed. Safe recruitment practices were followed.

Where people lacked capacity to make choices and decisions their rights under the Mental Capacity Act (2005) were not always respected. Some people had restrictions imposed upon their rights but we could not be assured this was in their best interests. People who had the capacity to make decisions were supported to have choice and control of their lives.

Systems to ensure people had enough to eat and drink were not consistently effective and this placed people at risk of insufficient food and fluid intake. People's day to day health needs were met and they were

supported to access healthcare as required. The physical environment had been adapted to meet people's needs, further work was required to ensure people's cognitive needs were met by the design and decoration of the home.

People's right to privacy was not always respected. People told us the quality of care varied between staff members, this meant they could not be assured they would be provided with consistently kind and caring support. People felt involved in day to day decisions about their care and support and families were offered opportunities to be involved in developing their loved one's care plans. People told us most staff understood what was important to them. However, this was not always reflected in care plans. People were encouraged to maintain their independence.

People were at risk of receiving inconsistent support as care plans did not provide an accurate or up to date description of their needs. People knew how to raise issues and concerns, however some did not feel comfortable doing so and the provider's procedure for managing complaints was not followed in all cases. People were given opportunities to get involved in meaningful social activity within the home and the local community.

The service was not well led. There had been a failure to make and sustain improvements identified at our last inspection. Systems to monitor and improve the quality and safety of the service were not effective and this placed people at risk of serious harm. Swift action was not always taken in response to known issues. Staff did not always have a good understanding of their role and were not effectively managed or supervised.

You can see what action we told the provider to take at the back of the full version of the report. 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.

The overall rating for this service remains 'Inadequate' and the service therefore remains in '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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from risks associated their care and support. People were placed at risk of serious harm.

People were not protected from improper treatment or abuse.

Medicines were not stored or managed safely. Equipment was not always clean and hygienic.

There were not always enough staff available to meet people's needs and ensure their safety.

Safe recruitment practices were followed.

Is the service effective?

Inadequate

The service was not effective.

People's rights under the Mental Capacity Act (2005) were still not respected.

There was an ongoing failure to provide staff with sufficient training to enable them to effectively meet people's individual needs. Staff were not provided with regular supervision.

Systems in place to ensure people had enough to eat and drink were not always effective and this placed people at risk of insufficient food and fluid intake.

The physical environment had been adapted to meet people's needs, further work was required to ensure people's cognitive needs were met by the design and decoration of the home.

People's day to day health needs were met and they were supported to access healthcare as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy was not always respected.

People could not be assured they would be provided with consistently kind and caring support.

People felt involved in day to day decisions about their care and support and families were offered opportunities to be involved in developing their loved ones care plans.

People told us most staff understood what was important to them. However, this was not always reflected in care plans.

People were encouraged to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a risk people may receive inconsistent support as support plans did not always contain adequate information to inform support. There was a risk people may not receive the support they required at the end of their lives.

People knew how raise issues and concerns, however they did not always feel comfortable doing so and procedures to ensure the correct handling of complaints were not always followed.

People were given opportunities to get involved in meaningful social activity.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective and this resulted in negative outcomes for people living at the home. Swift action was not always taken in response to known issues.

Appropriate action was not taken to analyse and investigate incidents which posed a risk to the health and wellbeing of people who used the service.

Staff did not always have a good understanding of their role and were not effectively managed or supervised.

Bowbridge 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, to look at concerns we received about the service and to provide a rating for the service under the Care Act 2014.

We inspected the service on 18 December 2017. The inspection was unannounced. The inspection team consisted of two 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.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit we spoke with eight people who lived at the home and the relatives of 10 people. We also spoke with five members of the care staff, a member of the catering team, a member of the domestic team, the deputy manager, the care manager and the manager.

To help us assess how people's care needs were being met we reviewed all or part of nine people's care records and other information, for example their risk assessments. We also looked at the medicines records of 11 people, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also 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.

The provider did not meet the minimum requirement of completing the Provider Information Return at least

once annually. 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 made the judgements in this report.

Inadequate

Is the service safe?

Our findings

During our previous inspections in August 2016 and April 2017 we found concerns with how risks associated with people's care and support were managed. This resulted in an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, some risks associated with people's care and support were still not safely managed. This exposed people to the risk of harm.

People were still not protected from risks arising from the behaviour of others living at the home. At our last inspection we found risks associated with people's behaviour were not effectively planned for. During this inspection this continued to be an issue. This was evident in feedback from people living at the home and their families, many people referred either directly or indirectly to physical aggression. One person told us, "[Person's name] has hit me four times but that is quite a while back. I don't think there is anyone else who would hurt you." Another person commented, "There's a violent person here, I don't feel safe. There's another person who kicks people." They went on to describe being physically assaulted on a number of occasions and described other incidents they had witnessed.

Despite there being a number of people living at the home whose behaviour posed a risk to others, systems in place to manage this and safeguard people were insufficient. Records showed one person often displayed behaviours which placed other people and staff at risk. There had been 13 incidents involving this person in the two months prior to our inspection, some of which had resulted in actual harm to other people or staff. Despite this, there was no risk assessment in place and the person's care plan contained only basic information about how staff should respond. The care plan did not contain any information about potential triggers, actions staff should take to de-escalate periods of extreme agitation or interventions that could be used to safeguard people. This did not assure us staff had all the required information to provide safe support. Furthermore, measures in place to protect people were not sufficient. For instance, staff conducted hourly checks when the above person was in their bedroom. However, we observed, and staff confirmed, no measures were in place to alert staff to when the person left their bedroom. This posed a risk that staff may not identify when the person left their room and which may pose a risk to others. Records showed the local dementia outreach team were working with the person. However the impact of this specialist support was not evident in the day to day practice of staff and their advice had not been incorporated in to care plans.

Staff did not have sufficient skills to manage incidents to protect people from harm. For example, a recent physical altercation had resulted in a person falling and sustaining a serious injury. Records showed that three minutes after the initial incident the perpetrator was able to gain access to the person again, whilst they were lying on the floor awaiting treatment, and cause further harm. This failure to safely manage incidents meant people experienced physical harm.

In addition to the above, there were no effective systems in place to analyse patterns of behaviour, identify the triggers and support staff to develop ways to reduce these behaviours. This meant opportunities to reduce the recurrence of these incidents may have been missed. Following our inspection the new manager informed us of actions planned to safeguard people from the behaviour of others. We will assess the impact

of this at our next inspection.

At our previous inspection we found the risk of people developing a pressure ulcer were not always assessed and planned for safely. This remained an issue at this inspection. Equipment designed to reduce the risk of pressure ulcers was still not used effectively. Two people's specialist air mattresses were not set at an appropriate level for their weight. This placed people at risk of development of pressure ulcers or further deterioration of existing pressure ulcers. Guidance to promote the management and healing of pressure ulcers was not always followed. Care records were not completed in a timely manner and were not always an accurate representation of the care provided. For example, we spoke with one person between 10:55am and 11:10am. Following this we checked their repositioning records which had been completed to state they had been 'stood' at 11.00am. We checked with the person who confirmed they had not been assisted to stand since 8.00am that morning. Another person required two hourly repositioning. However records of repositioning were not completed to demonstrate this had taken place as required. This failure to manage risk placed people at risk of further deterioration of existing pressure ulcers or development of new pressure areas.

Medicines were not always stored or managed safely. At our two previous inspections we identified concerns about the safe administration of medicines. At this inspection we found continued issues with the management of medicines.

We were not assured medicines intended to lessen people's anxiety and resultant behaviour were always used appropriately. One person was prescribed a medicine to help reduce their anxiety and consequent behaviour. There was no protocol in place detailing what the medicine had been prescribed for, what strategies should be used prior to administration or how much should be given. Medicines records showed the person was administered the medicine on a frequent basis. For example, it had been administered six times in the seven days preceding our inspection. Records did not document why the medicine had been given or evidence that it was given as a last resort. Where protocols were in place for 'as required' medicines they lacked detail. Another person was prescribed an anxiety medicine to be given as and when required. However, the protocol only stated to be given 'for agitation' and did not describe any approaches to be tried prior to administration. This lack of guidance meant we could not be assured medicines used to control people's behaviour would be given as a last resort.

Medicines records were not always sufficiently detailed. The coding on medicines records had not been used as intended which meant records lacked information about why certain medicines had not been given. For example when the code 'O' was used to denote 'other reason for drug not being administered' the reason for omission had not been recorded. This was an issue across all medicines records we reviewed. This made it hard to ascertain the rationale for some medicines being missed.

When people were prescribed creams for topical application there were not always clear details of how, where and why these creams should be applied and staff did not always record the application of these creams. For example, one person was prescribed a cream for topical application. Although the topical application record detailed where the cream should be applied, it did not detail the frequency of application. Consequently, application of the cream was variable, recorded as twice on some days and once on others with no rationale for this recorded. This lack of detail posed a risk that creams may not be applied as required which could have a negative impact on people's skin health.

We could not be assured that medicines were stored within the recommended temperature range for safe medicine storage. The temperature of the medicines fridge or room had not been consistently monitored. For example, daily temperature checks had not been completed on 8, 9, 10, 14, 16 or 17 December 2017. This

posed a risk that variations in temperature may not be detected which could have had an impact on the efficiency of medicines.

People were not protected from risk associated with the environment as people had access to areas of the service which posed a risk to them. During our inspection, we observed a number of rooms marked as 'please keep locked' were left open and could be accessed by people living at the home. This included rooms containing cleaning chemicals, medicines and hazardous equipment. This posed a risk that people who lacked the mental capacity to ensure their own safety may come into contact with potentially hazardous items.

All of the above information was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our April 2017 inspection we found action had not been taken to safeguard people from harm. This was a breach of regulation. Despite us bringing this to the attention of the provider we found this continued to be an issue at this inspection. Systems to ensure incidents of a safeguarding nature were identified and addressed were still not effective. This meant we could not be assured people were protected from the risk of abuse or improper treatment.

During this inspection we found evidence of a continued failure to report physical altercations between people living at the home to the local authority safeguarding adults team. We found evidence of nine incidents between May and December 2017 which had not been reported as required. As well as the above incidents of potential or actual physical harm we also found evidence that people suffered significant psychological distress. For example, we saw a record which documented one person had locked themselves in their room and stated to staff they were 'scared' of another person who lived at the home, hurting them. This failure to identify and take appropriate action in relation to incidents of a safeguarding nature meant we could not be assured people would be protected from abuse and improper treatment.

This was an ongoing breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our April 2017 inspection we found effective cleaning procedures were not in place which resulted in equipment not being sufficiently clean. Although, during this inspection, people and their families told us they found the home to be clean we found the cleanliness of equipment continued to be an issue. We observed mobility equipment such as hoists and slings were not clean. Some hoists were sticky and dusty and some mobility slings were stained and odorous. There were no effective systems in place to ensure the effective cleaning of equipment and staff did not have an understanding of their roles and responsibilities in this area. For example, we requested the laundering schedule for slings but were advised by a member of staff there were no records of sling laundering. A member of the housekeeping team, told us they were not responsible for cleaning mobility equipment but they were "not sure" who was responsible. This failure to ensure the effective cleaning of equipment meant that people continued to be supported using equipment which was not clean and posed a risk to their health. The manager told us they were in the process of taking action to make improvements. However it remains of concern that action had not been taken prior to this to ensure the cleanliness of the equipment.

This was an ongoing breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to meet people's needs and ensure their safety. Feedback

from people and their families was mixed. Whilst some people told us there were enough staff, others commented there were insufficient numbers of staff. One person told us, "I've only had to use it (call bell) once and unfortunately they (staff) were very busy and I had to wait a bit, quite a while. There's always supposed to be one person on the floor and at times there isn't. If someone calls in sick it makes it worse too, sometimes we'll get medication late if that happens." A relative told us, "Sometimes I think it's a bit minimal because sometimes you can go into the main lounge and there's no staff. They are not always visible. Other times it's fine." Another relative told us, "There is nowhere near enough staff. I can't say how many times we've stopped people from falling when they've tried to stand up." Staff also had mixed views about staffing levels. Some staff told us this was sufficient, whereas others commented that staffing levels were not responsive to changes in people's needs. The manager told us a tool was used to calculate the required staffing levels, this had been identified as an area for development and they told us the provider allowed them to increase staffing levels as required.

During our inspection we found that although there were enough staff on shift they were not always effectively deployed. We observed occasion's where staff were not available to respond to people's needs or to mitigate risks and this placed people at risk of harm. For example, despite being informed that staff should always be present in communal areas we observed 11 residents were left unattended in the first floor lounge for a short period of time. One person whose behaviour presented a significant risk to others was in the lounge at the time and the lack of staff monitoring placed other people at risk of harm. Furthermore another person, who was at risk of falls, was mobilising using a walking frame, we observed them trying to lift their walking frame over a wheelchair. This placed them and others at risk of harm.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act (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. 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.

During our previous two inspections we found that people's rights under the Mental Capacity Act (2005) (MCA) were not respected. This was a breach of legal regulation. At this inspection we found the provider had still not taken adequate steps to ensure people's rights under the MCA were protected. Mental capacity assessments and best interest decisions were not always in place as required. During our inspection we observed all bedroom doors on the ground floor were locked during the day. A member of staff told us this was to prevent people 'wandering' into each other's rooms. This meant people were not freely able to access their own bedrooms. Despite this restriction on people's freedom, their capacity to consent to the locking of bedroom doors had not been assessed. Furthermore, prior to our inspection we received a concern that images of people living at the home were being used on a social media site. We received feedback from the previous registered manager that consent was sought from people and for those who were unable to consent a decision was made in their best interests. Despite this, during our inspection we did not find any evidence that the decision to use images on social media were formally assessed when people lacked the capacity to consent. This meant we could not be assured that this was in people's best interests

Where mental capacity assessments were in place some were not sufficiently detailed. For example, one person frequently declined care and support. The person had been assessed as lacking capacity to make decisions in relation to their personal care. The associated best interests decision stated they should be 'assisted with all personal care' and the care plan stated, 'carers to assist in best interests'. However, there was no further information about how to assist the person if they refused care. This lack of guidance for staff posed a risk that their rights under the MCA may not be protected.

The above information was an ongoing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of poor hydration or nutrition as food and fluid intake was not always appropriately monitored. Although food and fluid charts were being completed for a number of people who had been identified as being at risk, these were not completed in a timely manner. This increased the risk of error and inaccuracies. We observed staff completing records up to seven hours after support was provided and heard staff discussing estimates of how much people had eaten or drunk earlier in the day. For example, we viewed food and fluid records for one person at 3.00pm, no entries had been made for that day. Where food and fluid records were completed these were not used effectively. Another person had been identified as being at risk of poor hydration and as a result the staff team were monitoring their fluid intake. However, staff were not calculating their total daily intake which meant it would not be

identified if they had not had sufficient amounts to drink.

Action was not taken when people had significantly decreased food and fluid intake. This meant we could not be assured people were protected from risks associated with dehydration or poor nutrition. For example, food and fluid records for a third person documented that in a 48 hour period they consumed an insufficient amount of food and fluid. We found no evidence of action being taken to seek advice, or to report concerns to the management team. Records showed the person had been admitted to hospital due to being 'unresponsive' following this period of reduced food and fluid intake. Had timely action been taken to address changes in the person's food and fluid intake they may have been able to access support or treatment sooner. Following our inspection the new manager informed us of actions planned to improve the recording and management of people's nutrition and hydration. We will assess the impact of this at our next inspection.

The above information was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections we found staff did not always receive adequate training or supervision. This was a breach of legal regulation. During this inspection we found continued concerns in this area. People continued to receive care and support from staff who did not all have the necessary skills and competence to support them safely. Whilst some staff had up to date training this was not always the case. Training records showed that 16 staff had no up to date training in safeguarding and we observed that this lack of knowledge or failure to effectively apply their knowledge had a negative impact on people who used the service. For example, we found some incidents of a safeguarding nature had not been referred to the local authority safeguarding adults team. The training record showed 13 staff did not have training in 'nutrition and wellbeing' and during this inspection we found evidence to demonstrate this had a negative impact on people living at Bowbridge Court. 10 staff did not have any training in managing challenging behaviour and a further 13 staff members training had expired in this area. This is of particular concern given the significant level of risky behaviours staff were managing on a day to day basis. This meant there was a risk some staff did not have the required competency to safely manage people's behaviours.

Training records showed some staff did not have any, or up to date, training across a number of areas. For example, one member of staff did not have up to date training in challenging behaviour, the Mental Capacity Act, moving and handling, medication, nutrition, dementia, safeguarding, equality and diversity, first aid or end of life. When staff had transferred from other roles within the home they had not always been provided with adequate training to ensure they had the skills to undertake their new role. For example, a member of staff who had recently moved from a non-care to a care role, had not had any additional training when they changed role. Consequently they did not have any training in challenging behaviour, infection control, dementia, fire safety, end of life or health and safety. The above insufficiencies in staff training, knowledge and skill placed people at risk of not having their needs met appropriately or safely.

At our last inspection we found staff did not always receive regular supervision of their work. At this inspection we found this was an ongoing issue. The new manager told us they were unable to locate records of recent staff supervisions. Consequently we were not provided with any evidence of staff supervision. Two of the three staff we spoke with told us they did not receive regular supervision of their work. This meant that staff were not given regular formal opportunities to access support and opportunities for staff to reflect on their practice and share any concerns may be missed. This was of particular concern given the above gaps in staff training and knowledge.

The above information was an ongoing breach of regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The new manager had identified DoLS as an area for improvement. They told us that, upon starting in post, they had identified a number of people where applications for DoLS authorisations had not been made as required. They said they had spent a significant amount of time completing these applications. Following our inspection visit we received confirmation, from the new manager, that they had taken action to make applications to the supervisory body for DoLS as required.

People told us the food was good, they had a choice and got enough. One person said, "There's a choice, sometimes it's a choice between two things you don't like so they'll do something else. Even if you've made your choice and don't fancy it when it comes you can change your mind. The chef is excellent." Another person told us, "We get plenty to drink, I tend to need a lot of water so I ask for it and I get it." We observed mealtimes on all three floors of the home and found these to be positive, sociable experiences. The dining areas were well presented and food was served thoughtfully to ensure it looked appealing. Staff ate with people living at the home and engaged in friendly conversation. People were offered discreet, compassionate support as needed and staff ensured people were included in the meal time experience. When people required specialist diets these were provided and the kitchen staff had clear information about people's dietary needs. People were offered drinks and snacks throughout the day.
People told us they were supported with their health and well-being and in the majority of cases staff made contact with relevant healthcare professionals as needed. One person explained, "I had a fall and they got an ambulance, that took a long time to come but the staff were marvellous, they looked after me." A relative told us, "[Relation] has needed a doctor a few times. The home have dealt with that. If they get over concerned they get an ambulance and they phone one of us." Another relative said, "[Relation] had a fall and straight away they got an ambulance and got them to hospital to be checked out. Somebody from the home went with [relation] and they brought them back." The outcomes of appointments with professionals including GP's, dieticians and specialist nurses were recorded in people's care plans. We received positive feedback about the support provided by staff from health professionals involved with the service. Improvements had been made since our last inspection to ensure care plans included personalised information about specific health conditions.
People and their families were positive about the home environment. One person told us, "It's got good views. It's airy and bright." Another person commented, "There's lots of little nooks and crannies where you can sit if you want privacy or a quiet chat." A relative said, "We like the home, we like the space, [family member] can walk about." Bowbridge Court is situated in a large purpose built premises. Consideration had been given to people's physical need in the design of the building, the home had wide, well-lit corridors with hand rails to assist with mobility needs. People's privacy had also been considered, as well as large dining and lounge areas on each floor there were smaller lounges where people could sit quietly or have privacy and every room had en-suite facilities. There was limited evidence to demonstrate that people's cognitive needs had been taken into account in the design and decoration of the environment. A number of people had dementia and we were told by staff that some had difficulty identifying their bedrooms. Despite this, we observed an inconsistent approach had been taken to helping these people orientate themselves, whilst some doors had been personalised, others only had a number. The use of dementia friendly signage and colour schemes was also inconsistent throughout the home. This meant we were not assured the provider had taken all reasonable steps to accommodate people's diverse needs in the design and decoration of the building.

Requires Improvement

Is the service caring?

Our findings

People's right to privacy was not always respected. Prior to our inspection we were notified of a significant restriction on one person's right to privacy. We were informed, by the new manager, that the person lacked the mental capacity to consent to this. During our inspection we found no action had been taken to protect the person's right to privacy. We spoke with a member of staff who told us they had raised concerns with the previous registered manager as the person did not have privacy when being assisted with personal care, they told us nothing had changed as a result of their feedback. The new manager confirmed that whilst a DoLS had been applied for, no practical interim measures had been implemented to protect the person's privacy. This meant we were not assured that all reasonable steps were taken to protect the privacy and dignity of people living at Bowbridge Court.

The above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, people told us that staff treated them with dignity and respect. One person said, "They call me [preferred name] and I like that. If somebody needs [continence care] or anything like that it is dealt with quietly, discreetly. The girls make nothing of it. It's what they are trained to do, there's no lack of dignity." Another person said, "They do respect my dignity when they wash me."
People could not be assured that they would be provided with consistently kind and caring support. Feedback from people who used the service about the caring approach of staff team was variable. Some people commented positively on the staff and told us that on the whole they were kind and caring. One person said "The carers are very good. If you've got any troubles you can talk to them." A relative commented, "It's fantastic, the staff are absolutely brilliant. [Relation's] not miserable, the staff are always happy around them. It's very upbeat, the staff are so lively, they cheer people up." In contrast other people commented that that the approach of the staff team was not consistent. One person told us "There's a tremendous variety in the care of carers. Some are good, others seem to be doing it just for the money, I don't know why they want to be carers, literally they couldn't care less." A relative told us, "Care varies, depends who's on, who's looking after [relation]."

During our visit staff treated people with warmth and kindness. We observed positive interactions between people and staff. For example, one person was seeking reassurance, a staff member responded quickly using physical affection to reassure the person. People's relatives told us they felt welcome at Bowbridge Court and felt the caring approach extended to them as visitors. A relative told us, "I like it, the staff are very good, look after you, always make you feel welcome. If it's dinner time they'll offer you dinner, you can make your own tea or coffee." Another relative commented, "As soon as I came and sat here somebody came and offered me a cup of tea."

People told us they felt staff knew them and made an effort to find out about their history and likes and dislikes. One person said, "They (staff) wanted to know about me and my life and what I'd done so staff know all about me." A relative told us, "The staff know [relation's] likes and dislikes, ask questions, have got to know them properly." Despite this positive feedback we found the quality of information in care plans

about people's individual preferences varied. Whilst some people's care plans contained detailed information about what mattered to them, other people's care plan's contained limited or no information. This placed people at risk of receiving inconsistent support.
People were involved in decisions about their support. One person told us, "I can go to bed when I want. I go to my room and watch TV. I can go up and down (floors) as I like. I can go out into the garden." People's relatives told us they were also consulted about their loved one's care and support and were involved in care planning. During our visit we saw that staff routinely checked with people about their preferences for care and support. People were offered choices about what they ate and drank and how and where they spent their time. Staff we spoke with had an understanding of their role in ensuring that people had choice and control. We observed that staff had a good understanding of people's communication needs and used this to inform their support. Most care plans contained information about people's communication and staff demonstrated a good knowledge of this. The new manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection but the new manager explained they would make a referral for advocacy should the need arise.
Despite the above positive findings about support provided by staff we found some of the systems within the home did not take account of people's communication needs and therefore did not maximise people's decision making ability or promote choice. For example, information about daily meals was displayed around the service in a pictorial format in an attempt to communicate this to people, however we saw that this information was incomplete or inaccurate. This could have been confusing for people with memory impairments and confusion.

People were supported to maintain their independence. Most people's care plans contained details where people were independent and areas where they required support and the environment was designed with people's independence in mind. Each floor of the home had a kitchen area that was accessible to people living at the home. Throughout our visit we observed people using these areas to prepare drinks for themselves. We also observed staff encouraging and supporting people's independence skills, for instance at meal times.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive care and support that met their needs as staff did not always have access to clear, detailed, up to date information about their needs. This was supported by feedback from people and their families who told us the quality of care and support at Bowbridge Court was inconsistent. One relative told us that care varied dependent upon each staff member, they commented this had an impact on how the person was supported to maintain their personal appearance. Another relative commented, "There's some very good staff but some are not so good. Some go out of their way to help, others couldn't care less." The relative of a third person told us they frequently found their relation, who was reliant upon staff to ensure their comfort and maintain their dignity, in an undignified and uncomfortable state. They told us they had spoken to staff about this and asked that their relation's care plan was amended; however the care provided had not improved and on the day of our inspection they had again found their relation in an uncomfortable state.

The quality of information in care plans was variable, some care plans were complex, whilst others were incomplete and some lacked detail. Care plans did not always contain adequate detail to enable staff to provide consistent support. For example, one person sometimes behaved in a way which resulted in them being in an undignified state in communal areas. However, their care plan did not provide staff with any information about how to support the person to maintain their dignity.

Although some care plans contained detailed information about what was important to people and their history this was not consistent. For example, one person had lived at Bowbridge Court for over two years. However, the life history and future wishes sections of their care plan were blank. In addition to this, care plans contained little evidence that people had been offered the opportunity to discuss their wishes for end of life care. For instance, one person had previously been on 'end of life care'. Despite this, their care plan did not contain any information about their wishes for the end of their life. This lack of information posed a risk people may not receive the support they required.

Staff also told us care plans were not always useful. We observed a staff member try to ascertain whether a care plan had been amended to reflect a change is a person's care requirements. They were unable to identify if the change had been made or not. They commented to us that the change could have been made in a variety of places so it was hard to find. They told us this was not an effective way to communicate changes as staff were unlikely to be able to search through care plans for changes. Another member of staff told us care plans were not effective as sometimes they contained too much information making them complex and other times they did not contain enough information. This placed people living at Bowbridge Court at risk of receiving inconsistent support.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with a range of activities and opportunities for meaningful occupation. The provider employed a regional activity coordinator who had responsibility for planning and facilitating activities in the

home. The new manager told us they were also in the process of recruiting a dedicated wellbeing manager who would be based within the home and would be tasked with providing people with opportunities for meaningful activity with a view to maintaining and improving their wellbeing. People told us there were a wide range of activities provided. One person told us, "There's a list of the activities for the week, singers, book readers, entertainers come in and do small performances. Last week we had 'Annie' and it was very good." A relative told us, "They do lots of entertainments, trips, there's always something they can do. To be fair it's the best activity programme I've seen. I'd put that at the top of the list of their good points." Another relative told us their relation had a choice of how to spend their time. They said "[Relation] reads the papers, the home get it (the paper) every day for them. They have activities. Someone came and did crafts with them, they have entertainers, a magician came in."

Throughout our inspection we observed people were offered a range of things to do. People were provided with the opportunity to watch a film and a number of people spoke positively about the experience. When staff had spare time they sat with people and chatted or engaged them in other ways such as colouring or games. Staff offered encouragement and praise and we saw people appeared to be enjoying themselves, laughing with the staff. People were also offered the opportunity to access the local community for trips to local attractions, shopping and meals. People who chose to stay in their rooms told us staff would pop in and check on them. A relative told us, "[Relation] likes to sit there (in bedroom) and watch TV. It's their choice. They (staff) don't ignore [relation], they keep checking up on them."

People's diverse needs had been identified and accommodated. For example, a number of people living at Bowbridge Court required support to attend a place or worship or practice their religion. This was recorded in their care records and some people were supported to attend their preferred place of worship and others attended ceremonies held within the home. We spoke with the manager about how they ensured they met their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. The new manager explained they had identified this as an area for further development.

There were systems in place to record and handle concerns and complaints. However, we found these processes were not always followed and people's confidence in raising concerns and complaints was mixed. Whilst most people and their relatives told us they felt comfortable raising issues, some relatives commented they did not have confidence that complaints would be treated sensitively or confidentially. For instance one relative told us, "I've made no formal complaints but staff and management are approachable. Sometimes I've spoken to the head office and they have always been very good, sorted things out." In contrast another relative said, "We wouldn't feel confident in raising issues because of consequences for [relation]. We've no confidence in confidentiality."

We looked at records of complaints received since the previous inspection. Although most complaints had been recorded as resolved they had not been handled as per the provider's complaint procedure. For example, the complaints procedure stated an acknowledgment letter would be sent within 48 hours of the complaint having been received, however this had been recorded as 'not applicable' in a number of cases. No reason had been recorded as to why the procedure had not been followed. We spoke with the new manager about this, they told us they had not received any complaints since starting in post and were unaware of why procedure had not been followed for previous complaints. They told us action would be taken to ensure proper recording of future complaints.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Throughout our inspection of Bowbridge Court we identified a number of shortfalls in the way the service was managed which led to ongoing concerns about the safety and quality of the home. It is of significant concern that a number of serious breaches of regulation at Bowbridge Court had not been addressed prior to this inspection. This is of particular concern given the history of non-compliance with the legal regulations.

There had been a failure to act on the concerns resulting from our last inspection. Improvements planned following our last inspection had not been completed or sustained. After our last inspection the provider sent us an action plan which provided assurances that all required improvements would be completed by the end of August 2017. Despite this, during this inspection we found ongoing concerns across a range of areas. For example, the action plan stated the action 'All risks to have accompanying risk assessment in place and care plan' had been completed. However, during this inspection we found an absence of risk assessments where risks associated with the people's behaviour had been identified. In other areas we found the impact of improvements cited in the action plan had not been sustained. For example, the action plan stated staff would be provided with training on the 'importance of appropriate record keeping', despite this in this inspection we found staff were still not completing records to evidence care had been provided as required. Improvements to care planning, training, medication, the Mental Capacity Act and governance and leadership had also not been sustained. This failure to take effective action to address the concerns identified in our previous inspection resulted in continued concerns about the quality and safety of care and support provided at Bowbridge Court and placed people at risk of harm.

Systems to monitor and improve the quality of the service were not robust. Although there were processes in place to monitor the quality and safety of the service these were not always effective. Consequently these systems had not identified all issues identified during this inspection. Some audits had not been completed effectively. The November 2017 medicines audit, documented protocols for 'as required' medicines were in place. However, during our inspection we found this was not the case. Some audits were incomplete or had not been completed to the required standard. For instance, the November 2017 infection control audit had not been completed to an adequate standard. Multiple areas of the audit, such as 'is the kitchen environment clean?' and 'are daily fridge checks complete?' had been marked as 'not sure'. This meant areas for improvement may not be identified.

Where audits had identified areas for improvement swift action had not been taken to address issues. For example, a care plan audit completed in October 2017 had identified action was required to assess a person's capacity to consent to a restriction upon their right to privacy and to make a decision in their best interests. Despite this having being signed off as complete, there was still no best interest decision made regarding the restriction at this inspection.

Furthermore, some audits were not completed frequently enough to identify and address areas of concern. For example, checks on the adequacy of mattresses were completed on a quarterly basis. This meant concerns with the integrity of mattresses were not identified in a timely manner. During our inspection we

found one person's mattress was odorous and had been penetrated with bodily fluid. This had not been identified prior to our inspection.

Audits conducted by the provider were also not effective in identifying areas of concern. A mock inspection audit conducted in October 2017 rated Bowbridge Court as 'Good' and did not identify concerns found at our inspection such as a failure to make safeguarding referrals, concerns about the management of risky behaviours or the failure to protect people's rights under the Mental Capacity Act. Furthermore, when areas for improvement had been identified, such as end of life care plans, action had not been taken to address these.

The provider did not have sufficient systems in place to record, analyse and learn from significant incidents. Incidents such as verbal and physical altercations were recorded in daily records, incident records and behaviour charts, but, there was no system to escalate concerns to the management team and no process for the collation and analysis of these incidents to reduce the risk of future occurrences. Although we saw some action had been taken to address issues arising from some incidents this was down to the skills and competency of individual staff members rather than being driven by effective systems and management. The new manager told us they had identified this as an area for development, and, as an interim measure had asked staff to escalate all concerns to them. However, it remained of concern that the provider did not have any system in place to analyse and learn from incidents of a behavioural nature. The failure to review and take appropriate action in response to incidents placed people at risk of harm.

The management and supervision of staff was not sufficient to ensure the provision of a safe and effective service. This had a negative impact on the quality of the service as staff did not consistently have an understanding of what was expected of them. For example, although staff had knowledge of safeguarding indicators and procedures they did not have a practical understanding of their role in safeguarding, and, consequently they had not taken action to escalate concerns, such as physical altercations between people, to the management team. Senior staff were not always effective in supervising the day to day practice of staff and this resulted in deficiencies in staff deployment and performance. Some people and their families commented on the impact of multiple changes to the management team at Bowbridge Court. One relative said, "There's been two or three new mangers and it's been up and down. It seems communication is a problem. You can ask the staff things and they say they don't know. If you check, it's difficult to read people's (staff) hand writing in (family member) log. Sometimes it's too brief for example 'assistance with personal care'. It's a case of good practice." Another relative commented, "There's a new manager and we hope it's going to get better. Some people will get looked after better than others, they (staff) do have cliques. You'll see four or five carers going out to smoke at the same time." During our inspection we observed multiple occasions where staff were not deployed effectively to respond to people's needs.

Systems to ensure the smooth and organised running of the service were not kept up to date. This meant the provider could not demonstrate compliance with the regulations in some areas. For example, despite us identifying concerns about the organisation and administration of DoLS applications and authorisations at our last inspection, we found there was still no effective system record and track DoLS. This meant the new manager was unable to tell us who had a DoLS authorisation in place. This is of particular concern given the fact that following our last inspection we imposed a condition which required the provider to submit monthly reports on all DoLS and any conditions in place. Although we had been provided with information about DoLS in monthly reports the information was not an accurate reflection of the service.

Training records were also out of date. The new manager told us the training matrix in place at the time of this inspection did not accurately reflect all training that had taken place. This meant it was not possible to ascertain any gaps in staff training. Again this was particularly concerning as following our last inspection we

imposed a condition which required the provider to submit evidence of staff competency on a monthly basis.

Many of the concerns identified at Bowbridge Court were similar to concerns found at previous inspections at the home and at other locations operated by the provider. This gives rise to concern about the provider's ability to apply learning from previous inspections and other locations to ensure the safe and effective running of the service.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of seven safeguarding incidents reported to the local authority. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection the new manager provided us with an action plan to address the areas of concern identified. We will assess the impact of the planned changes at our next inspection.

Despite the concerns identified during our inspection most people we spoke with told us they were, on the whole, happy living at Bowbridge Court and said that they felt the home was welcoming and homely. Staff also told us that they were happy working at Bowbridge Court and said the new manager had a positive impact on the atmosphere of the home. Staff members commented there had been infrequent team meetings under the leadership of the previous registered manager, but told us there had been a recent staff meeting held by the new manager. Records showed staff had been given the opportunity to share their ideas on improving the service at this meeting.

People told us they had an opportunity to influence some aspect of the home in regular residents and relatives meetings. One person said, "We have residents' meetings once a month. We are listened to even if some things take a bit of time." A relative told us, "I'm aware of residents' meetings but can't attend. They are quite good at sending letters keeping you informed."
A suggestions and comments board was displayed in the foyer and this evidenced that action had been taken in response to ideas and suggestions made by people living at Bowbridge Court.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the home and on their website.