Care UK Community Partnerships Ltd

Bowes House

Inspection report

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13 June 2017

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Bowes House on the 11 and 13 June 2017 and the inspection was unannounced. Bowes House provides accommodation and nursing care for up to 90 people who have nursing needs, including poor mobility or diabetes, as well as those living with various stages of dementia. The home also had a contract with the CCG (Clinical Commissioning Group) to provide rehabilitation for people, for up to 6 weeks. This aimed to either provide people with an alternative to a hospital admission. There were 81 people living at the home on the first day of the inspection and 84 people on the second day of our inspection.

Bowes House is owned by the organisation Care UK Community Partnerships Limited. The service is purpose built and provides accommodation and facilities over two floors. Split into four units, the units include; Aylesham (Elderly Residential), Weald (Nursing care), Barley (Rehabilitation) and Meadow (Dementia). Local school children were involved in the naming of each unit.

The service had a registered manager in place. 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.

We last inspected Bowes House in August 2016 when the service was rated 'Good'. After that inspection we received concerns in relation to poor staffing levels at night. This was a focussed inspection in response to these concerns. We looked at these concerns under the key question 'Is the service safe?' You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bowes House on our website at www.cqc.org.uk.

Systems were in place to calculate staffing levels and the provider used an electronic dependency tool known as CAPE. Staffing levels were reviewed monthly or sooner. Not all staff vacancies had been recruited to and the provider was using agency staff to maintain staffing levels. Staff recognised the need for agency staff but felt it had an impact. One staff member told us, "We are using agency staff whilst recruiting. We try and get the same agency staff but it isn't always possible. It then means we have to explain to them what to do, induct them and that takes time away from what we need to do." Staff rotas confirmed that staffing levels were being maintained with input from agency staff. The management team told us that staff turnover and use of agency staff may compound people's feelings that there isn't enough staff.

People told us they felt safe but felt staffing levels could be improved. People confirmed that although staff answered their call bell promptly, they were then advised that staff would return but often that would take a long time. One person told us, "I hear, I'll be a back a lot." We have identified this as an area of practice that needs improvement and have made a recommendation about responding to call bells.

People were protected by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Bowes House had

registration with the Nursing and Midwifery Council (NMC) that was up to date.

Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported from abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

Risks to people's wellbeing were assessed and staff knew what action they needed to take to keep people safe. People had individual evacuation plans outlining the support and equipment they would need to safely evacuate the building.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Bowes House was not consistently safe and we have revised the rating from 'Good' to 'Requires Improvement.'

People felt staffing levels were not always sufficient. Call bells were answered promptly but people were then informed that staff would return but people found it could take a long time for staff to return.

The management of medicines was safe. People received their medicines on time and by suitably qualified staff. Staff had a good understanding about how to recognise and report safeguarding concerns.

The environment and equipment was well maintained to ensure safety. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

Bowes House

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 checked 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, and to provide a rating for the service under the Care Act 2014.

This was a focussed inspection in response to concerns we received about poor staffing levels. The inspection took place on the 11 and 13 June 2017 and was unannounced. The inspection on the 11 June 2017 took place out of hours from 06.00am to 08.00am; this was because we wanted to speak with night staff. The inspection was carried out by two inspectors. We looked at the key question 'Is the service safe?'

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding quickly to information and concerns that had been raised with us.

During our inspection we spoke with 13 people, registered manager, deputy manager, two registered nurses and nine care staff. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five care plans and subsequent risk assessments. We also looked at two staff files, records of medicine administration, staff rotas and documents relating to the maintenance of the environment and staffing levels.

We last inspected Bowes House on the 1 and 2 August 2016 when it was rated as 'Good.'

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Bowes House. One person told us, "I would say I feel safe. I've got my call bell and staff are very efficient." Another person told us, "Oh yes, I am perfectly safe here." A third person told us, "Yes, I am safe. My son would definitely say something if he wasn't happy." Although people told us they felt safe, we areas of practice which were not consistently safe.

Prior to the inspection, we received a number of concerns about poor staffing levels, especially at night during the weekends. We also received concerns about staff turnover, use of agency staff and responses to call bells. Systems were in place to determine staffing levels. The provider used an electronic dependency tool known as CAPE. The dependency tool considered people's level of assistance required with personal care, nutritional, continence and what level of support they required to meet their social, emotional and psychological needs. Each person was then provided with a dependency score and based on those scores, the dependency tool calculated how many hours of care per week was required to safely meet people's needs. The registered manager told us, "People's dependency levels are calculated each month or sooner if needed and staff are quite good at reflecting people's level of need within the CAPE tool. We do though have to prompt staff to re-evaluate people's dependency level when they are experiencing an infection for example. When people experience a urinary tract infection, they can become more confused and need greater input." On a monthly basis (or sooner), the management team reviewed the dependency level and based on that, calculated staffing levels. The registered manager told us, "Although we have a dependency tool in place, we also listen to staff and will be flexible to the needs of the individual units and people's individual care needs. For example, the CAPE didn't reflect that we needed a twilight shift on Barley unit, but we implemented that based on staff's feedback." Staffing levels throughout the day consisted of two registered nurses, two unit managers, six team leaders and 14 care staff. The night shift consisted of two registered nurses, two team leaders and six care staff until midnight. After midnight, care staff levels dropped to five.

Staffing rotas and staff logging in and sheets confirmed that the provider was maintaining these staffing levels with the use of agency staff. A member of the management team told us, "We have reduced the number of agency hours for nursing staff. We were using 100 hours a week of agency nursing staff. However, that has now been reduced to 44 hours a week. We use the same agency and try and use the same agency staff to ensure continuity of care." Documentation confirmed that where concerns had arisen regarding the conduct of an agency staff member, the management team took action and requested that they were not sent back to work at Bowes House again. For example, some people raised concerns that one agency staff member was abrupt and rude in their approach. A member of the management team told us, "Whilst we recruit, we are using agency staff. We did have a number of new starters; however, sadly three found that care was not for them." Documentation reflected that since January 2017 14 staff had left. The registered manager told us, "I haven't been conducting exit interviews and I have mostly known the reasons why people had left. However, recently I have started to so we can audit the reasons why and a couple of people left where I wasn't really sure of their reasons." The management team confirmed they were recruiting to the vacant posts and advised they kept people and their relatives informed at every 'resident and relative meeting.' A member of the management team told us, "When staff leave, we can't tell people the reason

why, but what we have been noticing is that when staff are leaving, they go round and tell the residents which is lovely. But we now feel that may be creating an atmosphere of people worrying about staff turnover."

Despite a dependency tool in place to determine staff which was proactively used, people felt staffing levels were insufficient and staff had mixed opinions. Most night staff felt staffing levels were sufficient. One night staff member told us, "I've got no concerns about staffing levels. We use agency staff which isn't ideal but staffing levels are sufficient." Another staff member told us, "The ratio of staff to residents is fine. We do use agency staff but I am quite happy, I have no concerns." Another staff member told us, "We are using agency staff whilst recruiting. We try and get the same agency staff but it isn't always possible. It then means we have to explain to them what to do, induct them and that takes time away from what we need to do." However, staff who worked on the service's rehabilitation unit (Barley) raised the main concerns about staffing levels. One staff member told us, "I don't know where they get their ratios from, we have two people on the floor from midnight and it's not enough when we are full. We have a twilight person to help us get people to bed but they go off at midnight." Another staff member told us, "We have one care staff and one nurse on this unit, sometimes that's ok but residents change quickly and it gets very difficult. Having the twilight person has been a massive help." We brought these concerns to the attention of the management team. They told us, "Barley unit can be a difficult unit as it accepts referrals from the hospital at weekends and recently we have been asked to accept people who don't need rehabilitation, as there isn't enough space in the hospital. The capacity of the unit can fluctuate and people's needs can vary. We received feedback a couple of months ago, that staff were struggling to answer call bells at night and call bells were going to the emergency bell. We therefore implemented two twilight staff. They start at 18.00pm and finish midnight. However, the twilight staff can be flexible. If the unit needs them to stay longer they can or if one unit is having a busy night and the unit they are allocated to is quiet, they can work on the busy unit." Feedback from staff reflected that the flexibility of the twilight staff was not consistently being used as staff informed us that twilight staff left at midnight and were not asked to stay on if the night staff was particularly busy. We brought this to the attention of the management team to address.

The registered manager and management team had recognised that there was a culture within Bowes House of staff saying they worked on a particular unit and not for Bowes House. The registered manager told us, "We are having scenarios of staff saying they will only work on a particular unit and we want to change that culture. Staff should work for Bowes House and not a particular unit. That way, we can promote flexibility with staffing and if one unit is particularly busy ask staff to work there instead. We are therefore considering a general rota and when staff arrive on shift, allocate them to a specific unit." The current model of staff being allocated to a unit meant the management team did not always the flexibility of staff. However, they advised this was an area of practice they were improving upon.

Each person had a call bell which allowed them to summon assistance and help. We conducted an audit of call bell response times and ascertained that people's call bells were answered in either seconds or a couple of minutes. However, when we explored this with people they advised that staff answered the call bell to explain they would be back or were with someone else and would return. One person told us, "I'll be back in a minute. You hear that a lot. I don't think there is enough staff. There is always a delay. This morning, all I wanted to do was sit in my chair; I was waiting a long time. I can only judge on what I see." Another person told us. "There is never enough staff in care homes. Staff will say I'll be back. Sometimes they are quick; sometimes they take a long time." A third person told us, "I often hear I'll be back, it can seem like a long time though." A fourth person told us, "We could do with more staff, there doesn't seem enough. Staff can't help it, they try their best but when you need the toilet and staff say I'll be back, it seems like a very long time." We queried with staff the process of responding to call bells. One staff member told us, "I don't like the thought of people pressing their call bell and waiting, so we respond but might say, I'm just with so and

so and then I'll come and support you. Obviously, if it's an emergency, we will support there and then, but we usually respond and advise we will come back." We also informed staff that we had received reports of staff answering call bells promptly and then advising they would return but on occasions this could take a long time and we asked staff for their opinions on that. One staff member told us, "It's quite possible, it wouldn't be picked up on our call bell monitoring if that was the case. If that's what people are telling you then I would think there is definitely something in it that needs investigating."

Staff were observed responding to call bells during the inspection and the atmosphere of Bowes House presented as calm. We queried with people the impact of staff saying they will return once they have answered their call bell. One person told us, "It usually means I am waiting. They do try their best." Another person told us, "When they say I'll be back, even if it's only a minute, when you desperately need the toilet, a minute is a long time." Despite concerns with staffing levels, people told us they felt safe. Documentation reflected that people were receiving the care that they needed. For example, people who required regular repositioning where supported to change position regularly and those who required hourly checks to ensure their welfare, were checked upon hourly. However, people's experience was that there was not enough staff. The high use of agency staff, staff vacancies and delays in responding to people's request for people has compounded people's perceptions of staffing levels. We have identified this as an area of practice that needs to improve.

We recommend that the provider seeks guidance from a reputable source about responding to call bells.

There were systems in place to manage medicines safely. Medicine administration record (MAR) charts clearly stated the medicines people had been prescribed and when they should be taken. Information was also available on how people preferred to take their medicines. For example, one person preferred to take with a glass of juice. The MAR charts were up to date, completed fully and signed by staff. We observed staff when they gave out medicines. We saw medicines were given to people individually; the trolley was closed and locked each time medicines were removed. Staff signed the MAR only when people had taken the medicine. Medicines were kept in locked trolleys, which were kept secure. Staff followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol and clear PRN protocols were in place.

Staff recruitment practices were thorough; people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the provider to ensure they were suitable for the role. All new staff were required to undergo a probationary period during which they received regular opportunities for practice supervision. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration.

Appropriate steps had been taken by the provider and registered manager to reduce the potential risk of people experiencing abuse. Staff members demonstrated a good understanding of the different types of abuse and provided clear explanations of the actions they would take if they thought abuse had occurred. They knew where to find information on how to report any concerns to the local authority, who lead on any safeguarding concerns, if they needed to report an incident of concern. Staff confirmed that they had received training in safeguarding people and records confirmed this.

The risk of people receiving unsafe care and treatment had been assessed and actions implemented to

mitigate any such risks. The provider had consulted nationally recognised guidance such as the 'Health and Safety Executive (HSE)' and the 'National Institute for Health and Care Excellence (NICE).' There were individual risk assessments in place which supported people to stay safe, whilst encouraging them to be independent. Some people were supported to undertake positive risks. We observed some people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Steps had been taken to minimise the risk of people suffering harm if they did fall. For example, one person was identified at very high risk of falling. To mitigate the risk of harm, a low profile bed and crash mat had been given to them. The management team confirmed that sensor mats were checked daily by staff to ensure they were safe and in a good working condition but confirmed staff did not record that they were checked. The management team identified this was an area of practice that could be improved and agreed to take action. Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer.

Staff were knowledgeable about the people they supported and what element of their care routine may pose a risk. Some older people with health needs such as dementia and Parkinson's can be at heightened risk of choking. Initial choking risk assessments were completed for all people moving into Bowes House and subsequently reviewed. Where people were identified at high risk of choking, guidelines were implemented to mitigate the risk of choking. For example, one person's choking risk assessment identified a high risk assessment. Their care plan included clear guidelines for staff to follow which included: staff to provide one to one assistance at meal times and when eating due to a history of rushing when drinking and ensure sitting upright at all meal times.

Staff had a good understanding of how to keep people safe. Environmental risks were identified and managed. One person told us, "They do a weekly fire alarm which makes me feel safe." Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. In the event of the building needing to be evacuated, a place of safety had been nominated. People's individual ability to evacuate the building had been assessed and people had personal evacuation plans in place.