Bowood Care Homes Limited

Bowood Court & Mews

Inspection report

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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

We carried out an unannounced comprehensive inspection at Bowood Court and Mews in May 2017 and rated the service as 'Good'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bowood Court and Mews on our website at www.cqc.org.uk

This inspection took place on 11 September 2019 and was unannounced.

The inspection was partly prompted by an incident which had a serious impact on a person using the service. This indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.
We focused on two of the five key questions we ask of services. Is the service 'safe,' and is the service 'well-led.' This report only covers our findings in relation to these topics.

The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Bowood Court and Mews 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.

Bowood Court and Mews accommodates 90 people across two units, each of which have separate adapted facilities in a separate building. One of the units is called Bowood Court and the other is called Bowood Mews.

At the time of our inspection, there were 83 people living at the home, a number of whom were living with dementia.

Shortly before the inspection the registered manager resigned from their post. At the time of the inspection an interim manager was in charge at the home. We refer to this person as the manager throughout the report. 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.

Since our last there had been a number of changes in the overall management of the service. This had impacted the effectiveness of the governance and working practices. Experienced and long-standing staff members no longer worked at the home and this posed challenges to the management team.

People's experience of care at the home was not always reviewed and updated in a systematic manner. Where people had accidents and incidents, these were recorded by staff however were not always reviewed

and analysed promptly so that action could be taken to reduce the risk of further occurrences.

Care planning and recording did not reflect people's experience of care. Accurate fluid and food charts were not maintained. Opportunities to engage with families were not always promoted. Whilst meetings with families had been planned, they did not always take place. Although the registered provider was able to evidence how reviews of care delivered at the home occurred, we saw people's care was not always reviewed and updated accurately and promptly. Action was being taken to improve people's experience of care at the home.

People felt safe around staff that understand how to protect people from abuse. People were relaxed and comfortable around the staff supporting them. Staff knew how to report concerns both within the home and to external organisations like the CQC if needed. Training had been provided to staff about keeping people safe and the manager understood their obligations in reporting concerns reported to them.

Staff understood people's identified risks of harm or injury and overall supported people in line with actions described to mitigate those risks. Risks were recorded in care plans for staff to refer to. People were able to access support from staff when needed. Staff recruited to work at the home had undergone background checks to check they were suitable to work at the home. Staff understood the importance of reducing the risk of infection spreading and had access to protective clothing such as gloves and aprons.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not consistently safe.

People were safe around people staff who understood how to recognise the sign of abuse and how to report their concerns. Staff understood the risks that people lived with, although care records were not always updated to reflect people's experience of care. People were supported by staff and staff were recruited having had background checks to assure their registered provider of their suitability to work at the home. Staff understood how to limit the spread of infection.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Systems and processes were not effective in ensuring a safe service was provided to people and accurate records of the care afforded to people were not always maintained. Changes in the management of the service had negatively impacted the governance of the home and there were consistently missed opportunities to identify where improvements were needed. Action was being taken to address some of these issues.

Bowood Court & Mews

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

We received information of concern from the provider related to a specific incident. This incident is currently subject to investigation and as a result, we did not examine the circumstances. Our focused inspection was planned due to the information we received that indicated potential concerns about the management of risk at the service. We looked at the areas of safe and well led.

This inspection took place on 11 September 2019 and was unannounced.

The inspection team consisted of three Inspectors, an Inspection Manager and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was dementia care.

As part of the inspection we spoke to 18 people and four relatives.

We spoke with the Operations Manager, Compliance Manager, Hospitality Manager and Registered Provider. We also spoke with 12 staff.

We reviewed four people's care records, checks the registered provider completed, minutes of staff and relatives' meetings as well as complaints and comments about the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2017 this service was rated as Good in the key question of "Is the service Safe?" At this inspection we found improvements were needed around how risks to people's health, care and support were recorded and monitored.

Risk assessments had been completed for people. However, when accidents and incidents occurred, such as people experiencing falls, these did not always prompt a timely review of people's risk management plans. Staff therefore did not always have the information they needed to minimise risks of harm or injury to people. The manager told us they had uncovered a backlog of accident and incident forms that had been completed by staff but had not been reviewed and analysed promptly by a manager. They assured us these were now being reviewed.

We saw in care records we reviewed that information about people was minimal and limited. For example, we saw for one person their fluid records did not reflect the amount of fluid they had consumed. Their records indicated that they had not had any fluid whilst we saw the person sitting with a drink. There was a risk therefore that staff did not understand how much fluid had been consumed by the person which was necessary to monitor for people, for example who were prone to conditions such as urinary tract infections.

We saw in another person's care records, records did not reflect how much the person had eaten. The person had been identified as needing a diabetic diet but again records did not reflect what we observed the person eating. This was particularly important as the person's intake of food was relevant for their diabetes management. The registered provider told us they had recognised this issue and had already arranged training for staff to improve how they completed records.

We saw there were sufficient numbers of staff at the home and observed people had access to care and support promptly at the times they needed it. We also checked staff rotas and saw staffing numbers tallied with assessed staffing levels required to support people safely. However, people received care from a number of different new staff because of staffing changes in the home. One relative told us, "There is a high turnover of staff. It is unsettling. My family member does not like new staff." A visiting healthcare professional we spoke with also told us, "There has been a high turnover of staff. It has had an impact. People are cared for by different staff. New staff are not always up to date on the needs of people which can be unsettling for people." The manager told us about a number of recent changes within the staffing structure caused partly because of long standing staff leaving.

Staff spoken with however, had a good understanding of people's care needs. For example, one staff member we spoke with could tell us that a person needed a soft diet. Staff could also explain to us how they helped to managed people's skin integrity. Some people's skin was prone to breaking down. Staff could tell us which people needed support such as specialist cushions or encouragement to move to reduce the likelihood of their skin breaking down. We saw pressure relieving equipment was in place.

People told us they felt safe around staff they knew. One person told us, "I have never been treated badly."

Relatives we spoke with told us their family member was safe living at the home. One relative told us, "Oh I have never seen anything of concern here." Staff understood how to keep people safe and understood how to report any concerns they had both within the home and also to organisations such as the CQC. A staff member told us, "I have had abuse awareness training. I have no concerns here. If I did I would report to the manager. I would not tolerate bad practice or abuse." The manager understood their obligations for recording and sharing their concerns and information about concerns was shared with the registered provider for them to analyse.

The registered provider has systems in place including background checks to assess the suitability of potential staff. We reviewed three staff files and saw recruitment checks included DBS (Disclosure and Barring Service) checks as well as reference checks. Staff we spoke with also confirmed checks were completed before they commenced work at the home. One staff member told us, "I gave a character reference and an employee reference. I wasn't allowed to start until my DBS came back."

People's medicines were stored and handled safely by trained staff who supported people to take their medicines in line with their prescription instructions. During the inspection, a new pharmacy had commenced working with the home. We saw staff arrive for their medication training on how to use the new system. The registered provider told us they had identified a number of problems with the previous method of ordering medicines and it was hoped this new system would improve how staff were able to order and store medicines. Staff competency to support people with the medicines was checked and updated regularly.

We asked staff about the availability of equipment used as part of people's care and support. For example, slings for use when transferring people were individual to each person. One staff member told us, "Everyone has their own sling. We only leave breathable slings under people. We have oodles of slings, never short." We saw staff supporting people to transfer safely from one seat to another using hoists.

The home was clean and tidy, actions were taken to reduce risks of infection. For example, staff used personal protective equipment such as gloves and aprons. A staff member told us, "The home is kept clean. We use aprons and gloves for all personal care and change in between, we always have loads (of gloves and aprons)."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2017 this service was rated as Good in the key question of "Is the service Well led?" At this inspection we found improvements were needed around quality monitoring.

The registered manager had recently left their employment. The home was currently being managed by an 'interim' manager. This manager was not registered with us but was applying to become the registered manager.

There was a lack of consistent leadership at the service due to the changes within senior management within the home. At this inspection we found the governance and the oversight of the quality of the services provided continued to be impacted by these changes and the staff team's concerns had not been addressed effectively by the provider.

There had been several staffing changes at the home since our previous inspection. Some senior, experienced and long-standing staff no longer worked at the home and whilst positions had been recruited to, newer staff did not know people as well. The registered provider shared with us that they were working with staff to change some of their working practices and this was affecting staff morale and staff attitudes to work and would take time to settle. They explained they had taken a long-standing member from Bowood Court to the Bowood Mews. Whilst staff we spoke with spoke positively about this change, the registered provider told us all of these changes had exposed several concerns in how the home was being managed and it would take time to embed changes.

Quality assurance processes included regular checks at the home. However, it was not clear how issues had not been identified sooner. For example, accidents and incidents were recorded with the expectation of these then being submitted to the provider for analysis. This had not always happened and internal audits had failed to identify this for a period of time. The registered provider and manager assured us action had already been taken to address this and work was underway to review all historic records.

The manager also told us they had identified that care plan information was not of the standard they expected. Information available to staff about people was minimal and limited. The manager suggested the enormity of changing all the care records since taking ownership of the home had contributed to this, however they also accepted care records did not reflect people's experience of care. Action was being taken to address this.

Effective monitoring of people's fluid (drink) and food charts did not take place. For example, checks had not identified one person's record showed they had not had anything to drink at all during the day of our inspection visit and yet we saw this person enjoying a drink.

People and their relatives were not always involved or consulted about changes in the home. For example, meetings planned for did not always take place which meant opportunities to involve people and their relatives were missed. The manager told us meetings had been cancelled but could not tell us the reason

why.

Systems to monitor the quality and safety of service were not operated effectively. Complete records of care afforded to people were not maintained. This was a breach of Regulation 17(2) HSCA 2008 (Regulated Activities) Regulations 2014.

The registered provider was working to address other improvements they had identified. A new post had been created to monitor the quality of care being delivered at night. This post was created in order to improve the consistency of care across the home at night

The registered provider told us they were working with other stakeholders to improve care at the home. They explained how they were working with the local authority on improvements in care planning. They were also working with the local pharmacy to develop and improve practice within the home both in terms of ordering and also in terms of managing people's medicines.

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 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality and safety of service were not operated effectively. Complete records of care afforded to people were not maintained.