# Ideal Carehomes (Number One) Limited

# Bowbridge Court

## Inspection report

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## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Requires improvement |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This inspection took place on 25 and 27 November 2014. The inspection was unannounced. Bowbridge Court provides residential care for up to 54 older people, including people with dementia, over three self-contained floors. On the day of our inspection 41 people were using the service.

The service did not have a registered manager in place at the time of our inspection. A new manager had been recruited and the area manager told us they would apply for registration shortly. 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 and associated Regulations about how the service is run.

When we last inspected Bowbridge Court in May 2014 we found there were improvements needed in relation to how people gave consent to their care and treatment, and the management of their medicines. The provider sent us an action plan telling us they would make these improvements by September 2014. We found at this

# Summary of findings

latest inspection that the provider had made the improvements in line with the action plan they provided us with for the management of people's medicines. However we found the improvements stated in the action plan for how people gave consent to their care and treatment had not been made.

People received their medication when they were meant to and they were given this sensitively.

People told us they felt safe at the service. Staff understood signs that may indicate if someone had been abused and they knew how to pass any concerns about people's safety to the local authority.

A number of staff had left the service, but new staff had been recruited to replace them. There were sufficient staff on duty but sometimes they did not work as effectively as people expected. The acting manager had identified ways to make staff more effective in the way they worked.

Staff received regular training to provide them with the knowledge they needed to care for people. However staff did not have opportunities to discuss how they were doing or if they had any difficulties they needed to discuss. This was because staff had not been having supervision or appraisals.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS is part of the MCA, which is in place to protect people who lack capacity to make certain decisions because of illness or disability. DoLS protects the rights of such people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed. We found this legislation was not used correctly to protect people who were not able to make their own decisions about the care they received.

We saw some people were not eating as well as they could, because they were not provided with the support they needed to eat their meals. This put their nutritional intake at risk. Where people were at risk of not eating properly the systems used to monitor this were not used effectively.

People were supported to access healthcare services when they needed medical attention. However plans of treatment were not always followed, so people did not get the maximum benefit from these.

Whilst we saw some examples of people being treated with compassion and respect we also saw occasions where people did not receive their care and support in a compassionate way. Some people described experiences where staff had not treated them with the care and kindness they expected.

There were times when people did not receive the care they needed or make the choices they wanted. We found examples where people's care plans were not accurate and these did not provide staff with the direction about people's care they should.

Concerns were raised that sometimes information was not communicated between staff. Staff did not feel any suggestions they made were listened to. Systems to monitor the quality of the service were not used to identify any improvements needed.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

People were protected from the risk of abuse because the provider had systems in place to recognise and respond to any allegations or incidents that occurred.

People received their medicines as they had been prescribed and these were managed safely.

Measures were being put into place to provide more consistent and stable staffing arrangements.

**Good**

**Is the service effective?**
The service was not always effective.

People were not protected from decisions being made against their wishes because they were not protected under the Mental Capacity Act 2005.

Staff were provided with training about their role and responsibilities. However they had not been provided with the individual support to make sure they put their learning into practice.

People's nutritional intake was not properly monitored to ensure they had sufficient hydration and nutrition.

**Requires improvement**

**Is the service caring?**
The service was not always caring.

There were occasions when people did not receive care and support in a kind and caring way, and their dignity was not maintained.

People and their relatives were able to express their views on how their care should be provided.

**Requires improvement**

**Is the service responsive?**
The service was not always responsive.

People sometimes did not receive their care and support as planned and they were not able to make the choices they would like to.

People were not supported to follow their hobbies and interests.

When people or their relatives raised concerns these were not always acted upon through the proper procedure.

**Requires improvement**

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

**Requires improvement**

# Summary of findings

People could not rely on information being passed on between staff members. Staff felt their views and suggestions were not valued.

The procedures followed to monitor the quality of the service were not effective and did not identify areas that needed improving.

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

We inspected the service on 25 and 27 November 2014. This was an unannounced inspection. The inspection team consisted of one inspector 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 previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with 10 people who lived at the service, 10 visiting friends and relatives, five members of care staff, a peripatetic manager who had been running the service, the newly appointed acting manager and the area manager. We also spoke with two healthcare professionals who visited the service. We observed the care and support that was provided in communal areas. We looked at the care records for five people, as well as other records relating to the running of the service, including audits of the service, staff meeting minutes and staff training records.

Good

# Is the service safe?

## Our findings

The last time we inspected the service we found there had been a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found people could rely on their medicines being looked after and given to them when they needed them. Improvements had been made to the way people's medicines were managed and administered, and daily checks and weekly audits now took place to ensure these were maintained.

People were happy with the arrangements for managing their medicines and said they received these when they needed them. One person said, "They are very good over that, I have my tablets four times a day. I get them on time." A relative said, "They deal with all that, it's automatically done."

We observed part of the lunchtime medicines round and saw staff giving people their medicines in a way that made it a positive experience. This was done by taking the time to talk to the person about something that interested them. A person who used the service said, "The staff on 'medication duty' do look after you." There was information available about how each person liked to take their medicines and we saw people were given this in the way described. A relative said, "There is no problem with medication, they [staff] deal with the prescription."

The area manager told us they reorganised the arrangements for ordering and supporting people to take their medicines. They said they were now satisfied people were safe when receiving their medicines. A staff member told us they had their competency assessed that morning to ensure they were able to give people their medicines safely. The most recent senior staff meeting minutes showed that oversight was given to the medicines systems and action was taken to ensure this was managed as safely as possible.

All the people who used the service told us they felt safe at the service. One person described to us how they had not felt safe in their room and had told staff about this. The person said, "I complained loud and hard and they moved me to the top floor. I feel safe now." Relatives told us they felt their relations were safe. One relative said, "I feel [name] is safe. If anything was not right we would say so." Our observations found people to be at ease when they were with staff. Staff demonstrated that they had been trained to protect people from abuse. They told us they understood the different types of abuse people could face and what signs may indicate someone had been harmed. We saw how information was made available to staff to guide them on the procedures to follow if they had any concerns about abuse.

Two people who used the service had been assessed to be safe to leave the service independently, and did so to access community resources. One person told us they had been out earlier in the day and met up with some friends.

Staff told us they would support people to do things they wanted to safely. A staff member gave an example that if someone wanted to make a hot drink, they would only step in to do any part of the activity where a person may be at risk of harm. The staff member explained that if a person was unsteady holding the kettle they would put the hot water in the cup for them, but the person would do the rest. We noted that when someone rang their call bell for assistance staff responded promptly so if anyone was unsafe they were assisted promptly.

Some of the people who used the service and relatives told us they felt there were occasions where there were not enough staff on duty and there was a lack of consistency due to a high staff turnover. They gave examples of what made them hold this view, including long waits for a call bell to be answered, and relatives being left waiting for some time to be let into the building when they rang the doorbell. A relative said, "They had a high turnover of staff, [relation's name]'s no idea who's who, I haven't."

The acting manager and area manager agreed people had not been receiving consistent care. In order to address this they told us the staffing levels had not been reduced despite lower occupancy, so as a result of this staff had more time to see to people's needs and provide more consistent care. The acting manager told us they would be making some changes in the near future on how staff were deployed to work to provide people with more consistency. Staff told us that most of the time they had sufficient staff on duty to provide people with the care and support they required to meet their needs.

The acting manager and area manager agreed there had been a high turnover of staff, but told us new staff had been recruited, and we saw some new staff attended an

Good

# Is the service safe?

induction day during the inspection. Although people had experienced inconsistent care and there had been a high turnover of staff, measures had been, or were being, taken to rectify these.

Requires improvement

# Is the service effective?

## Our findings

The last time we inspected the service we found there had been a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found the improvements the provider told us they would make had not been made. This meant people were still at risk of not being able to make decisions they were able to.

The area manager told us they had not implemented the actions they submitted in their action plan for a variety of reasons, including the change of manager at the service and some confusion about what needed to be done. The area manager said they had now received further guidance and were clear what they needed to do. This would involve changing the provider's prepared documentation for assessing people's ability to make a decision, and providing staff with training.

The acting manager and area manager told us they did not think anyone at the service was prevented from making any decision they were able to because they did not have the proper systems in place, however there was a risk this could happen. It was recorded in the most recent senior staff meeting minutes that, "There are a lot of cases where the care plans say they (people who used the service) have no capacity to make decisions, however they are able to give simple answers on non-complex decisions."

Staff were not clear about the process they were required to follow to assess anyone's capacity. They also were not clear about when an application should be made for a Deprivation of Liberty Safeguards (DoLS.) The area manager said a representative from the local authority had visited and reviewed one person's care plan and as a result the acting manager was now going to make an application for a DoLS.

We found that the registered person had not protected people against the risk of receiving care and treatment without their consent. This was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people's views on the meals provided to them were mixed. One person said, "The food is alright, good, I don't eat much but I like what I have." Another person said, "One thing I must mention, the food has deteriorated, it is not as varied as it used to be, sometimes it is not bad, sometimes blooming awful." People were not provided with meals at appropriate intervals. A person who used the service said, "Tea is around half past four so by the time it gets to six thirty in the morning I'm starving."

There were occasions where people did not receive the choice or support they required to encourage them to eat their meals. People were expected to choose what they wanted to eat the previous day, so it was possible they may forget what they had chosen, or fancy something different when the mealtime came around. A person who used the service told us at lunchtime, "We don't know what we are getting until it comes." We saw some people requested accompaniments to go with their meal but they were not provided with these. Several people were encouraged to sit at the meal table to have their meal and were given the assistance they needed, however we also saw other people who needed assistance were not provided with this. For example one person was having difficulty to cut up their dinner, but there were no staff available to assist them.

The acting manager said they intended to improve the menu so it provided people with better choices, as they felt the choices provided were limited. Staff were aware of which people had to follow particular diets for their health and wellbeing. We looked to see how people's weight was monitored and where someone was identified as being at risk of weight loss how their food and fluid intake was monitored. We saw there were occasions when the evaluation made of weight records was not accurate. We looked at food and fluid monitoring records and saw these were not accurately completed and the information was not used to identify if the person had consumed the required food and fluid input. For example the acting manager told care staff how much one person had eaten at lunchtime, but this had not been recorded correctly.

We found that the registered person had not protected people against the risk of inadequate nutrition and hydration. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training to provide them with the skills and knowledge they needed for their role and responsibilities We saw a group of new staff having an induction to prepare

Requires improvement

# Is the service effective?

them for when they started to work at the service. We asked the group of new staff if the induction had been helpful and informative and they all said it had been, and that they were looking forward to starting work. Staff told us they had regular training provided and this tended to take place in a small group, where they could discuss issues together. Staff told us they had been asked if they wanted to study for a formal qualification and those staff who did had enrolled onto an appropriate course for their area of work, such as a diploma in health and social care.

Staff had not been provided with the support intend to ensure they had the skills and confidence to carry out their role effectively. The acting manager said supervision had not been taking place regularly, but they were now implementing a supervision structure so all staff received regular support where they could discuss their job role. A senior care worker said the acting manager had asked seniors to organise supervision sessions to provide staff with support as these had not been taking place.

Staff made appropriate referrals to healthcare services so people could receive the healthcare support they required. One person told us when they had needed to see a doctor, "They [staff] were very good in getting him." They also told us the doctor came to review their medication. Another person said staff had, "Got the doctor almost straight away when I was ill with stomach pains." Relatives told us staff called a doctor or arranged for their relation to go to hospital when needed and kept them informed about this. The acting manager said staff were good at picking up signs when people were not well and contacting healthcare professionals.

On occasions people did not receive the care and/or treatment that was recommended for them. We spoke with two visiting healthcare professionals, one had limited contact with the service but was happy with the contact they had. The other professional had regular contact and told us staff were proactive in making referrals, and were usually able to provide the information they needed. However the healthcare professional said when they left exercises for people to do, these were times these were not seen through. They also said if they advised a person would benefit from some aids or equipment they had experienced difficulties and delays in this being provided.

Requires improvement

# Is the service caring?

## Our findings

People did not receive a consistent approach from staff in the way they were cared for. One person said, "Some staff are absolutely wonderful, others you have the feeling you are just a job and that's it." Another person said, "Some are scrupulous at giving you drinks, some don't bother. Some are very careful at changing your water, others it doesn't cross their minds that you might want fresh water."

We saw occasions where staff spoke politely with people and showed an interest in them and their families. These were light hearted interactions which created a pleasant atmosphere. On other occasions we saw staff assisted people in a more task oriented manner with little interaction. A relative told us although staff appeared to get on well with their relation they did not know how well staff really knew them. The relative said, "I don't know if they have any idea of their history, they've never asked me." Another relative said, "Some staff know a bit [about their life history], but they don't really know much." We found some staff had limited knowledge about people's care plans and did not know how to refer to them to find out about people's care.

Staff tended to be task focused and at times did not take opportunities to provide people with attention or appreciate the impact they had on them. For example we saw a person take hold of a staff member's arm, but as they were occupied talking to another staff member they did not respond to the person. We observed occasions where staff were talking to each other when they could have been with people who used the service. One relative said, "Staff seem to spend a lot of time doing paperwork, sometimes you see three of them at one table." Staff told us they did not have the time to sit down with people and give them individual attention or organise things for them to do as their time was fully occupied with people's care.

We saw one person was not involved in the mealtimes with other people, and ate separately in another part of the room. We asked staff the reason for this and they said they had been told to do so by a senior member of staff. Following our discussion the staff included the person in the next mealtime. One staff member told us the person had given them "A big hug" which the staff member believed to have been as a result of the changes they made.

We informed the acting manager of the incidents we had witnessed and they said they would carry out some observations to identify any practices that needed to be improved.

There were occasions when staff did not understand the need to make sure that people had their privacy and dignity maintained. People told us there were times when staff could be more attentive and did not appear to be pro-active in anticipating people's needs. For example they would ensure people who required full assistance with washing and dressing were presentable, however those who maintained some independence were not always supported to change their clothes and ensure they were wearing ones that were clean. During our observations we saw staff responded to people who needed their assistance, but did not keep a check on people who exercised some independence in case they needed some help.

We found that the registered person had not protected people against the risk of inappropriate care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's religious needs were known and catered for. There were religious discussion forums and services held, and some people had representatives from places of worship come to visit them. Staff spoke of having discussions with people about differences between different cultures.

People were supported to express their views. A relative told us they had discussed how their relation's need would be met and that the care plan had been updated following the discussion. Another relative said, "I have been in conference with a senior manager and discussed all [relation]'s needs."

Requires improvement

# Is the service responsive?

## Our findings

People did not always receive care and support in a way that met their needs. During a tour of the building we heard a person call from a toilet for help a number of times. We alerted this to a staff member and the person was then provided with the assistance they needed. We saw it was recorded in the person's care plan that the person preferred a staff member to wait outside the toilet for them as this made them feel safe, but this had not happened.

There were times when people did not make the choices they wanted to maintain control over their independence. A person who used the service said, "Staff tend to put me to bed early, they finish at eight [o'clock] and want to sort me out before they go, but I don't mind". We asked the person if this was what they wanted to happen and they replied, "No, I wouldn't go that early." Some people commented that the radio station which was usually selected was chosen by staff and did not play music that was relevant to people who used the service. One person told us, "I can't stand the noise."

People's needs, choices and preferences were not always reflected in their care plans. Staff told us about one person's needs, however when we looked at the person's care plans these had not been referred to or included in relevant care plans on how to meet the person's needs. The area manager said, "I know the care plans are not up to scratch, they are work in progress." We asked some staff if they understood some of the assessments used, including how to identify if a person was at risk of pressure damage to their skin. Staff did not know about this assessment or how this informed them of the risk the people faced with regard to pressure damage.

Although we saw during our visit a number of people, visitors and staff enjoy a visiting entertainer, several people and relatives expressed concern at the lack of activities that were usually available. One person said, "I wish they could find something to occupy our minds." Another person told us, "I sit and chat, that's about it." A relative said, "One thing lacking is activities; they don't have an activity co-ordinator or an activities programme." Staff told us they tried to provide things for people to do but this was difficult and they got disrupted as they had to attend to people's care needs. A staff member said, "If we were sat there in a chair all day we would be bored." Another staff member said, "I asked about taking some people out, but I was told if I wanted to do that I would have to come in on my day off."

We found that the registered person had not protected people against the risk of inappropriate care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were aware of how to respond to people's complaints and told us of occasions when these had been dealt with in a way that made improvements for people, we found people could not always rely on their complaints being responded to appropriately. A relative told us they had complained to staff that another person was going into their relation's room and taking things. The relative said they had asked staff if the room could be locked when their relation was not there, but they had been told that this was not possible. The acting manager was new in post and was unaware of this as it had not been reported to them. The acting manager told us about another complaint that had been made by a relative and showed us the documentation made of this. This had been investigated and the outcome of this fed back to the relative. The acting manager told us the relative had been satisfied with the response they had given them.

There was information displayed about how people who used the service or their relatives could make a complaint.

Requires improvement

# Is the service well-led?

## Our findings

People were at risk of not getting the care and support they required because there were problems with communication at the service. We found people had been told different things which they found confusing. People gave us examples where they had been confused about appointments, costs and menus. A relative told us, "Communication is not good, if you tell [one member of] staff something it doesn't get filtered across."

Staff told us they were not kept properly informed of events at the service, such as the recent change of manager. We also found staff did not use the systems in place to provide them with information. Staff were expected to sign staff and senior staff meeting minutes to confirm they had read these. The majority of staff had not signed these to show they had read them so they may not know significant details or events effecting people who used the service.

Staff did not feel the culture within the service encouraged them to speak out freely and they told us that any suggestions they made were not listened to or acted upon. A staff member said, "We suggest things, get told it is a good idea but then nothing comes of it. There is only so much you can say till you get fed up and don't bother anymore." Staff told us of a number of suggestions they had made about how to make the environment more homely and supportive to people with dementia, but these had not been considered. As a result improvements were not made to the environment that would make it more welcoming for people. When staff had introduced some fun oriented pictures and signs in line with people's interests they had been told to take these down.

We saw several people had either a recent photograph of themselves or one from their earlier life on their bedroom door. Staff said this helped people to identify which was their room. Staff said they thought this would be helpful for other people who did not have a picture; however no one knew how to arrange this.

Most people we spoke with were aware there had been issues about the leadership within the service over recent months. The previous registered manager had left the service and there had been temporary management arrangements in place. Events had taken place that the provider should have sent us notifications about, which they had not done so at the time, but did so after we had prompted them to do so. A notification is information about important events which the provider is required to send us by law.

People thought the new acting manager was making improvements to the management of the service. Some people told us they had attended meetings the new acting manager had arranged for relatives and residents. A relative told us one improvement was that some staff now had name badges so they knew who was who. The area manager told us they were now getting more positive feedback from people who used the service and their relatives.

Although there was no office on each of the floors an office area had evolved in each dining room where staff carried out paperwork. This meant people's confidentiality may not be respected because files and other records were left on display during the day and staff discussed personal information where they could be overheard by other people who used the service or any visitors. The acting manager told us they had raised in a recent staff meeting about promoting confidentiality in the communal areas and we saw the minutes where this had been mentioned. The 'office area' had been removed from each floor on the second day of our visit.

There was a system in place to carry out monthly audits on a range of services provided. We saw these audits had been completed in a tick box fashion and did not identify any shortfalls in quality of the service being audited. For example the audit on the floor management folder for October 2014, where the food and fluid charts were kept, identified that these were being completed, but did not show they were not being completed properly. The area manager said that due to the recent temporary management arrangements the auditing system had been completed, but had not been used as a way to make improvements. The area manager told us they knew there were improvements needed at the service. They said, "We know where we are and where we need to be."

We found that the registered person had not protected people against the risk of inappropriate care and treatment. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>**The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people who used the service in relation to the care and treatment provided for them. Regulation 11(1).** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**The planning and delivery of care did not meet people's needs and ensure their safety. Regulation 12 (1)(2)(a)(b)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**The registered person did not identify, assess and manage risks to ensure people's health, safety and welfare was fully protected. Regulation 17 (1)(2) (a) (b).** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br><br>**People were not protected against the risk of inadequate nutrition. Regulation 14 (1)(a)(c)** |