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?	**Requires Improvement**
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**

Summary of findings

Overall summary

This inspection took place on 30 August 2016, it was an unannounced inspection. Bowbridge Court is run by Ideal Care Homes (Number One) Ltd. It is situated in the town of Newark in Nottinghamshire. The service is registered to provide accommodation for 54 older people who require personal care. There were 51 people living at the service on the day of our inspection. The service is split across three floors, each with communal living spaces.

We carried out an unannounced comprehensive inspection of this service on 25 and 27 November 2014. Breaches of legal requirements were found in relation to the care, treatment and safety of people, consent, nutrition and hydration and governance. We conducted this inspection to follow up on breaches identified in our November 2014 inspection and to look at the overall quality of the service.

There was no registered manager for the service at the time of our visit and there had not been one in place since June 2016. A new manager had recently been appointed however they had not yet started in post, on the day of our visit there was a new acting 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.

During this inspection we found that although people felt safe in the service, people were not always protected from the risk of abuse and information of concern was not always acted upon or shared with the local authority swiftly. Risks in relation to people's care were not always planned for appropriately to ensure people received safe care and support. Safe recruitment practices were not always followed.

Medicines were not always stored or managed safely. There were not always enough staff to provide care and support. People were supported by staff who had not received adequate levels of training.

People could not be assured that they would be provided with effective support in relation to their nutrition and hydration. People had their day to day healthcare needs met but where people had health conditions they could not always be assured that they would receive effective support.

People were supported to make day to day decisions but where people lacked capacity their rights under the Mental Capacity Act 2015 were not respected.

People were not always treated with dignity and their right to privacy was not always respected. Staff were caring and had positive relationships with people using the service. People were supported to make choices about how they spent their day. People had the opportunity to get involved in activities in the home but these were not always based upon people's interests and hobbies.

People's care plans did not provide a detailed description of people's individual needs and preferences and

did not contain all the relevant information to enable staff to provide effective support. People and their families were involved in the development of their care plans but were not involved in care plan reviews.

There was a lack of effective governance from the provider which put people at risk of receiving poor care. Quality assurance systems were not effective in identifying areas for development and action plans were not consistently developed or implemented. People and staff were not involved the development and running of the service.

The management team, led by the new acting manager, were approachable and open. People using the service felt able to share any concerns with the management knew how to raise concerns. Complaints and concerns were responded to appropriately. Staff were given feedback on their practice in supervision and they felt comfortable discussing issues, concerns and ideas with the management team.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staffing, consent and good governance. We also found a breach of the Care Quality Commission (Registration) Regulations in relation to notifications that the provider is required to make to the CQC. 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.

Medicines were not always stored or managed safely.

Risks in relation to people's care and support were not assessed or planned for appropriately.

People were not kept safe from harm as incidents were not always reported swiftly and staff did not always have an understanding of safeguarding procedures.

There were not enough staff to provide care and support to people at all times.

Is the service effective?

Requires Improvement

The service was not always effective.

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

People were supported by staff who had not received adequate training. Staff were provided with regular supervision and support.

People had their day to day healthcare needs met, but staff did not consistently have a good understanding of people's health conditions.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and compassionate and treated people with respect.

People were not provided with information in a way that was accessible to them.

People were not treated with dignity at all times and their right to privacy was not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving inconsistent support and were not involved in planning their care and support.

People were provided with the opportunity to get involved in activities but these were not tailored to people's individual hobbies and interests.

People were supported to maintain relationships with family and friends and visitors were welcomed into the home.

People were supported to raise issues and concerns and there were systems in place to respond to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems in place to monitor and improve the quality of the service were not effective.

There was a lack of effective governance from the provider which put people at risk of receiving poor care.

People and staff were not involved in giving their views on how the service was run.

The new management team were approachable and proactive. People and staff felt able to share ideas or concerns with the management.

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. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 25 and 27 November 2014 inspection had been made and to look at the overall quality of the service.

We inspected Bowbridge Court on 30 August 2016. This was an unannounced comprehensive inspection. 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 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 contacted commissioners (who fund the care for some people) of the service and asked them for their views. Before the inspection, the provider completed 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.

During the visit we spoke with six people who used the service, three relatives, four members of care staff, the cook, two deputy managers and the quality support manager who was acting manager on the day of our visit. We also spoke with one visiting health professional. We observed care and support in communal areas. We looked at the care records of six people who used the service, medicine administration records, staff training records and four staff files, as well as a range of records relating to the running of the service.

We 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.

Requires Improvement

Is the service safe?

Our findings

People could not always be assured that there were enough staff to meet their needs. People using the service and their relatives told us that they felt that the service was short staffed and that this had an impact on the care people received. A relative we spoke with told us, "There are not enough staff, you need two to lift someone on that machine (hoist), so there's only one to do everything, (but) they do a good job." Another relative told us, "There is a shortage of staff, they (staff) are under terrific pressure, can't always be there, my relative can't come out of their room. They are really stretched and under pressure, it takes two carers to help my relative. My relative thinks they don't care."

We reviewed call bell records which showed that people were not always provided with support in a timely manner when they used their call bell to summon support. These records showed that whilst some calls were responded to within seconds, there were occasions where people had to wait 15 – 30 minutes to be attended to by staff. During our visit we saw that although people's needs were normally responded to quickly there were two occasions where people were not provided with support in a timely manner. On one of these occasions we heard a person calling from their room for support and we also noted that their call bell was sounding. A staff member did not attend to this person for approximately ten minutes. On the other occasion we heard another person calling from their room for around five minutes. When we saw the person had a small wound which was bleeding we intervened and summoned a member of staff.

We spoke with the acting manager about staffing levels who shared the provider's method for calculating these and informed us of their current staffing level. When we reviewed staff rotas these showed that shifts were not always staffed to the level determined by the provider. For example the provider's calculations identified that five staff should be on duty overnight to ensure people's needs were met. Staffing rotas showed that there were not always five members of staff on shift throughout the night and staff we spoke with told us this was "very occasionally" the case and when there were only four staff on at night it was a "stretch". Incident records showed that there had been a high number of falls in recent months, many of these falls were unwitnessed and during the night. The acting manager told us that they had identified the high incidence of falls and that they were considering reviewing staffing levels in light of this, however this work had not yet been undertaken.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and safety were not always properly assessed or well managed. Risk assessments relating to falls were not always assessed correctly. For example, one person's care plan contained a risk assessment which should have been used to work out the risk of the person falling. This was completed incorrectly because staff had not taken into account the number of falls the person previously had. This meant the assessment did not accurately show the level of risk that the person may fall again and what support the person required to minimise the risk of them falling again.

Care plans relating to falls did not always contain sufficient detailed information for staff about the risks

associated with people's care. For example one person had been assessed as being at high risk of falls and had a motion sensor in place to alert staff should they move around in their room. Records showed that the person occasionally turned the sensor off or moved it so that it could not trace their movements. This was not detailed as a risk in the falls care plan and there was no information about how to mitigate this risk. Staff were not able to describe any additional controls that were in place to mitigate this risk. We saw records which showed that this person had a high number of recent falls, some of which took place in their room whilst they were alone.

Although staff were routinely recording accidents and incidents these were not effectively analysed and investigated to identify any trends or patterns. We saw that some of people had a high number of repeat falls and but actions related to mitigating the risk of future falls were limited and normally stated 'motion sensor in place'. In addition to this no action had been taken in response to the high number of recent unwitnessed falls.

Risks of people developing a pressure ulcer were not always assessed and planned for safely. Pressure ulcer risk assessments were completed monthly and people who had been assessed as being at risk of developing pressure ulcers were provided with equipment to reduce the risk. However, staff did not always have a good knowledge of this and care plans did not always provide adequate detail of this equipment or how it should be used.

One person had been assessed as requiring a specialist mattress to reduce the risk of skin damage. The care plan did not specify the required settings for the mattress but stated 'staff to check if bed and mattress in working order'. During our visit we found that the mattress was not set at an appropriate level for the person's weight. We spoke with a member of staff and the deputy manager about this neither of whom were aware of the correct setting for the mattress or how to operate it. The deputy manager told us "I'm not sure (what setting the mattress should be on); they are all set when they are delivered to us by the Red Cross." When asked what they would do in the event of power failure or if the settings were accidently changed they responded, "That's a good question, I'm not sure." This lack of knowledge increased the risk of people developing skin damage. We also saw that re-positioning charts were in place for people at high risk of developing pressure ulcers were not being completed correctly.

People could not be assured that risks associated with their health conditions would be managed or responded to appropriately. Care plans did not contain detailed information about the risks associated with people's health conditions and staff we spoke with did not always have adequate knowledge of these risks. For example one person who used the service had epilepsy which caused them to have seizures. There was a basic care plan in place relating to epilepsy but this did not detail how often the person had seizures, the triggers, how to support the person and minimise risk or if any rescue medication prescribed. There was also no risk assessment in place identifying what risks the person faced and needed to be reduced. Staff we spoke with did not have a good knowledge of how to support the person with their condition. One member of staff we spoke with told us, "I didn't really know what to do if [name] had a seizure but I was working when it happened the other day. It was okay and we got through it and now I know what to do if it happens again."

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not always be assured that the systems and processes in place to protect them from potential harm and abuse were being used as intended. There were occasions where the correct safeguarding procedures had not been followed. Some safeguarding incidents were not referred to the local authority in a timely manner. For example we saw that one incident was not referred to the local authority until seven days

after the event. Staff we spoke with were aware of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to their manager. One member of staff told us "I would go straight to the management and record it, if necessary I would ring head office and go to CQC." However not all staff were aware of the role of the local authority safeguarding team. We viewed training records which showed that 26 staff had either had no safeguarding training or their safeguarding training was out of date.

Despite this, people and their relatives told us they or their relations felt safe living at Bowbridge Court and had confidence that any concerns they raised would be dealt with appropriately. One person who used the service told us, "I feel safe, nobody would hurt me." A relative we spoke with exclaimed, "Safe? Yes I think they do keep people safe I had previous relatives here, I feel quite happy."

People could not be assured that safe recruitment practices were always followed. We saw one staff file where there was no record of the detail of the person's Disclosure and Barring Service check in their file. The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work vulnerable adults. This helps employers make safer recruitment decisions. There were also gaps in the person's employment history. This meant the provider did not have records of all the relevant information about this person's employment history to make a decision about the suitability of this staff member. This put people at risk of being supported by unsuitable staff. Other staff files contained all the necessary information. References from previous employers had been sought to determine if staff were of good character and checks through the Disclosure and Barring Service were completed as part of the recruitment process.

People could not always be assured that they would receive their medicines as prescribed. We checked the medication administration records (MAR) and saw that staff were completing these records correctly. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. However, where 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. This issue had been picked up by a recent medication audit but no action had yet been taken to improve practice in this area. Some people had a medication profile detailing how to support them with medicines. However, two of the six people's records we viewed did not contain a medication profile which meant that staff did not have access to information about the person's allergies or how the person preferred to take their medicines.

People could not always be assured that their medicine would be administered by competent staff. Although staff had received training in the safe handling and administration of medicines there was not an effective system in place for checking the competency of staff to administer these. The acting manager told us that staff competency to administer medicines was assessed annually; however we found that this had not happened. One member of staff had not had their competency to administer medication assessed since 2014.

When people were prescribed medicines to be taken as and when they required them (PRN) there were not always written protocols in place detailing what these medicines had been prescribed for or when they should be taken. This meant that staff did not always have clear information about when to give people these medicines. For example one person had been prescribed a medicine to relieve their pain as they came towards the end of their life, there were no details of when this medicine should be administered which put the person at risk of suffering unnecessary pain and discomfort. There were PRN protocols in place for other medicines however they did not always contain adequate levels of detail. For example one person was prescribed medication to relieve their anxiety. There was a PRN protocol in place but it did not clearly describe what other strategies should be used, prior to medication, to relieve the person's distress.

Medicines were not always stored safely. Fridge and room temperatures were monitored daily and recorded as being within range. However, we tested one fridge and found that the temperature was significantly above the safe range for the storage of medicines and it was unclear how long this had been an issue for. We shared this feedback with the acting manager who took immediate action to rectify this issue.

Medicines audits were completed monthly; however the quality of these were variable. The most recent audit was incomplete and did not identify the issues we found during our inspection.

Requires Improvement

Is the service effective?

Our findings

In our November 2014 inspection we found a 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. People's rights under the Mental Capacity Act were not respected. We asked the provider to make improvements and during this inspection we saw that further improvements were still required in this area.

The Mental Capacity Act 2005 (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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not protected as the principles of the act were not always correctly applied. MCA assessments and best interest decisions were not always in place as required. For example, one person using the service was at times resistive to personal care, it was unclear if the person was able to make decisions in this area of their life and there was no MCA assessment or recorded best interests decision in place. Another person was not able to consent to the content of their care plan and other aspects of their care and treatment, however there was no MCA in place relating to this. A consent form had been signed by the person's relative 'on behalf' of the person and this covered taking photos, administering medicines, and providing a personal allowance. However there was no indication that this relative had any legal powers, such as a Health and Welfare Power of Attorney, to provide consent on behalf of the person.

A number of the MCA assessments we saw were not decision specific and covered the person's general capacity to make day to day decisions. In addition to this decisions made in the best interests of people were not always recorded. We saw two people's care plans contained an MCA assessment which concluded that both people had 'fluctuating capacity'. Neither care plan contained any further detail about how to support the person with decision making to maximise their capacity.

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). The acting manager had an understanding of DoLS and we saw that a number of DoLS applications had been made over the past 12 months. However we found that the management team did not have an oversight of whether or not any DoLS had been granted.

Staff had a basic knowledge of the MCA but were not able to clearly describe how the act applied in their role. Staff did not have an understanding of DoLS and were not aware if anyone one had a DoLS in place, one member of staff told us, "Yes I think probably everyone on the middle floor has one (DoLS)." Whilst another member of staff told us, "No I don't think anyone does (have a DoLS). We saw that although some staff had recent training in the MCA a significant number of staff had no training in MCA or their training had expired.

Some people had 'do not attempt resuscitation' orders in place. These had been completed by people's GPs and family members had been involved in some of these decisions. Where people lacked capacity to consent to this we saw that there were no specific mental capacity assessments and no recorded best interests decisions in place. This did not protect people's rights under the MCA.

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

Where people had capacity they were supported to make decisions and we observed that staff spoke with people and gained their consent before providing support or assistance.

People received care and support from staff who did not all have the skills and qualifications necessary to support them safely. Training records showed that there were a high number of staff who had either not received any training or their training was out of date in areas such as safeguarding, equality and diversity, the MCA, dementia awareness and infection control. For example we saw that one senior member of staff did not have any up to date training, because all the courses they had previously attended had expired. Records showed that 27 staff did not have any recent training in equality and diversity, 17 of these had not had any training in this area and a further 10 staff member's training had expired. This meant people were at risk of not having their diverse needs accommodated.

Staff we spoke with told us they had found their training useful and felt that the training they received was good quality. One staff member said, "The training here is amazing." Another member of staff told us, "We have ongoing refresher training." We found that the staff we spoke with did not always have a good knowledge of healthcare conditions experienced by people using the service and we saw that people had not received specific training in areas such as diabetes or epilepsy. One member of staff we spoke with said, "We have had some training about people's specific needs but now you mention it I think we probably need more." Another member of staff said "We have told them (provider) that we would like more training about things like epilepsy, and I'm hoping that they take it up."

Despite the above gaps in training people told us they felt that staff were well trained and competent. One person's relative told us, "The staff team are stable, they have been here a long time and they know what they are doing."

People were supported by staff who had regular supervision and support. The provider told us in the PIR that, "The staff team are supported in their roles by regular supervisions." Staff we spoke with were positive about their supervision meetings and told us that they had recent supervision. One member of staff we spoke said "I actually had one two weeks ago, yes it's useful," and another staff member told us they had regular supervision in which they received feedback on their practice.

New staff were provided with an induction period when starting work at Bowbridge Court. The provider told us in the PIR that, "Staff training consists of a thorough and robust induction. Two weeks formal classroom training is followed by a structured 'on the job' six month long induction programme." Staff told us that they were provided with good training and support when starting work at the service. One member of staff we spoke with recalled their induction and told us they felt that it prepared them well for the role.

In our November 2014 inspection we found 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. People were not protected against the risk of inadequate nutrition and hydration. We asked the provider to make improvements and during this inspection we saw

that some improvements had been made in this area but further improvements were still needed.

People told us that they were given plenty to eat and drink, but feedback about the quality of the food was varied. One's relative said, "People get soggy chips, the food comes up on the big trolley, they need a dumbwaiter." Another relative commented that their relation had complained that the food quality had deteriorated recently. However a person using the service told us, "Food and drink is good quality." A third relative told us, "The food is fresh and they make lovely cakes."

During our inspection we observed lunch in the three dining areas. Staff told people what was for lunch and provided appropriate support and encouragement to people to eat their meals. Food was freshly cooked, people were provided with condiments when they asked and people were offered a choice of drinks and desserts. Most people appeared to enjoy their food. Staff were responsive to people's needs and noticed when one person was not eating their meal and provided them with assistance. Another person did not want what was offered and staff acted quickly to provide alternative options. We saw that people were offered drinks and snacks throughout the day and there were baskets of fresh fruit, crisps and other snacks available on each floor.

People could not be assured that they would be provided with effective support in relation to their nutrition and hydration. Although care plans contained a satisfactory level of information about people's dietary requirements we found that the kitchen team did not have information about these requirements on the day of our visit. We spoke to the cook who was also a senior carer and they explained that, "I just prepare meals based upon my knowledge of people's dietary requirements, I've not seen any information about it in the kitchen, they used to have something but I don't know where it would be." This put people at risk of receiving food that did not meet their requirements.

In contrast, care staff we spoke with had a good knowledge of people's dietary requirements. One person had been assessed by the Speech and Language Therapy (SALT) team as being at risk of choking. The SALT team had advised a specific diet and we saw that care staff ensured that this diet was provided on the day of the inspection.

There were systems in place to identify when people were at risk of losing weight but these were not always used as intended. We saw that when concerns had been identified the staff team had implemented food and fluid records to ensure adequate levels of nutrition and hydration. However these were not always effective as records had not been fully completed and there was no evidence that the information from the records was analysed to identify further issues and concerns. This put people at risk of malnutrition or dehydration.

People could not always be assured that they would receive effective support in relation with their health conditions. Staff we spoke with did not always have a good understanding of people's health conditions. People's care plans did not consistently provide an adequate level of information to enable staff to provide effective support nor did they contain guidance for staff on how to recognise that a person's health condition may be worsening. For example, two of the four staff we spoke with could not describe the symptoms a person with diabetes may experience despite the fact that the service supported a number of people with the condition. Another person's assessment documentation recorded that they had a particular health condition, however this was not recorded anywhere in their care plan and staff we spoke with were unsure if the person did indeed have this condition. This meant staff may not realise if the person's health condition was deteriorating and there was a risk that people may not be enabled to access support from external health professionals when needed.

People were supported to attend routine health appointments and staff arranged for health professionals to visit people regularly. We saw evidence of the involvement of a range of health professionals in people's care records including GP, district nurse, chiropodist, dentist and optician. We also saw records of the staff team contacting the 111 service to access advice when they were concerned about someone's wellbeing. Outcomes of appointments and advice from health professional was clearly recorded in people's care plans.

When people were unwell or had a short term health condition the staff team implemented 'short term care plans, these enabled the staff to keep track of the person's wellbeing. For example we saw that when one person had a wound, a short term care plan had been put in place and was used to detail any changes to their condition. There also was evidence that the district nurse was visiting regularly to provide treatment.

Requires Improvement

Is the service caring?

Our findings

Staff did not always respond quickly or appropriately when people were experiencing distress or discomfort. Whilst we saw that the needs of people who chose to spend their time in communal areas were responded to quickly, this was not always the case when people chose to spend time in their bedrooms. This meant that there was a risk that people may not get their needs met. We saw two different people in their bedrooms both of whom appeared to be showing signs of distress. Staff did not attend to people's calls for assistance in a timely way. We observed that when a staff member attended to one of these people they did not ask the person what assistance they required, they engaged a short, friendly conversation and left the person without providing any assistance.

Despite this, people and their relatives were positive about the staff team and the support they provided. One person told us, "I am very happy, I have no complaints." Another person told us, "I can't fault it, we are looked after." A relative of someone using the service told us, "I think they do treat people as individuals, one [staff member] is very good, a real caring attitude." We also saw a number of positive comments left in a compliments book including, "They (staff) have supported me with diplomacy and professionalism" and, "The staff are dedicated, caring and friendly." The atmosphere at Bowbridge Court was calm, relaxed and homely and people were supported by staff who were kind and caring. During our visit we saw examples of positive interactions between staff and people who used the service.

We observed respectful relationships between staff and people who used the service. Staff were friendly and wore name badges which clearly showed their first names in large print. Staff used people's names and, when appropriate, touch, to address them. One member of staff told us, "If people need a hug they get one here." Staff we spoke with all said they enjoyed their job, one member of staff we spoke with spoke proudly about the service and told us, "We give good care." Another member of staff told us, "I describe it as a hotel with a bit of extra thrown in." We saw one person being supported by staff to use a piece of equipment to aid their mobility, the staff member was reassuring and the person appeared calm and reassured. We also saw that staff and people who used the service shared mealtimes, once people had been served their meals staff ate a meal and chatted with them.

People's rooms were personalised and contained personal possessions and photographs. One person we spoke with told us, "There is no restriction on what you want in there (bedroom), they have to get someone to put up pictures, but there are no restrictions." We also saw that people's photos were displayed on their bedroom doors and quite often this included something that was important to the person. For example one person had a photo of them enjoying a previous hobby. Care plans contained information about people's interests and hobbies and staff used this information to inform their conversations with people who used the service.

People were involved in decisions about their support. 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 a clear understanding of their role in ensuring that people had choice and control. One member of staff spoke about giving people as

much choice and encouragement as possible saying this, "Helps people to retain control."

No one using the service was using an advocate to support them express their views. Advocates are trained professionals who support, enable and empower people to speak up. The acting manager informed us that they would support people to access the services of an advocate if needed and there was information about a local advocacy service displayed on a notice board in the service.

People could not always be assured that information would be communicated to them in an accessible manner. Some of the systems within the home did not take account of people's communication needs and memory impairments and therefore did not maximise people's decision making ability or promote choice. Information about planned 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 inaccurate and confusing as the pictures did not reflect what was actually served. For example on the ground floor the lunch options appeared to be mixed vegetables and ice cream, however we saw that people were served fish fingers and mash with vegetables. People were asked to choose what they wanted to eat the previous day and we saw that at lunch time many people could not recall what they had chosen. This was not an accessible way of supporting people to make a meaningful choice.

In contrast we observed that on an individual level staff had a good understanding of people's communication preferences and used this to inform their support. Care plans contained information about people's communication and staff demonstrated a good knowledge of this. For example, at lunch time a member of staff was serving drinks, we saw that the member of staff modified their communication style depending upon the person. They supported one person's choice by asking, "Which juice would you like to drink, purple or orange?" to which the person responded "purple" the staff member then moved to the next person and asked "Blackcurrant or orange juice." It was clear that this approach put people at ease and maximised people's decision making ability.

People's right to privacy and confidentiality was not always respected. Although staff we spoke with had a good understanding of the importance of protecting people's privacy in relation to their personal care, they did not always apply this knowledge to other areas of their support. For example we saw a member of staff supporting a person to complete a 'privacy and dignity' customer satisfaction survey in a communal lounge. The person had a hearing impairment so the member of staff spoke loudly which meant that the conversation could be easily overheard by other people in the room. The member of staff did not ask the person if they would prefer to complete the survey in a more private area where they could not be overheard.

We observed that in other areas of support staff respected people's privacy. Staff knocked before entering people's rooms and ensured that their doors were closed whilst providing intimate personal care. We saw that some people chose to spend time in their bedrooms with visitors and staff respected their privacy. A relative we spoke with told us, "Yes they absolutely respect [relative]'s privacy."

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support. Each person living at Bowbridge Court had a care plan which contained information about their preferences, details of support they required and areas of their life in which they were independent. Whilst some parts of the plan were adequate other areas lacked detail and some information was missing. Some care plans contained in depth information about the person's life history, where as other care plans did not have information in this area. This meant that staff did not always have access to information about what was important to people to inform their support.

Care plans relating to people's health needs were basic and not focused on individual need. There was reliance upon generic information printed from the internet. This meant that staff did not have access to personalised information about how people's health needs impacted on them and staff we spoke with did not always have a good understanding of this.

Some people using the service communicated with their behaviour. Care plans did not contain sufficient detail about how to support people in this area. For example one person was sometimes resistant to personal care, staff we spoke with described how best to support the person in the least restrictive way possible but this information was not contained in the person's support plan. This lack of information meant that there was a risk that the person may not receive the support they need or it would not be provided in the least restrictive way possible.

Information in people's plans was not consistently accurate or up to date and we found instances were plans contained contradictory information despite these having been reviewed by staff. For example, one person's care plan stated that the person was independent in a particular area of their life however in the 'care plan evaluation' records it stated that the person now needed a significant amount of support and assistance from staff in this area, the care plan had not been updated with this new information.

Staff we spoke with were able to describe people's support needs and told us they felt able to meet people's needs. However there was a risk that people may not receive the care they required because their care plans contained inaccurate or out of date information. We spoke with one member of staff who told us that new staff did not always read care plans and instead learnt from shadowing more experienced staff. This put people at risk of receiving inconsistent support.

Despite this people told us that they received the care they required and this was flexible to meet their needs and preferences. One person said, "They (staff) know me very well and know what I like." Another person told us "I don't find it (the home) overpowering with regimentation." A relative of someone who used the service described how the staff team knew their relation well and ensured that they made adjustments to accommodate for their relation's sensory impairment. They told us, "Staff move [name]'s plate so they can see the food that they have missed."

People and their relatives were involved in some aspects of their care planning. We saw that people and their families, where appropriate, had been involved in their assessment prior to moving into the service.

However there was no evidence that people were offered the offered the opportunity to get involved in the routine review of their care plans.

People were supported to maintain relationships with family and friends. The deputy manager spoke with passion about how the service prided itself on building relationships with people's families and friends. During our visit we saw many relatives and friends visiting people. People spent time together in communal areas and appeared to feel comfortable and relaxed. People's friends and relatives were greeted warmly by staff, they were included in conversations and offered drinks and snacks. People were also supported to spend time with their friends and relations in their bedrooms and staff respected their right to privacy. The service was spacious and had multiple communal areas where people could choose to spend time with their relatives.

People were enabled to take part in social activities; however these were not based on people's individual preference. One person said, "It's a bit on the boring side sometimes." Another person told us, "There are not a lot of activities as such, (but) staff are obliging and meet my needs." A relative we spoke with told us, "There are activities on but nothing that [name] really wants to get involved in."

The provider employed a regional activities coordinator who took responsibility for implementing a programme of varied activities including entertainers, singers and art and craft classes. The acting manager informed us that this programme of activities was based upon feedback from people using services across a number of Ideal Care Homes services. There was no evidence that information about people's individual interests and preferences were used to inform the programme of activities.

We saw photos displayed around the service of activities that had taken place. On the day of our inspection an exercise class was taking place and people were offered a choice about whether or not they wanted to join the group. We saw staff supporting and encouraging people's involvement in this. The service had a hairdressing salon, café and arts and crafts room which were open at different points throughout the week. The acting manager also told us about a new project to introduce themed evenings where people could invite their friends and relatives to join them for a restaurant style meal with entertainment. The service had recently held a 'little Italy' evening.

We observed that whilst some people took part in activities others spent the majority of their day largely unoccupied. Staff told us that if there was no outside entertainer in the service that they were responsible for arranging and leading activities. One member of staff told us that they did sometimes get time to facilitate activities but this was often interrupted by the need to attend to people's support needs. There were no records of what activities had taken place and who had taken part, which made it difficult to ascertain how frequently activities were offered and how often people were enabled to take part in meaningful occupation.

People could be assured complaints would be taken seriously and acted on. People told us that they felt able to make a complaint and knew how to do so. One person's relative told us, "They have dealt with anything I've had, if I see something that's not right I tell them." Another relative described how their relation had raised concerns about an issue which they and their relation felt had been dealt with swiftly and appropriately. People and their relatives told us they felt comfortable raising a concern or complaint and felt confident that it would be acted upon.

Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to a manager. Staff told us they were confident that the management team would act upon complaints appropriately. There was a complaints procedure available in the reception area. We saw

records of complaints raised since our last inspection and there was evidence that these were investigated and the outcome of the complaints were recorded.

Requires Improvement

Is the service well-led?

Our findings

In our November 2014 inspection we found 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. There were not effective governance or management systems in place to ensure people received high quality care and support. We asked the provider to make improvements in this area but during this inspection we saw further improvements were still required.

Auditing and quality assurance systems were still not effective. Although there was a system in place to carry out monthly audits across a range of areas we saw that some of these audits were incomplete and some had been completed using a, tick box system which did not identify shortfalls in the quality of the service being audited. We saw audits that had been completed by the previous manager were not effective in identifying issues and that robust action plans had not been developed as a result of the audits.

Care plan audits had been conducted by the management team however they had not been effective in picking up issues that we found during our inspection such as out of date and missing information as well as inaccuracies in risk assessments. A recent infection control audit had identified that cleaning schedules were not effective because night staff were not always completing them. No action plan had been developed as a result of this audit and there was no record that improvements had been made. We reviewed recent cleaning schedules and found that tasks were not always recorded as being completed and this was still a particular issue during night shifts.

People could not always be assured that changes were made to improve the service as a result of accidents and incidents. Accidents and incidents were not effectively analysed and there were no clear actions recorded to try and reduce the risk of people falling.

The provider did not have robust systems in place for quality monitoring the service and ensuring action was taken when issues were identified. A mock inspection was undertaken in May 2016 by the provider's head of compliance. This was a robust audit which identified many areas for improvement. However an action plan developed by the previous manager had failed to address many issues in the audit and consequently we found during our inspection that many of the issues cited in the report were still unresolved. For example the mock inspection found that, "Thirty three staff did not have up to date safeguarding training." We found that there were still a significant number of staff without current safeguarding training during our inspection. Issues related to insufficient staffing levels and "Concerns about falls increasing on a night when staff were working one member of staff down," had also been cited in the mock inspection report, however no action had been taken to resolve this issue. Staff rotas still showed that some nights continued to be staffed below the level determined by the provider, and the incidence of unwitnessed falls during night shifts was still high.

We also saw a record of the most recent quality assurance visit conducted by the provider's regional director in June 2016. This did not identify the above inadequacies in the governance and quality assurance systems and indeed stated that audits were, "Excellent quality, with cross referencing, clear and concise action plans

with lessons learned." Where issues had been identified action had not been taken to rectify them. For example the audit identified that, "Front covers (of medication administration records) with photos in place needs to have more information, allergies, GP, etc." We found that this action had not been completed.

The providers approach to care planning did not promote high quality, safe care that respected people's rights. For example, the providers Mental Capacity Act (MCA) assessment form did not enable the service to comply with the principles of the MCA. The form issued by the provider was general and did not relate to specific decisions. Although it stated on the form that, 'This is for care planning purposes only and not about specific decisions' this was not enforced by the provider. It was not clear what forms should be used to assess and record assessments of capacity and best interests decisions so consequently the service was not able to evidence how it respected people's rights under the MCA.

Forms designed to assess the risks associated with people's care and support, such as falls risk and pressure ulcer risk did not clearly detail what controls measures had been put in place to reduce risks or detail the residual level of risk after control measures had been put in place. We also saw that staff made frequent errors in assessing risk using these forms and this had not been identified in quality audits. The providers systems and the failure to check the effectiveness of these put people at risk of improper treatment and potential harm.

During our previous inspection we found that people using the service and staff did not have opportunities to contribute to the running of the service. During this inspection we found that some improvements had been made, but these had stopped when the management of the service had changed. The acting manager informed us that whilst monthly meetings for people using the service had been planned, the previous manager had not held these meetings. We were informed that a meeting had taken place approximately three months prior to our inspection but there were no minutes of this meeting. There had been no meetings for people using the service since June 2016.

We found that staff had not recently been given the opportunity to contribute to the development of the service. Whilst staff did feel they could make suggestions about the service this was on an informal basis as there were no formal systems in place to support and enable staff involvement. Staff meetings were infrequent and records of the most recent meeting showed that only six staff were able to attend. The acting manager had identified this and we saw that a full staff meeting took place during our visit.

The provider did not have adequate systems in place to ensure that staff had appropriate training and this put people at risk of being supported by staff who did not have the appropriate skills and knowledge to provide safe, effective care. Records showed that this was a longstanding issue; however the provider's quality assurance systems had failed to pick this up.

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

Although the provider had notified us of some events in the service, they had failed to notify us of all safeguarding incidents within the service. A notification is information about important events which the provider is required to send us by law. This meant that CQC was not always informed about important event in the service which could have effected on our ability to monitor whether or not the service was providing safe care and support.

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

The home was required to have a registered manager in post as a condition of their registration. There was no registered manager in post at the time of the inspection and the service had been without a registered manager since June 2016. The registered provider had employed one other manager during this time but the registration process had not been completed. The provider informed us that a new manager had recently been recruited however they had not yet started in post. During our visit the service was being managed by the quality assurance manager for Ideal Care Homes.

People using the service and their relatives raised concerns about the number of managers that had been employed by the service and the impact of this. Due to the changes in the management team people were not sure who managed the service and seemed to identify mainly with the front of house manager who took responsibility for the administration in the service. One person said "Now, who is the boss?" When we asked another person if they knew who the manager was they told us, "I wouldn't know, I've never had cause to complain". A relative told us, "There have been hiccups (since the last registered manager left) you can tell if there is a problem because you can see it in the staff morale." Another relative told us, "There have been five managers, only one who is fantastic, they (the provider) moved them to another service."

Despite this people we spoke with told us that they felt happy living at Bowbridge Court and spoke positively about the service. People told us they would feel comfortable to talking to staff and managers should they have a problem or concern and thought that they were kept informed. One relative told us, "Both deputy managers are good, I'm happy that they will deal with things. I trust them, they have phoned me at home and keep us informed." Another relative told us, "I'm happy, they ring if they need to."

Staff we spoke with were aware there had been significant change in the leadership of the service over recent months and acknowledged that the changes had been unsettling for the team. The previous manager had left the service and there had been temporary management arrangements in place. However, staff remained positive and felt that this was due to the strength of the deputy managers and the support they received from their colleagues. One member of staff told us "I feel confident in every person I work with."

Throughout our time at Bowbridge Court the management team were open, honest and receptive to feedback. The acting manager had only been in post for a short period of time, however in this time they had started to build up an understanding of the issues at Bowbridge Court and had developed an action plan in response to this. We spoke with the Head of Compliance for Ideal Care Homes who had recently visited the service, they also had a good understanding of the problems faced by the service and they were committed to making improvements. Following our visit the acting manager took swift action to develop an action plan based upon the feedback we shared.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Care Quality Commission (Registration) Regulations (2009) The CQC were not notified of all safeguarding allegations. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent. People's rights under the Mental Capacity Act 2005 were not respected. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. People were not protected from the risks associated with their care and support.

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 Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance systems and processes were not in place to ensure the safe and effective running of the location. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing There were not a sufficient number of staff on duty at all times to ensure the safety and comfort of people using the service. Regulation 18 (1) (2) (a) (c)