Maria Mallaband 17 Limited

Bowerfield 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 21, 22 November and 12 December 2017. The inspection was unannounced on the first day and on the 12 December when the inspection was carried out at night.

The service was last inspected by the Care Quality Commission (CQC) on 15 and 16 August 2016 where we rated the service as requires improvement overall. Following the last inspection, we asked the provider to complete an action plan to show us what they would do and by when to improve the key question; is the service safe, effective, responsive and well-led to at least good.

At this inspection we found that action had been taken to address some of the findings in the requirements made at the last inspection. However, we identified a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance, in relation to the recording of topical medicines.

We also found that the provider had not fully considered a recommendation we made at the last inspection in relation to staffing levels. We found the home was still not sufficiently staffed to meet the high physical needs of some people.

We identified three further breaches of the Regulations. These were in relation to records in respect of service users, staffing levels and staff supervision.

Although we saw records that showed day staff were provided with up to date supervision and support, night staff told us they had not received supervision following the reduction of night staffing levels.

Bowerfield Court is a nursing home in High Lane, Disley, Stockport. The home is a purpose built facility registered to provide accommodation and nursing care for up to 40 people including younger adults with high level physical needs. The home also supports respite placements and provides end of life care. At the time of the inspection there were 31 people living at the home.

There was a registered manager in post at the time of the inspection. 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.

Two people and a person's relative told us they did not always feel safe living at Bowerfield Court particularly at night time. Systems in place to consult people about whether they felt safe and protected whilst living at Bowerfield Court were not fully utilised.

Call bells were not always responded to in a timely way. Staffing levels were not sufficient at the time of the inspection to meet the needs of people who were cared for and supported by the service.

Any specific requirements or risks in relation to people taking particular medicines were clearly documented in people's care records. However governance systems to help ensure topical medicines were administered and recorded were not used effectively.

Systems were in place and used to assess, monitor and mitigate risks relating to people's health, safety and welfare. Risk assessments were in place to minimise the potential risk of harm to people during delivery of their care.

Care records were reviewed frequently and showed people's dietary requirements indicated the type of food people had eaten and what they had drank. However we found some care records were not consistently maintained and accurate in relation to fluid and food intake/output amounts. Also some care record entries had not been initialled to verify the entry was accurate when changes were made to some records.

A robust recruitment and selection system was in place to minimise the risk of unsuitable people being employed to work in the service. Staff confirmed that the training they received was appropriate and supported them to carry out their job roles effectively.

The registered manager understood the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Records in relation to the Mental Capacity Act 2005 and consent were complete and up to date. Any restrictions were deemed to be in people's best interest and the least restrictive.

We observed staff interactions with people living at the home were caring, patient, and empathetic. Staff had developed a good rapport and understanding of the people who used the service and treated people with kindness and respect. People were supported to participate in general and therapeutic activities that promoted their independence, physical and mental needs.

Complaints were addressed and recorded appropriately by the management team. People who used the service and their relatives told us they knew how to make a complaint and felt able to approach any member of the staff team if they had any concerns.

Processes were in place and followed to ensure the premises and environment was safe for people to use.

The provider was displaying their CQC rating at the premises and on their website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they did not feel safe living at Bowerfield Court. At the time of the inspection we found staffing levels especially at night were not sufficient to meet the needs of people who were cared for and supported by the service.

Governance systems in place to help ensure topical medicines were administered and recorded were not used effectively.

Safeguarding policies and procedures were in place and written information showed how to mitigate any risks to people. This was identified and detailed in their care plans.

Is the service effective?

Requires Improvement

The service was not always effective.

Records we reviewed showed that staff received regular supervision and support to help make sure people were provided with care and support to meet their needs. However night staff told us they had not received supervision following the reduction of night staffing levels.

People's needs were assessed prior to them moving into the home. Their nutritional needs were being met through a choice of suitable foods being offered and with the support of appropriate healthcare professionals.

People's healthcare needs were monitored and support was also provided from external healthcare professionals, such as doctors, physiotherapists and dieticians.

Is the service caring?

Good

The service was caring.

We observed positive, caring and friendly interactions between staff, people who use the service, their relatives and friends.

Staff were dedicated, open and welcoming recognising the

needs, likes, dislikes and personal preferences of the people they cared for.

People's assessed needs were taken into account when care and support was being planned.

Is the service responsive?

Requires Improvement

The service was not always responsive

Call bells were not always responded to in a timely way to meet people's identified care and support needs.

People's health care reviews were held monthly or more frequently if necessary. Specialist guidance was included in people's care records to address any changes in their health.

Meaningful, social and therapeutic activities tailored to people's individual needs were provided for people to participate in should they wish to do so.

A complaints procedure was in place and shared with people who used the service and their relatives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to consult people about whether they felt safe whilst living at Bowerfield Court were not used effectively.

Accurate and complete records in respect of each person's care and treatment were in place to assess and monitor the services provided.

People and their relatives described the management team as approachable.

Bowerfield 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21, 22 November and 12 December 2017 and day two was announced. On the first day the inspection was carried out by two adult social care inspectors and a specialist advisor (SPA). SPA provide specialist advice and input into the Care Quality Commission's (CQC's) regulatory inspection and investigation activity to ensure CQC's judgements are informed by up to date, credible, professional knowledge and experience. The second day of the inspection was carried out by one adult social care inspector. The third inspection visit took place at night and was carried out by two adult social care inspectors.

Bowerfield Court is a purpose built home registered to provide accommodation with nursing care for up to 40 people which includes younger adults with complex physical care needs, older people, respite care and end of life care. At the time of this inspection 31 people were receiving a service.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service, in particular statutory notifications about incidents, accidents, safeguarding matters and any deaths. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Prior to, during and after the first day of inspection we received some information of concern about the night staffing levels operating at the service. We followed up this information and carried out a night visit at the service on 12 December 2017.

Following all three inspection days we received information about the service from the local authority adult social care team. They made positive comments about the quality of the care and support provided to people living at Bowerfield Court and had no concerns.

During the inspection we spoke with the registered manager, deputy manager, regional quality compliance manager, head of clinical standards, regional director, four care workers (including night care workers), two nurses, four people who used the service and two visiting relatives. We also had the opportunity to speak with the visiting general practitioner and a visiting neuro-physiotherapist.

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. We carried out a lunchtime observation to see how people were supported during meals in order to help us understand people's mealtime experiences.

We reviewed documents and records that related to the care and support of four people and the management of the service. We looked at people's medicines records and the recruitment records of six members of staff. We walked around the home and looked at all of the communal areas including toilets and bathrooms.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2016 we made a recommendation that the provider considered making adaptations to the dependency tool and review nursing and general staffing numbers to take into account people's complex health and nursing needs. A dependency tool helps to determine the levels of staffing required for a service. Prior to, during and after this inspection we received some information of concern about the night staffing levels operating at the service.

On the first day of inspection we spoke with staff about the staffing levels at the service and they said, "Low staffing levels result in us fire-fighting", "I always bring up the issue of staffing, but nothing happens. If they are short staffed next door (Bowerfield House), we are expected to help out there", "The residents are lovely; they have a lot of needs and there's not really enough staff to do everything", "Some residents can take up to an hour, to do everything [care tasks], and we do things properly here, they can't be rushed", "It's very heavy [workload] and a lot of turns for a lot of the residents" , "It can take a while to answer the buzzers if we are all busy, so another carer would make a big difference" and "It's far busier downstairs [ground floor] it's hectic there; we really struggle with the low staff numbers."

During the inspection we observed that a person's call bell had been buzzing for just less than eight minutes. We asked a nurse why this had not been answered in a timely way and they told us that one care worker was with another person and another care worker was on their break. The nurse told us they could not respond to the call bell immediately because the person was a 'double' (required two staff to support them) and there was no one else available to assist at that time. When asked by the nurse the care worker came off their break earlier than planned to provide assistance. At 11.50 we saw the call bell control panel was showing that two people on the first floor had been waiting for assistance for over 16 minutes. When we visited the first floor we found both call bells had been cancelled and were no longer displayed on the screen.

We asked the registered manager for and were provided with copies of staffing levels reports from 29 September to 24 November 2017. We were also provided with a copy of the service user dependency scores and showed the current direct care hours required for each person during the day. The dependency tool identified that the majority of people being supported required assistance in areas such as eating, transferring position, toileting and dressing. We checked the staff rota which indicated that at the time of the inspection staff on duty had the required skills to meet people's needs. However from our observations and from our discussion with staff we identified that staffing levels were not sufficient to meet people's needs safely.

We followed up the information of concern received regarding staffing levels at night and carried out a night visit at the service on 12 December 2017. We asked the nurse to confirm the number of staff on duty and they said, "Tonight there is one registered nurse, two care workers and one senior care worker." This was confirmed when we checked the number of staff on duty.

During the night visit people we spoke with told us they did not feel safe particularly at night time People

who were able to speak with us about staffing levels said, "The staff here are brilliant. The regular staff pick up shifts and their leave is cancelled." They added, "It's a great home apart from that." When we asked a person if they felt safe living at Bowerfield Court they said, "I don't feel safe at all" and "On a scale of one to five (five being the highest risk) I feel my level of safety is a four, which is a high risk."

A visiting relative spoke with us about the staffing levels at night and said, "The staff are amazing, but they're running round like headless chickens. There used to be four on at night which was ok but with three on duty, if there's an emergency it's not enough. If [my relative] got upset after I left, the staff used to sit with them to calm them down but there's no time for that now." They added; "The staff numbers don't increase even if the respite bed is occupied."

During the night time visit we observed staff to be very busy and rushed. When time allowed we spoke with two staff about the night time staffing levels. During the conversation we heard a person who used the service calling out for staff. A staff member said, "I'd love to sit with that person, they just want a chat. We just don't have time for people." Another staff member added, "We're supposed to do the laundry and clean the communal areas too, but we don't get the chance; staff levels are lower because of the empty beds but I don't think it's right; we just need one extra care worker." Both staff added, "The residents can get up or go to bed when they chose. When people like to get up early, we can't always assist them; it's the same with going to bed, people are waiting until we can get to them" and "If someone was ill or needed to go to hospital at night we would struggle; an accident or incident could take two staff away from the service."

From our observations, discussions with people using the service, a visiting relative and night staff, we were not satisfied there were sufficient staff deployed at night. This meant people were at risk of receiving unsafe care and treatment because the registered provider had not ensured there were enough staff to meet people's assessed care and support needs safely.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We shared these concerns with the registered manager who said, "Bowerfield Court is not a specialist unit. By nature and continuous development the service has evolved to accept people with particular nursing needs. The service is bespoke and unique because of the resident category. We look at the dependency tool and analyse the information on a weekly basis. Staffing levels are reduced according to our occupancy levels. Staff are adaptable to people's needs and we recognise that all of the staff do a fantastic job." They told us that they wanted to move away from the existing dependency tool in order to provide a service that meets people's needs and wishes. They had reviewed a costing tool to present to the funding clinical commissioning group (CCG) which in turn could help the provider to increase staffing levels.

Following the inspection we received information from the Registered Manager confirming a staff forum was established where staff can discuss openly their concerns and worries.

At our last inspection in August 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance in relation to the management of topical medicines. At this inspection we found improvements had not been made to meet the requirement of this regulation and the service remained in breach of the regulation.

A medicines policy and procedure was in place and followed by staff to ensure the safe management of medicines. This helped to ensure the safe and effective use of medicines in the home by advising on processes for handling, storing and administering medicines. Records reviewed showed that the provider

routinely carried out staff medicine competency assessments.

Some people were prescribed topical medicines for certain conditions or to protect their skin and separate topical medication administration records (TMAR) were in place. People's topical medicines were also recorded with their oral medicines on their primary medication administration record (MAR). Primary MARs were required to be signed following administration of all prescribed medicines. When we examined 14 TMARs we found signatures were missing on seven of them. However we identified that people's primary MARs had been signed to indicate that topical medicines had been administered for those people. When we informed the deputy manager of our findings they confirmed that nurses responsible for signing both MARs had not followed the services protocol relating to topical medicines. This meant accurate records of topical medicines administered were not being kept and there was a risk that people may not receive their medicines as prescribed by their General Practitioner (GP). Staff we spoke with explained that they sometimes had to interrupt a medication round to answer call buzzers and this increased the risk of medication errors.

This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

As a result of our findings the registered manager immediately carried out a 'topical cream knowledge spot check' with the nurses. This helped to ensure they understood the services procedure, stipulations and their responsibility to record and administered medicines accurately following best practice.

Records showed that people's wound and pressure area care was managed and recorded appropriately. However, we found records were not completed to show that pressure mattress settings were being checked and recorded. This meant that people were at risk of developing pressure sores or poor skin integrity because an accurate and complete record of mattress settings was not being kept.

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

At our last inspection in August 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that there was a potential risk to people because window restrictors did not meet the full Health and Safety Executive (HSE) specification for window restrictors in care homes and they could potentially be loosened. At this inspection we found the provider was meeting this requirement of the regulation. We checked the window restrictors in the home and found all windows in the home had been fitted with appropriate window restrictors that could not be loosened and were in line with HSE specifications.

Staff we spoke with understood their role in protecting and keeping people safe, including their responsibility to notify the local authority of any safeguarding matters that could be seen as a potential situation of abuse or inappropriate care and treatment. Training records indicated that staff had completed safeguarding adults training and staff refresher training was provided annually to all staff using the company 'safeguarding adults basic awareness booklet'. We found that the staff team had access to procedures that were in place to minimise the potential risk of abuse or unsafe care practices. Staff we spoke with confirmed they had received safeguarding and whistleblowing training (raising a concern about a wrong doing in the workplace) and knew who to report concerns to if they suspected or witnessed abuse or poor practice.

We looked at the care records of four people and documentation in place had been individualised to provide staff with clear directions on meeting people's needs. Information included clearly documented risk

assessments and how staff should manage those risks identified. Observations of the staff team during the inspection indicated they were knowledgeable, skilled and competent in meeting peoples identified needs. People's healthcare needs were carefully monitored and discussed with the person or their nominated family member as part of the care planning process.
Care records seen confirmed visits to and from healthcare professionals such as General Practitioners (GP's), community dieticians, a neuro-physiotherapist and speech and language therapist (SALT). Records documented the reasons the visit was requested and what the outcome of the visit had been. This information was shared with the staff team during handovers between changing shifts.

A robust recruitment and selection process was in place and the six staff personnel files we looked at contained relevant pre-employment documentation, including a criminal record check. These checks are carried out by the Disclosure and Barring Service (DBS) and help employers make safer recruitment decisions to minimise the risk of unsuitable people being employed to work with vulnerable people.

We walked around the building and found that it was well maintained and clean. Systems were in place and records kept to confirm that regular maintenance of the building and servicing of equipment used throughout the home was being regularly checked and serviced by an approved and reputable service engineer. Risk assessments were also in place for the environment and health and safety audits were undertaken periodically.

Regular infection control audits were carried out by the management team and appropriate measures were in place to ensure infection control risks were minimised, including the use of personal protective equipment (PPE) such as disposable vinyl gloves and plastic aprons. We examined a copy of the infection control audit report following an audit carried out by Stockport Local Authority in September 2017. The overall score awarded to the service meant that at that time, the service was compliant with infection control processes

The building was purpose built to support people living with an acquired brain injury, physical/sensory impairment and those who used motorised wheelchairs/ mobility aids. Corridors were wide enough for people to manoeuvre around the building without being restricted and were clear of any obstacles. This enabled people to freely access other parts of the building as safely as possible.

Personal Emergency Evacuation Plans (PEEP) had been put in place for each person living at Bowerfield Court. This information gave relevant details to emergency services about what support people would need to evacuate the building safely. Fire-fighting equipment was well maintained.

We saw that appropriate documentation had been completed by the registered manager and deputy manager to record any accident or incident that may have taken place involving a person using the service, staff member or visitor. All accident and incidents were logged to make sure this information was closely monitored and followed up for action and the outcome recorded.

Requires Improvement

Is the service effective?

Our findings

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. A DoLS tracker was in place to monitor when applications had been made to the supervisory body (the local authority) when any applications had been authorised and the DoLS expiry date. The registered manager told us and we saw records to show that DoLS had been granted for seven people living at the home and applications had been submitted to the supervisory body for other people. The registered manager and deputy manager both demonstrated an understanding of the legislation as laid down by the MCA and DoLS. Staff also had access to information about applications and authorisations on individual care files.

At our last inspection in August 2016 we found that some relatives had signed consent forms on behalf of people without the home being clear they had the authority to do so, through the legal granting of Power of Attorney (POA). At this inspection we saw that the registered provider was now keeping a record (matrix) of people whose relatives had been legally granted POA. This ensured the registered provider knew which relatives had authority to consent to the care and support provided. A power of attorney is authorisation to represent or act on another's behalf in private affairs such as finance, or other legal matters.

We examined records that showed staff training was carried out 'face to face' either in-house or via an external trainer. Records seen confirmed that staff had or were in the process of completing training in mandatory topics such as; safeguarding vulnerable people, medicines management, basic life support, moving and handling (theory and practical), food hygiene, mental capacity and deprivation of liberty safeguards and understanding equality and diversity. Additional staff training was also provided in topics such as; dementia with de-escalation, defensible documentation, sepsis, epilepsy/motor neurone/ multiple sclerosis, catheter care, Parkinson's and Huntington's condition. Clinical skills training was available in topics such as; head injuries, seizure management, post falls, acute infections and symptoms, diabetes, full nursing observations and Percutaneous endoscopic gastrostomy (PEG). This is a medical procedure to provide a means of feeding when oral intake is not adequate.

Staff we spoke with had a good understanding of people's needs and the support they required. They also confirmed that the training they received supported them to provide the care people required. They told us they had received a 'good' induction to the service and had access to training which was carried out following the provider's regional training plan. A care worker we spoke with made positive comments about the training provided and undertaken saying, "I've worked here for over 10 years. We have a mixture of e-learning and practical and we do the updates on line. The physiotherapist updates us on moving and

handling techniques. The training is good."

We spoke with the regular visiting General Practitioner who had been visiting people at Bowerfield Court for over 15 years. They made positive comments about the staff training and said, "Staff here are trained exceptionally well; because of the quality of the training, I trust the staff to make judgements and relay accurate information to me. This is always done to a very good standard."

Day staff we spoke with and records seen demonstrated that supervision was taking place and sessions were planned on an on-going basis. Records indicated that supervision sessions had taken place with staff throughout August and September 2017 and the registered manager also provided us with a supervision schedule for planned supervision for the coming months. However night staff we spoke with told us; "We've not had supervision since we went down to three care staff on a night." This indicated that people were being cared for at night by staff whose performance and development had not been monitored periodically to ensure appropriate skills and competencies were maintained.

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

People's care and support needs were assessed before they moved into Bowerfield Court and included their own or their relatives involvement in the assessment process. Information recorded in people's care records was complete and up to date. Records showed that staff used information from the initial needs assessment to develop the detailed care plans. Associated records highlighted people's abilities, dependency level, support required to maintain their independence and the desired outcome following the support given. This meant care workers and nurses were enabled to provide the right care to people in a person centred way. These records included where people required particular consistency of food and fluid preferences if thickener was to be used. This information helped to make sure people's needs and preferences could be appropriately maintained and effectively met. A thickener is used for people who have dysphagia (difficulty swallowing). It is added to foods and liquids to bring them to the right texture so they can be safely swallowed to provide required nutrition/ hydration and minimise the risk of choking.

Hot and cold drinks and snacks were made available between meals and were offered routinely mid-morning and mid-afternoon. We observed the mealtime experience for people on the ground floor unit. We saw the main meal was a choice of two main dishes and a dessert which looked appetising and nutritious. Fresh orange/apple juice, water, tea and coffee were offered to people by staff. People we spoke with were aware there was always a choice and that acceptable meals for them to eat would always be provided. The atmosphere during this time in the dining room was pleasant, peaceful and sociable. Adapted cutlery and cups were used wherever possible to help promote people's independence and maintain their dignity.

At the peak of the mealtime we saw 10 people were in the ground floor dining room having lunch. Of these, five people required full assistance to eat. Seven people were having lunch in their room. We observed staff caringly and patiently assisting or serving people and this was done at the pace of the person and staff remained focused on the task. We saw only two care workers on duty on the ground floor dining room and additional staff members (a domestic and activities coordinator who had received appropriate training) were assisting people to eat. Both domestic and activities coordinator told us that nine times out of ten they were needed to help assist people in the dining room. The staff supporting were chatty and sat beside or facing people whilst assisting them. We observed good staff interaction with all the people throughout this period. After the mealtime we checked if people's individual food and fluid intake charts had been completed and we found that some had.

Observations of the staff team throughout the inspection indicated they were knowledgeable, skilled and competent at meeting people's identified needs. People's healthcare needs were carefully monitored and discussed with the person or their nominated family member as part of the care planning process.

The visiting GP told us, "There is good communication between the nurses and the GP. As a GP coming into the home I can always speak to the senior nurse in charge who I know is knowledgeable about all of the people and information is disseminated quickly. I have a good rapport with all of the service users and I have no concerns about their nutrition, hydration or skin integrity; By working in this way, we can as a team, work out what is the best course of action for the person."

A visiting neuro-physiotherapist made positive comments about the effectiveness of the staff team and said, "Communication is good here; I can write my notes in people's care records; I have no concerns about the people who live here or their positional changes." People able to speak with us told us they felt their needs were being met in a way that they wanted and needed and that the staff were 'helpful' and 'supportive.'

When we walked around the building we found facilities available to meet the assessed care and support people needed. Aids and adaptations were available throughout the home including hoists and adapted baths. Where people were at particular risk of falls, 'falls mattresses' were placed at the side of beds to minimise the risk of any injury should a fall out of bed occur. Lounge and dining facilities were available on both floors as were toilets and bathrooms.

A wheelchair accessible passenger lift, adjustable profiling beds, and a nurse call system were provided for people to support their mobility and comfort needs.

Good

Is the service caring?

Our findings

People who lived at Bowerfield Court who were able to express a view about the service they received told us about the caring nature of all the staff. Comments we received from people included, "I've not been here long, but it's very nice. I sit with my relative every day, have my meals and the food is good; The girls [staff] are very kind here and I feel safe with them. I like to come back to my room at the end of the day. They [staff] have fixed my precious pictures on the wall, so that's nice for me."

When we looked in people's bedrooms we saw that some people were being cared for in bed. For example we observed two people in their own bed, each using a pressure relieving mattress and bed rails were in place to prevent them from falling out. People looked comfortable. For people using oxygen, we saw this was provided via an oxygen unit correctly positioned at the foot of the bed. The oxygen piping was not restricted and was in full view to enable the nurses to make periodic checks. Records were in place to confirm these and bed rails checks were being carried out.

People and their relatives all thought staff respected people's privacy and dignity. For example, we saw staff always knocked and waited for a response before entering bedrooms. People told us visits from relatives or friends were mostly uninterrupted by staff to maintain their privacy. A person using the service told us they were confident that staff helped them to be as independent as possible, mainly by encouraging them to do things for themselves at their own pace following the instructions in their written plan of care. They said, "I'm alright, despite having a disability, the staff are really good and know me well enough to let me do most things for myself."

We saw good examples of empathy and compassionate care, whether it was trying to persuade people to eat their food but knowing when to leave them to then try again later if that was what they wanted, or offering alternatives, showing the choices available. We observed staff being patient whilst assisting people to eat, concentrating on the task gently at the person's pace. We observed staff reassuring the person, telling them what was about to happen prior to the task being undertaken.

We observed people who looked comfortable in their environment and staff being friendly and polite towards those they were supporting. We observed good examples of positive interactions between staff and people who used the service, both when they were carrying out specific tasks and when they were passing each other on corridors. All staff knew people's names, likes and dislikes, preferences for food and drink and when to give little but important touches that form good person centred care. We observed friendships, good humour and laughter in the home. We did not witness any examples of poor care or poor staff interactions.

The visiting GP and a neuro-physiotherapist made positive comments about the staff approach towards people and said, "It's a really nice, friendly environment at Bowerfield Court; staff are always busy, but on hand to help" and "The staff give comfort and care and know when to hold people's hand."

Documentation seen in people's care files indicated that where agreed, and in line with the service's

confidentiality policy, information about a person's wellbeing and health was discussed with families or others identified as important to the person. The registered manager was aware of their responsibility to ensure information about advocacy services was available for people and/or their families if required, and we saw such information was in place. The availability of such information ensured people's interests could be independently represented if they wanted support from someone not involved with the service to act on their behalf if and when needed. These systems ensured that appropriate support was in place when the person may want help in making decisions about their care and future needs.

Requires Improvement

Is the service responsive?

Our findings

A person who used a wheelchair told us, "I've been waiting half an hour at the nurse station for staff to take me to meet up with my relative." A care worker we spoke with told us, It's really hard and we could do with more staff. We are always busy, especially in the mornings." This showed people's personal care needs were not always responded to in a timely way and risks to their safety and wellbeing were not minimised as reported in the Safe domain of this report.

People's care records and care plans were person centred and developed around each person to meet their assessed needs. We found in some care records that the quality of hand written notes was difficult to read and some entries had been crossed out but not initialled to verify the entry was accurate. Supplementary care charts in people's rooms were easy to access, however not always completed. For example records of expected fluid and food intake/ output amounts were not completed in some care plans. This meant that staff would not automatically know if the amounts taken by a person were sufficient/ insufficient.

Not all of the care files contained a personal profile (pen-picture) in order to help develop relationships further and to provide staff with more information about the person's background and previous lifestyle. The registered manager told us that the personal profiles were a 'work in progress' and hoped these would all be completed within the next two to three weeks. We will monitor this at our next inspection.

People's likes, dislikes and preferences had been recorded within the care plans and we could see that relatives who knew the person best had provided additional and helpful background information. Where people had been assessed as lacking capacity, best interests assessments had been completed, including information about the person's wishes at the time when their health may start to deteriorate.

A part time physiotherapy assistant was in place to support the visiting physiotherapist and occupational therapist in carrying out neurology assessments and individual planned exercise programmes with people. We saw further evidence on people's care records that they were provided with treatment and support via the use of a local hydrotherapy pool. This helped to ensure that people with certain conditions could maintain their health and wellbeing, relieve pain, improve their general fitness and prevent further conditions from developing. Assistive technology such as 'Possum' was in place to support people with different types of physical impairment and maintain their independence. Assistive technology can be used to increase, maintain, or improve the functional capabilities of people living with a disability.

An activities coordinator was in post to help promote people's individual wellbeing by providing a range of appropriate and suitable activities that were in line with people's identified interests and hobbies. The activities coordinator had worked at Bowerfield Court for 10 years and knew all of the people well. They told us about recent initiatives that had taken place or were planned for the coming months such as, a craft fair to be held at the service where craft stallholders would sell products to people and their relatives. "It encourages public awareness and support", they said.
We looked at photographs displayed in the home which showed a visit to the zoo in July. Plans for 10 people from Bowerfield Court to visit a theatre in December to watch the Cinderella pantomime were in progress.

Regular service user meetings took place, which people's relatives could also attend. Meeting notes were displayed on a notice board for people to read.

The activities coordinator told us they enjoyed organising and involving people in group activities, "With as many residents as possible; it's good fun", they said. They told us that one to one activities were also provided to people who were being cared for in bed, for example a person enjoyed sensory time, using sensory lights to project images on the bedroom ceiling along with soothing music and gentle conversation. Following best practice guidance, hand massage and gentle hand manipulation was also provided to people with conditions such as an acquired brain injury (ABI). Stimulation of muscle reflexes has been known to help people regain some muscle and communication function for example, eye movements to indicate a basic responses to a question. Records of activities and individual participation were kept up to date in a separate activities file and also in people's care records. We were unable to speak with people who could give their views about the activities provided, however the activities coordinator said, "I'm getting good feedback from people, which is great."

People's records and any confidential documents were kept securely, not on display and could only be accessed by designated staff. This ensured that confidentiality of information was maintained. Communication between staff was carried out privately at shift handover meetings between oncoming day and night staff. The handover was thorough and highlighted those people who may need extra support throughout the day, especially where people were unwell or had had an unsettled night. A written record of the handover was kept and this gave oncoming staff a quick overview of the on going support the people needed.

An End of Life (EoL) care policy and procedure was in place. We were told by the deputy manager that all nurses had received EoL care training and knew the processes to follow when EoL care was required. Whilst the provider was not following a specific EoL care model, they had made enquiries about adopting the Six Steps programme; however there was a long waiting list for care workers to receive training in this topic. The service was currently following the East Cheshire and/or Stockport Local Authority EoL care best practice guidance for people whose place at the service was being funded by one of these local authorities. In addition to this the service liaised with Macmillan nurses and the hospice team when appropriate.

At the time of the inspection one person was receiving end of life care. We reviewed this person's care records and found that their wishes, medication, hydration/nutrition, personal care needs, pressure area and comfort were being recorded, considered and planned. Any additional arrangements were discussed with the registered manager, the person's general practitioner and nurses. The meeting would also discuss triggers to highlight areas of decline such as weight loss and pain. The services EoL care policy and procedure was person centred and geared towards helping the person, and their relatives to have full control about decisions relating to the person's future and end of life care needs.

Complaints were addressed analysed and recorded by the management team with. People who used the service and their relatives told us they knew how to make a complaint and felt able to approach any member of the staff team if they had any concerns. Guidance telling people how to make a complaint was displayed on notice boards around the home. The policy allowed complaints to be escalated to the local government ombudsman if the complainant remained dissatisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2016 we identified that systems were not in place to ensure there was proper assessment and monitoring of the quality and safety of the service. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good governance. At this inspection although some improvements had been made we found a continued breach of the requirements of the regulation.

The service had a manager who was registered with the Care Quality Commission (CQC) in December 2016. They were present at second inspection day and at the night visits. The registered manager also managed the neighbouring care home, 'Bowerfield House', which is a 26 bed nursing home that is also part of the Maria Mallaband Care Group. The registered manager is a qualified nurse and was supported by a deputy manager. A regional management team also supported the registered manager providing managerial oversight of the day to day running of the services and service delivery. The registered manager worked collaboratively with external agencies and was committed to providing an improved service to people. They promoted a person centred approach to help make sure people's needs and preferences were being met.

We found the provider was not consistently maintaining accurate records in relation to topical medicines and pressure mattress settings. Whilst the provider had considered a recommendation made at the last inspection in relation to staffing levels, we found the service was still not sufficiently staffed to meet the high physical needs of some people living at Bowerfield Court. These findings are discussed throughout this report.

People told us they did not always feel safe living at Bowerfield Court and staffing levels were not sufficient during the day and night. One person told us they felt their level of safety was a high risk especially at night time and they were concerned that call bells were not being responded to in a timely way. Another person using the service told us they felt people's dependency levels had been assessed inaccurately and the dependency tool, used to help determine the levels of staff required, did not identify the true range and complexity of people's needs.

People we spoke with and a visiting relative told us that it was 'to the staff's credit' that people living at Bowerfield Court received safe and compassionate care. One person said about the current staff team, "The night staff are familiar faces but they're full-on and it's a case of how much time do staff spend with you, because they're always onto the next job."

All of the staff we met were open, welcoming and dedicated to the people they cared for and supported. Whilst staff understood their role and responsibility to the people living in the home all of them were concerned about and commented on their 'hectic workload', 'fire-fighting' and the 'difficulties' of working with low staff numbers. Two staff said, "The risks are the call bells which need to be answered within five minutes. What if they're critical and staff can't get to people in time."

We asked the registered manager and regional director if during meetings held with people they had been

asked whether they felt safe living at Bowerfield Court. They told us they had not considered asking people this question within the service user satisfaction questionnaire, at service user meetings or during people's care reviews.

Governance systems in place had not identified the concerns we found in relation the supervision of night staff as detailed in the Effective domain of this report.

In order to ensure good service continuity a business contingency plan was in place. This plan identified potential risks and threats to service provision and the provider's actions should they occur. Meetings were held with people who used the service and their representative or relatives and people were given an opportunity to say what they liked about Bowerfield Court but also what, if any, improvements could be made. We examined notes of the meetings which were kept to ensure an accurate account of people's verbal contribution was maintained.

The provider completed clinical indicator reports in order to provide comparative information about the quality of the service provided at Bowerfield Court. This information was also shared with the National Health Service (NHS) Clinical Commissioning Group (CCG) and local authority quality monitoring team. We examined a sample of reports which highlighted any patterns that emerged, for example in relation to hospital admissions, people's weight loss, the number of modified diets, infections, deaths, falls and pressure sores. Information gathered was reported and reviewed at regional director level where actions would be identified and recorded on an audit action plan. Information from this document was analysed in order to assist in anticipating seasonal trends and risk planning prior to a potential health or environmental events.

The registered manager shared with us copies of the various organisational policies/ procedures such as, complaints and suggestions, safeguarding, accidents/ incidents, medicines management and staff recruitment. Policies and procedures help the provider to guide the actions of all individuals involved in the service and provide consistency in all practices carried out in the home. Policies we looked at were being kept under review.

We checked our records before the inspection and saw that accidents and incidents that the Care Quality Commission needed to be informed about had been notified to us by the registered provider. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems in place to help ensure topical medicines were administered and recorded were not being followed. Complete and contemporaneous records in respect of the care and treatment provided were not up to date. 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staff were not deployed at night to meet people's assessed care and support needs safely. People were being cared for at night by staff whose performance and development had not been monitored periodically to ensure appropriate skills and competencies were maintained. 18(1) (2)(a)