Bowerswood House Retirement Home Limited

Bowerswood House Residential Home Limited

Inspection report

Bowers Lane
Nateby
Preston
Lancashire
PR3 0JD

Tel: 01995606120

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bowerswood House Residential Home Limited is a residential care home providing personal care to 17 older people at the time of the inspection. The service can support up to 24 people.

Bowerswood House Residential Home Limited is situated near the village of Nateby. There is a lounge and a separate dining room for people to enjoy. Parking is available outside the home.

People's experience of using this service and what we found
There is a history of not meeting legal requirements and people were at risk of avoidable harm. Medicines were not always managed safely which placed people at risk of harm.

The service was not being well-led. Auditing systems did not always identify the concerns found during the inspection and documentation was not always completed accurately.

Notifications were being made to the commission as required, however there was no policy to guide staff. We have made a recommendation about providing written information for staff.

The last fire risk assessment was completed in 2018. We have made a recommendation about the formal review of fire risk assessments.

People said they were happy at the home and they liked the staff. People were cared for in a clean and homely environment by staff who were caring, competent and keen to improve the service provided.

Recruitment procedures were followed to ensure staff were suitable to work with people who may be vulnerable. People were supported by staff who had time to spend with them and risk assessments were completed to help ensure risks to people were identified and managed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update. The last rating for this service was inadequate (published 5 May 2020) and there were three breaches of regulation. At this inspection enough improvement had not been made and sustained and the provider was still in breach of regulations.

This service has been in Special Measures since 3 February 2020.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 30 October and 5 November 2019. Breaches of legal requirements were found. The provider sent us written assurances and documentary

evidence of the action they had taken to improve the service in relation to safe care and treatment, good governance and the notification of incidents.

We carried out this focused inspection to check made improvements and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bowerswood House Residential Home Limited on our website at www.cqc.org.uk.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

The provider responded quickly to our concerns and has taken action to mitigate risk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to the safe management of medicines, record keeping and audit systems.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. In addition, we will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'requires improvement.' The service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Bowerswood House Residential Home Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an inspector and a medicines pharmacist inspector.

Service and service type
Bowerswood House Residential Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to ensure we worked closely with the provider to ensure the risk of infection was minimised and national guidance in infection prevention and control were followed during the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and two external professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with five members of staff including the provider (who was also the registered manager), quality manager and three care workers.

We reviewed a range of records. This included six people's care records and 10 people's medication records. We looked at one staff file in relation to recruitment. A variety of records relating to the management of the service, including environmental records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at environmental records and also at medication records and care records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At the last inspection we found the provider had did not always manage medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection we saw that improvements had been made in some aspects of medicines handling however we found that medicines were still not always handled safely which put people's health at risk. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Staff administering medicines had all received training and had their competencies assessed. However, the person assessing their competency did not have training in competency assessment and had not had their own competency assessed.
• One person was given an incorrect dose of their medicine for nine days because staff did not follow the printed directions on the label and on the Medication Administration Chart. There was no robust method of reconciling medicines when they were delivered.
• One person ran out of paracetamol for five days. This meant their medicine was not available as required by regulation.
• Medicines were not always stored safely. The keys for medicines storage were hung up in an unlocked key safe in an unsecure area of the home. Creams were not stored safely in people's bedrooms or bathrooms.
• People were at risk of being given medicines which they were allergic to because the home did not have a system in place to make sure people's allergies were recorded accurately.

Since the inspection the provider has provided documentation to show the actions they have taken to address the concerns found during the inspection.

We found no evidence that people had been harmed however, the provider had failed to manage medicines safely. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At the last inspection we found the provider had failed to carry out individual risk assessments, fire signage was not always displayed, and care records did not always contain important information about people's

health needs. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. Risk assessments for people were carried out, fire signage was displayed, and care records contained person centred information.

• The quality manager completed risk assessments in key areas such as falls, nutrition and skin integrity. Actions to minimise risks were documented and staff were knowledgeable of these.
• The provider displayed fire signage in the home to help people evacuate in the event of an emergency. Staff could explain the action they would take to protect people in the event of fire, and this was recorded on individual care records.
• The fire risk assessment at the home had been completed in 2018 and there was no evidence this had been formally reviewed since to assess if it was still effective. The quality manager told us an appointment was being made with an external person to review the risk assessment to ensure it remained accurate and relevant.

We recommend the provider seeks and implements best practice on the frequency of fire risk assessment review.

• The provider had introduced an electronic record system. Paper records were in the process of being transferred onto this and people's care was being reviewed. We viewed two people's care records which recorded the health condition they lived with and the action staff needed to take to support their wellbeing.
• Staff followed people's risk assessments. A staff member moved a person's mobility frame out of another person's way to maintain safety. Systems and processes to safeguard people from the risk of abuse
•The provider had systems to protect people from the risk of abuse. Staff we spoke with told us they had received training in safeguarding, and they would act to keep people safe. They were able to give examples of abuse and said they would raise any concerns with the provider, quality manager or the local safeguarding authority to ensure people were protected.
• People told us they felt safe and they trusted staff. One person told us staff were, "Lovely."
• A relative told us their loved one's safety was promoted. They shared that since moving to the home the number of falls they had been having had reduced. They also shared that their loved one often needed to be admitted to hospital prior to moving to the home due to a health condition. Since living at the home their health had improved because of staff support and they had not had to go to hospital.

Staffing and recruitment
• The provider carried out sufficient checks to ensure prospective employees were suitable to work with people who may be vulnerable.
• The provider deployed staff effectively. People we spoke with voiced no concerns about the number of staff available to support them One person told us, "You're never alone here. They come and check me, make sure I'm ok, have a chat. It's grand." A relative commented, "Staff have time to sit and talk to people and [family member] doesn't have to wait for care."
• Staff told us they had enough time to support people safely and they had time to spend with them to chat and have a cup of tea. One staff member said people enjoyed the time staff were with them and time was, "That little bit extra that makes all the difference."

Preventing and controlling infection
• The provider had systems to protect people from the risk of infection. PPE and infection control gel was provided throughout the home and staff wore appropriate PPE to minimise the risk and spread of infection.
• Staff told us they received weekly training in infection prevention, including training relating to Covid -19.

• Extra cleaning was taking place to help minimise the risk and spread of infection.
Learning lessons when things go wrong
• Since the last inspection the provider had reviewed the audit systems in the home and a new audit system had been introduced. The quality manager explained that on review of the previous system, it was found improvements could be made, so a new system was currently being implemented.
• Staff told us checks were carried out and they received feedback on these. Staff told us they were keen to learn and improve the care delivered and they valued this feedback.
• Audits had not identified some of the concerns we found on inspection. Medicines audits had not identified the shortfalls in medicines and records were not always accurate. This has been addressed within the domain 'well-led' within this report.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection audits had not identified improvements needed to maintain compliance with the fundamental standards. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There is a continued failure of the provider to meet legal requirements. Not enough improvement had been made at this inspection and we also found some records were not always completed or accurate. The provider was still in breach of regulation 17.

• The medicines policy did not provide adequate guidance for the safe handling of medicines. For example, there was no guidance on how to record the quantities of medicines within the home.
• The records about medicines were not always accurate and did not always show they could all be accounted for or that medicines had been given as prescribed. For example, the quantities of medicines were not always accurate and did not show medicines could be accounted for or given as prescribed.
• Staff failed to accurately record the application of prescribed creams and the administration of prescribed food supplements which meant it was not possible to show people had been given them as prescribed.
• Some medicines with limited life must be dated when they are opened, however the staff did not always record the date accurately.
• Some medicines with limited life must be dated when they are opened, however the staff did not always record the date accurately.
• Assessed risk was not documented in relation to a person self-administering some of their medicines.
• The monthly medicines audits failed to identify the concerns found during the inspection about medicines.

• There is a history of repeated failure to meet the fundamental standards, As this inspection evidences, they had failed to meet the fundamental standards of regulation 12 and 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, inspection reports published in December 2015, August 2017, September 2018 and May 2020 evidence repeated failure of the registered provider to meet and sustain compliance with regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded quickly to our concerns and provided us with documentation which showed how improvements would be made.

These matters were a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as audit systems were ineffective and records were not always completed accurately or at all.

• The provider had introduced a new audit system. The quality manager told us not all audits had been completed due to the challenges from the Covid 19 pandemic. However, a new audit system had just been introduced. This had yet to be embedded into practice at the home and we will review this at the next inspection to assess its ongoing effectiveness.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection we found specific events were not notified to the Care Quality Commission as required. This was a breach of Regulation 18 Registration Regulations 2009 (Notifications of other incidents.)

• At this inspection we found notifications had been made to the Care Quality Commission as required, however there was no policy in place to guide staff on the action to take. This meant staff may not always know what to do if the provider and quality manager were absent.

We recommend the provider seeks best practice guidance from a reputable source on the submission of notifications and documents these so individual responsibilities are clear.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
• The provider was working to improve the service. A quality manager had recently been appointed to support change and drive improvement. Staff told us they felt the provider had made improvements since the last inspection and the quality manager was making further changes to improve the service.
• The provider sought people's views. Due to the current restrictions in place due to Covid 19, the provider sought people's views by using a suggestion box and individual conversations. Relatives told us the provider was approachable and they were asked for their views.
• A board in reception recorded people's views. For example, new furniture had been requested, the provider had responded to this and on the day of the inspection new furniture was being delivered.
• The provider engaged with relatives. Photographs and videos of family members were shared with relatives to support both parties to remain engaged with each other during the Covid-19 pandemic. One relative commented, "It brought me great comfort. I was reassured, it was lovely to see [family member] so happy."
• The quality manager was currently investigating a medicines error. They told us they would share the outcome of this and offer an apology to the person involved.

Working in partnership with others
•The provider was working with other professionals to ensure people received medical advice if this was needed. For example, we saw technology was used to support people to have face to face meetings with health professionals.
•The provider sought advice and guidance from relevant professionals. Since the last inspection the provider had been working closely with a representative from the Clinical Commissioning Group and the Care Home Liaison Team to gain knowledge and best practice information and improve the care provided.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit systems were not always effective and records were not always accurate. Regulation 17 (1) (2) (a) (c) (e) (f)