CareQuality Commission

Care UK Community Partnerships Ltd

Bowes House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Bowes House on the 1 and 2 August 2016. Bowes House provides accommodation and nursing care for up to 90 people who have nursing needs, including poor mobility or diabetes, as well as those living with various stages of dementia. The home also had a contract with the CCG (Clinical Commissioning Group) to provide rehabilitation for people, for up to 6 weeks. This aimed to either provide people with an alternative to a hospital admission. There were 78 people living at the home on the days of our inspection.

Bowes House is owned by the organisation Care UK Community Partnerships Limited. The service is purpose built and provides accommodation and facilities over two floors. Split into four units, the units include; Aylesham (Elderly Residential), Weald (Nursing care), Barley (Rehabilitation) and Meadow (Dementia). Local school children were involved in the naming of each unit.

The service had a registered 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.

At the last inspection undertaken on the 15 and 16 March 2015, we asked the provider to make improvements in relation to care plans and risk assessments to ensure sufficient guidance was provided to staff to provide safe care. This included the care for people who had lost weight. In addition, we asked the provider to make improvements to the opportunities available for meaningful activities, encouraging those receiving rehabilitation to self-administer their medicines and for care plans to be personalised to the individual. The provider sent us an action plan stating they would have addressed all of these concerns by October 2015. At this inspection we found the provider was meeting these regulations and had acted upon the recommendations made.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLs) which applies to care homes. Applications to restrict people's freedom had been submitted to the appropriate DoLS office and people had individual DoLS care plans. However, staff were not consistently aware of who was subject to a DoLS authorisation and what it meant for the individual. We have made a recommendation for improvement.

The principles of the Mental Capacity Act (MCA) were not consistently embedded into practice. Further work was required to clearly demonstrate whether people had consented to their care plan, photograph being taken or sharing of information. We have made a recommendation for improvement.

Staff had completed training to enable them to carry out their roles. There was an ongoing programme of training and development for staff. Upon commencing employment with the provider, staff were subject to an induction. However, documentation was not consistently completed to evidence when staff had finished

their induction and were deemed competent to work alone. Where concerns had been raised regarding the competency of staff, we could see that individual action had been taken, however, documentation failed to evidence how the management team had oversight of staff's progress and how they continually assessed staff's competency. We have made recommendations for improvement.

People's nutrition and hydration needs were met. The kitchen team were dedicated and passionate about providing good quality food which in return promoted people's quality of life. People were provided with a wide range of food options and individual dietary requirements were catered for. Where people had not met their daily fluid intake target, further work was required to ensure this was effectively shared with staff to ensure all staff encouraged people to drink more that day.

There were appropriate arrangements in place for monitoring the quality of the service that people received. The provider took into account the views of people, relatives and staff through surveys. The results were analysed and action was taken to make improvements for people living at the home. The registered manager carried out unannounced visits to the home to make sure people were receiving appropriate care and support. Staff said they enjoyed working at the home and they received good support from the management team.

People said they felt safe and staff treated them well. One person told us, "I feel extremely safe living here. Although it was hard moving in I knew I wasn't safe living by myself. Living here, there are staff available at all times and I know I'm safe." Appropriate recruitment checks took place before staff started work. There were enough staff on duty and deployed throughout the home to meet people's care and support needs.

Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported from abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

People had access to relevant healthcare professionals to maintain good health. Records confirmed that external healthcare professionals had been consulted to ensure that people were being provided with safe and effective care. People's clinical needs were assessed and met. People received good health care to maintain their health and well-being.

Dedicated activities coordinators were in post who provided a wide range of interaction, engagement and stimulation. One person told us, "The activity coordinator who takes us out on the bus is fantastic, they design trips to see places we have not been before and the trips are very interesting and informative, I really enjoy their outings." A visiting relative told us, "Staff are quite responsive and try to encourage mum to do activities." Further work was underway to ensure that those who did not enjoy group activities, were not at risk of social isolation.

People's privacy and dignity was respected and staff had a caring attitude towards people. We saw staff smiling and laughing with people and offering support. There was a good rapport between people and staff.

Feedback from people and their relatives was positive about the care, the atmosphere in the service and the approach and openness of the staff and registered manager. Comments included, "I am very happy here and would not have any difficulty recommending Bowes House to my friends, I have been made to feel very welcome. I cannot fault it."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Bowes House was safe.

People told us they felt safe living at Bowes House and staff were aware of the measures to keep people safe. Risks to people's safety were identified and measures were put in place to reduce these risks as far as possible.

Medicines were stored, administered and disposed of safely. The environment and equipment was well maintained to ensure safety. There were enough staff on duty to meet the needs of people. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

Bowes House was not consistently effective.

Staff's understanding of Deprivation of Liberty Safeguards (DoLS) varied, and not all staff members could confirm who was subject to a Deprivation of Liberty Safeguard and what that meant for the individual person. The principles of the Mental Capacity Act (MCA) were not consistently embedded into the care planning process.

The provider's induction programme did not consistently demonstrate that staff were deemed competent to work unsupervised.

Staff received essential training to meet people's needs and had detailed knowledge about people's individual preferences. Staff recognised that people's healthcare needs could change rapidly and mechanisms were in place to maintain people's health and wellbeing.

The kitchen team were dedicated to providing high quality food. A sociable lunchtime experience was made available to people

and people were supplied with a wide range of food and drink throughout the day

Is the service caring?

Good

Bowes House was caring.

Staff communicated effectively with people and treated them with kindness, compassion and respect. People's privacy and dignity was respected by staff.

People were supported in a stable and caring environment. The staff promoted an atmosphere which was kind and friendly. The companionship pets bring to older people was recognised by the management team and the home had guinea pigs on site for people to pet and stroke.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to. The care to be provided when people reached the end of their lives had been sensitively planned taking into account their wishes.

Is the service responsive?

Good

Bowes House was responsive.

People had individualised care plans which reflected their life history, what was important to them and how best to support them. Staff understood the principles of delivering person-centred care.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them.

People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Good

Bowes House was well-led.

Staff spoke positively about the management team and their leadership style. Staff described their style as open and approachable.

There was an open and transparent culture within the service and the engagement and involvement of staff and people was encouraged by the management team and used to drive improvements.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support.

Staff said they enjoyed working at the home and they received good support from the registered manager and unit managers. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

Care Quality Commission

Bowes House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 2 August 2016 and was unannounced. The inspection team consisted of one inspector, an inspection manager, specialist nurse advisor and an Expert by Experience in older people's care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service this included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete 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. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we spoke with 13 people and two visiting relatives. We spoke with various staff that included the registered manager, the deputy manager, activities coordinators, chef, maintenance worker, clinical lead, two registered nurses, three team leaders, three unit managers and six care staff.

We reviewed a range of records about people's care and how the service was managed. These included the care records for 14 people. We 'pathway tracked' people living at the service. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Medicine administration record (MAR) sheets were reviewed, four staff training, support and employment records, policies and procedures, quality assurance audits and incident reports and records relating to the

management of the service. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounge and dining area and spent time observing the lunchtime experience for people and the administration of medicines.

Bowes House was last inspected on the 15 and 16 March 2016 where concerns were identified and the service was rated as Requires Improvement.

Good

Is the service safe?

Our findings

People told us they felt safe living at Bowes House. One person told us, "I feel extremely safe living here. Although it was hard moving in, I knew I wasn't safe living by myself. Living here, there are staff available at all times and I know I'm safe." Relatives also confirmed they felt confident living their loved ones in the care of Bowes House.

At the last inspection we identified areas of improvement in relation to the management of pain assessments for people living with dementia and systems were not in place to empower people to regain their independence with their medicine regime. Additionally, documentation failed to reflect the individual settings of air mattresses. Recommendations were made and at this inspection, we found improvements had been made.

For people requiring the support of an air mattress (inflatable mattress which could protect people from the risk of pressure damage), it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. Improvements had been made since the last inspection. Staff were now recording on a daily basis, the setting of the air mattress to ensure it remained on the correct setting. Monthly audits were also completed by the maintenance worker to ensure the mattresses remained safe and fit for purpose.

Bowes House had safe systems for administration of medicines. All medicines were securely stored. Full records were maintained of medicines brought into Bowes House, given to people and disposed of. All staff who supported people with their medicines did this carefully and did not rush people. They gave people the help they needed to take their medicines, including drinks of their choice. They checked each person had fully swallowed their medicine before signing that the person had taken their medicine. Where people were prescribed medicines on an 'as required' basis, there were clear protocols outlining the reasons a person needed their medicine and how often it was to be given in 24 hours. Systems were in place to assess people's pain levels and ensure appropriate pain relief was provided to people when required.

Helping people to look after their own medicines is important in enabling people to retain their independence. For people receiving rehabilitation on Barley Unit, systems were now in place to enable people to regain their independence with their medicines regime before returning home (if safe to do so). A staff member told us, "When a person comes onto Barley Unit, after 48 hours, we begin the self-administration process. A self-administration risk assessment is completed and we then work with the person to empower them to become independent again." People's ability to safely self-administer medicines was re-evaluated to ensure it remained safe for them to do so.

There was a sufficient number of staff on duty at all times to meet people's needs in a safe way. Staffing levels were based on people's individual care needs. Each person had an individual care needs assessment. This was inputted on the provider's electronic care system, which would then determine the number of hours of care that individuals required. The registered manager told us, "There are limitations to this system, as it doesn't always fully en-capture people's social and psychological needs. If the nursing staff come to me

and say additional staffing is required, I don't then look at the CAPE tool. I go on what the nurses say as they are out on the floor." As a result, and in response from feedback from nursing and care staff, one to one staffing levels had been provided to one person over the weekend due to a significant change in their care needs.

People, staff and relatives felt staffing levels were sufficient. One staff member told us, "Only just are staffing levels manageable. There are days when we are short as staff go off sick, but we manage and people always get the care that they need." One person told us, "The girls do look busy but they always help me and never rush me." We conducted an audit of call bell response times and ascertained that people's call bells were answered in either seconds or a couple of minutes.

Bowes House was experiencing a higher than average levels of sickness, staff were also taking annual leave due to the summer holidays and not all vacant posts had been recruited to. The registered manager told us, "We are using agency staff more often than not." Where sick leave was recorded as the absence from work, the registered manager operated a robust return to work policy and monitored sick leave. This enabled the registered manager to explore why staff were taking sick leave, but to also minimise the risk of future sick leave where possible. The registered manager told us, "Some scenarios have resulted in disciplinary action but for others we have empowered the staff to see occupational health or access counselling." The use of agency staff had been noticed by people and their relatives. However, people recognised this be may related to the summer holidays. One person told us, "The staff are lovely here, I'm not very keen on the agency staff. There is a lot of agency staff, and I don't think that system should be had. I don't agree with agency staff. I don't know them and have to tell them what to do for me. I've paid good money here and I don't agree with agency staff." Another person told us, "Staff are very good but they are always very busy especially around now when its holidays times." We found there was a commitment to ensuring staffing levels were safe and recruiting to vacant posts to minimise the use of agency staff.

Systems were in place to ensure people's rights were protected and people were kept safe from harm. These included clear systems on protecting people from abuse. Training records confirmed staff had received adult safeguarding training. Staff talked to us about their responsibility to recognise and report any abuse. They were able to give examples of what they considered to be abuse and neglect and told us they would always report any incidents to their line manager or raise concerns directly with the local authority. Where safeguarding concerns had been identified, appropriate action had been taken to ensure the person was safeguarded and their rights protected and upheld.

Suitable measures had been taken to ensure that people were safe, but their freedom was not restricted. Some people were supported to undertake positive risks. We observed some people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Where specific risks had been identified, risk assessments were in place to mitigate the risk of harm but enabling the person to retain their independence. Risk assessments included; falls, nutrition, choking, moving and handling and pressure damage. Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer.

Staff were knowledgeable about the people they supported and what element of their care routine may pose a risk. Older people with health needs such as dementia and Parkinson's can be at heightened risk of choking. Initial choking risk assessments were completed for all people moving into Bowes House. Where people had been identified at high risk of choking, staff demonstrated a firm awareness of the strategies required to mitigate the risk of choking. One member of care staff told us, "We have one person who requires a puree diet but for personal reasons chooses not to have a puree diet which places them at risk of choking.

We therefore provide discreet supervision when they are eating and make sure they don't eat too fast."

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Where staff had commenced work before their DBS check being received, a robust risk assessment had been completed which assessed their competency and calibre. They also did not work unsupervised until their DBS had been received. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. In the event of the building needing to be evacuated, a place of safety had been nominated. The home had been subject to water damage and on-going work to the flat roof was taking place. As a result of the water damage, two people's bedrooms had been subject to damage and they required moving to move suitable rooms. The registered manager told us, "Work is scheduled to commence and we are aware of the urgency to complete the work and have been escalating our concerns."

Requires Improvement

Is the service effective?

Our findings

People spoke highly of the staff and felt confident in their skills and abilities. One person told us, "The staff are very good." Another person told us, "They know how to look after me." A third person told us, "I can't fault the staff." Despite people's high praise for staff, we found care and support was not always delivered effectively.

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. Staff were able to confidently describe the main principles of the legislation. One staff member told us, "It's about an individual's capacity to make specific decisions." We saw that staff obtained people's consent, for example, before providing care or helping people to move. Mental capacity assessments had been completed where it was identified the individual may not be able to consent to living at Bowes House. However, the care planning process did not consistently reflect the principles of the MCA. For example, care plans did not consistently identify if the person consented to their care plan, consent to have their photograph taken or to their information being shared. A member of the management team told us, "We have recognised that we need to complete more decision specific mental capacity assessments, for example, where the person may not be able to consent to their care plan." We were shown one capacity assessment which had been completed for an individual who lack capacity to consent to their care plan.

The provider had recognised further work was required to embed the principles of the MCA into the care planning process. We recommend that the provider considers national guidance on MCA and care planning.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied.

Staff confirmed they had received training on DoLS, however, staff were unable to tell us how they would identify a deprivation of liberty or who was subject to a DoLS. Throughout the course of the inspection, we spent time on the individual units. When talking to staff on those individual units, we asked, "can you advise who is subject to a DoLS or where a DoLS has been applied for?" Staff were unable to recall this information. Although DoLS authorisations were in place, people's rights were not protected as staff were unaware of who was under a DoLS and what it meant for those individuals. From our observations, we could see that staff regularly took people out and about and people had the freedom to move around the home and the provider had recognised where people were deprived of their liberty.

Under the MCA code of practice, lap belts can be seen as a form of restraint. A member of the management team told us, "We have recently revised our policy and made it clear that lap belts should only be used in transit, once the person has been moved, the lap belt should be undone, so as to not restrict their freedom any further." We observed one person sitting in their wheelchair all afternoon with their lap belt done up, therefore restricting their ability to freely move from their wheelchair. Staff regularly went up to this person offering refreshments, however, did not support the person to undo their lap belt. Their individual care plan reflected the lap belt was used as a form of safety but did not reflect it should only be used during transit. We brought this to the attention of a member of the management team who confirmed they would update the care plan and re-iterate to staff the importance of lap belts only being used in transit.

We recommend that the service seeks guidance from a reputable source about to how embed DoLS training
.
Staff were aware of their roles and responsibilities and confirmed they felt valued as employees. One staff member told us, "I love working here. I feel listened to and valued." Upon commencing employment with the provider, new staff were subject to an induction programme. The registered manager told us, "All new staff complete a two week induction, where they receive a buddy and go through how the home operates, e-learning training, meet the various teams and meet the residents. They are then signed off by their buddy as competent to work unsupervised. With some staff it takes longer than two weeks, but we need to ensure they are competent to work alone." However, documentation was not consistently in place to reflect the induction programme which demonstrated staff were competent to work unsupervised. We were shown one completed induction programme which clearly demonstrated that the staff member was competent to work unsupervised. However, this was not yet consistently embedded into practice, as the management team had only just started completing documentation to reflect staff's level of competency.

Where concerns had been raised regarding staff's competency, we could see that individual action had been taken by the management team. For example, raising safeguarding concerns and holding individual meetings with the staff member concerned to ensure the risk to people was minimised and support to the staff member was provided. However, documentation such as supervision notes and appraisals did not consistently reflect how the management team had clear oversight of these concerns and how they monitored staff's progress to ensure the competency of staff. The management team confirmed the action that had been taken to support staff and monitor their progress, however, documentation failed to reflect this.

We recommend that the service seeks advice and guidance about the management and recording of staff competency.

A programme of essential training was provided to staff to enable them to carry out their role effectively. Staff spoke highly about the training provided and also felt requests for specific training were met. One staff member told us, "Recently we've requested end of life training, which the management team are looking at arranging for us." There was an effective system to record and monitor staff training and highlight when refresher courses were due. On average, 88.89% of staff were up to date with their training. Where staff required prompting to complete training, we saw that texts were sent to staff to act as a reminder. For example, a fire safety audit identified not all staff had completed their fire safety awareness training. A text was sent to staff to remind them to complete the training. Registered nurses received on-going clinical training and supervision which also maintained their continuing professional development.

Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. People's changing health needs were reviewed on a regular basis and referrals were regularly made to healthcare professionals. The management team adopted a culture whereby staff understood that

people's care needs can change on an hourly basis. One care staff told us, "People's care needs can change so rapidly and we have to be aware of that." Staff members recognised the impact particular health conditions could have and advised they felt confident in delivering effective care. One staff member told us, "One person is living with Parkinson's and they get these sensations that there feet are stuck to the ground. When they get those sensations, I rub their feet which helps alleviate that feeling." A GP was allocated to the home who visited on a weekly basis. Nursing staff spoke highly of having an assigned GP; they felt it enabled them to work more closely with the GP surgery and enable concern's regarding people's healthcare needs to be escalated more quickly.

Management of pressure damage is an integral element of providing effective care to people living in nursing homes. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses, regular re-positioning and application of barrier creams. Care staff demonstrated a firm awareness of the measures required to minimise the risk of skin breakdown. One staff member told us, "Some people receive three hourly turns as it reduces the risk of their skin breaking down."

Bowes House provided care and support to people living with a swallowing difficulty. For people assessed with swallowing difficulty, the use of thickened fluids when drinking is required to minimise the risk of choking and aspiration. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual as otherwise they can place the person at risk of aspiration. Without prompting, staff could consistently tell us the quantity of thickener people required compared to fluid. One staff member told us, "One person requires one scoop of thickener to 150mls of fluid." Where people were assessed as living with a swallowing difficulty, input from the dietician and Speech and Language Therapist had been sourced and individualised plans of care were in place. Some people required a soft or puree diet and we saw these were provided. Clear guidance was in place regarding the texture of the soft/puree diet and consideration was given to making the meal as presentable as possible.

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' This was fully embedded into practice. With permission, we joined people for their lunchtime meal on Meadow unit (dementia unit), Barley (Rehabilitation) and Aylesham (Residential). Tables were neatly decorated and laid and people were asked where they would like to sit. Staff members showed people the individual meal choices available which enabled them to make a choice. People were encouraged to be as independent as possible. For example, blue plates were provided for some people which enabled them to see and pick up the food easily in comparison to a white plate. Where people required support to eat and drink, staff sat down at the table with them, providing support at their own pace. Staff providing support also interacted with everyone on the table alongside the person they were supporting, ascertaining how there day was going and talking about their life history. Music was softly playing in the background which added to the calm and homely atmosphere created.

People spoke highly about the food provided. One person told us, "It was lovely today." Another person told us, "The pastry chef's pastries are beautiful." Other people felt they would like more traditional food, but overall felt the food was good. The kitchen team demonstrated a strong commitment to providing excellent quality of food and in return quality of life. Feedback was regularly sought from people on how they found the food and this was used to help devise the menu. Catering meetings were also held in partnership with people so they could contribute to the design of the menu. The kitchen team at Bowes House had recently been published in the magazine 'Care Home Catering' where they spoke about they how celebrated nutrition and hydration week at Bowes House. The kitchen and management team recognised the

importance nutrition and hydration plays in the care for older people. Alongside holding the nutrition and hydration week, Bowes House was holding an 'eating as we age' event in September 2016.

Staff recognised the importance of promoting nutrition and hydration. Throughout the inspection, we observed staff members continually offering people drinks and snacks. Unless the need for a low calorie diet was identified, all food provided was fortified to help enable people maintain a healthy and stable weight. Records of weights demonstrated that no one was losing weight and most people living at Bowes House were putting weight on. Where people were at risk of malnutrition, food and fluid charts were in place. A recent initiative introduced by the management team was for the night staff to calculate people's daily fluid intake. During the morning handover, night staff would then share with the team if the person had not met their daily fluid target. The food and fluid chart for one person reflected their daily fluid target was 1500mls. On the 1st August 2016, it had been calculated they had only achieved 830mls. We queried with staff whether this had been shared in handover. Staff confirmed it had not. They were therefore unaware of the need to encourage this person to drink more fluids. We brought this to the attention of the management team who confirmed this area of practice required more time to be embedded.

We recommend that the service seek support and guidance about the management of embedding changes in care practice.

Good

Is the service caring?

Our findings

People we spoke with told us that the staff were caring and treated them with respect. One person told us, "The staff are lovely." Another person told us, "It's lovely here; they look after me and always treat me with respect." A third person told us, "They respect my space which I like."

People were cared for by caring, empathetic, kindly staff who cared for the people they were looking after. One staff member told us, "I love it here, best home I've worked in. I love the residents and looking after them." Another staff member told us, "I love hearing their stories." We heard laughter, banter and informal conversation between people and staff. Staff and people knew each other well and were relaxed in each other's company.

At the entrance to the home, was Lynn's café. Lynn's café acted as the hub of the home. With direct access to the patio area and seating round the coffee shop, Lynn's café acted as the area where people and staff gathered throughout the day. Coffee, tea and other refreshments were available along with the daily newspaper as well as fresh cakes. The atmosphere at Lynn's café was calm but also interactive, warm and homely. A piano was available for people to freely play. One person was observed playing the piano and staff told us that since moving into Bowes House, their confidence with playing had greatly improved. Throughout the inspection, we saw people gathering at the coffee shop, sitting with relatives, or sitting together, chatting drinking coffee or eating a cake.

A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. Bowes House had a dedicated dementia unit (Meadow unit) which was designed to specifically meet the needs of people living with dementia. The registered manager told us, "To help orient people to their bedrooms, we asked them or their family members what the colour of their front door used to be. We then print their name in large print on the coloured paper (the colour of their old front door. We plan to eventually paint panels on their door in the colour of their old front door." People living with dementia often make use of past experiences to make sense of the present. The design of Meadow unit had been coordinated so that each wall was a different theme from a different era. One wall was a comic book theme, while another was a film theme with pictures of old films from the 1950s and 1960s. This helped to trigger memories and enhance people's past skills, hobbies or occupations.

Guidance produced by Age UK advises on the importance pets bring to older people. Bowes House recognised the importance pets bring to older people living in a care home. The home had two guinea pigs for people to pet, hold and take care off. A member of the management team also brought their dog into work every day which people enjoyed. The staff member told us, "The dog is amazing with the residents; she seems to know to be gentle around them and also looks out for them. The other day, one of the residents was coughing in Lynn's café, she jumped up and barked asking to be let out, she immediately went over to the resident and placed her head on their chair, as if to check they were ok. I also take her round to see residents in their bedroom and one resident told me, how they were feeling extremely low one day, but having her to stroke really cheered them up."

We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. Staff took their time to talk with people and showed them that they were important. Staff always approached people face on and at eye level, they demonstrated empathy and compassion for the people they supported. On Meadow unit (dementia), one person was becoming distressed as they couldn't find their bedroom. They told us, "I'm rather silly, I just can't find it. I thought it was down here." A member of staff came over and sensitively explained where their bedroom was. Together they proceeded to walk to the person's bedroom holding hands, joking about getting lost.

Friendships between people had blossomed while living at Bowes House. Throughout the inspection, people were seen sitting interacting together. Laughter was heard
throughout the inspection and at lunchtime, people were observed sitting in groups with people with whom they had developed friendships. At lunchtime, people were seen sitting together, chatting and laughing whilst enjoying their lunch time meal.

People's wellbeing was taken into account by staff. We heard staff constantly asking people if they were okay or if there was anything they needed. Staff regularly noticed if people were not drinking and gently sat down next to them to try and encourage them to drink or ascertain if there was a drink they would prefer. Staff empowered people to make their own choices and decisions. After lunchtime on Meadow unit, people were beginning to move from the dining area, staff asked people, "where would you like to go, would you like to go to your bedroom or into the lounge?" One person approached a member of staff, giving them a hug. The staff member responded, by saying, "Thank you that was lovely, what would you like to do now, we could watch television or would you like a rest."

People could be confident that best practice would be maintained for their end of life care. Two staff members were completing the Gold Standards Framework. The Gold Standards Framework is a national accreditation scheme which provides staff with the skills and expertise to provide a gold standard level of care for people nearing the end of their life. With pride, staff members told us they provide dignified care to people reaching the end of their life. One staff member told us, "I feel we provide excellent end of life care. Towards the end, we provide care that isn't intrusive but ensures people are comfortable, clean and pain free. We always make sure someone is with the person, even if we just sit and hold hands with them." People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. Detailed end of life care plans were formulated in partnership with the person which reflected what was important to them. For example, one person's bedroom was rearranged, so their bed overlooked the garden as this was important to the person. Bowes House provided overnight accommodation for loved ones to ensure they could be near as their relative approached the end of their life.

Staff encouraged people to do as much as possible for themselves. Staff worked in partnership with people on Barley unit (rehabilitation) to help them regain their confidence before they returned home. One staff member told us, "The physiotherapists or occupational therapists set the rehabilitation goals; we then work with the person to achieve those goals. We have one person at the moment who is keen to go home but needs to be able to walk further. We encourage them to mobilise and build their confidence with walking." Staff were aware of the importance of providing the right level of support to ensure that people's needs were met, but also to enable them to do as much for themselves as possible. People were provided with equipment, where needed, to enable them to move around independently and to eat without assistance.

People's right to privacy and dignity was respected. People were assisted discreetly with their personal care

needs in a way that respected their dignity. Staff had helped people to dress in the way their care plan said they preferred and to have belongings with them that were of importance, for example, their handbag. People had been supported to wear their glasses, dentures and hearing aids if they needed these. Staff recognised the importance of promoting and supporting people to maintain their individuality. Throughout the inspection, we heard staff knocking on people's bedroom doors, gaining permission before entering and greeting people warmly. Staff were heard saying, "Good morning, how are you today." Care plans detailed if ladies required support to apply their make-up or if they liked to wear perfume and whether men preferred a shave or not. The management team also recognised the importance of pampering and enabling older people to be pampered. Every other Friday, a therapist visited the home and people were provided with the opportunity to have a massage, get their nails done, or have aromatherapy or reflexology. The registered manager told us, "The therapist has been a real success and people seem to really enjoy coming along for a specific treatment."

People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting, taking people out and being welcomed by staff.

Good

Is the service responsive?

Our findings

People we spoke with told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. One person told us, "The girls care very well for me." Another person told us, "I feel the staff listen to me."

At the last inspection we identified areas of improvement in care planning. Care plans lacked personalisation and personal history, such as people's life history. We made a recommendation that the service considered researching the National Institute for Health and Care Excellence quality standard for mental wellbeing of older people in care homes.

Personalised care planning is at the heart of the health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. We found improvements had been made since the last inspection. Care plans had been updated to reflect the person's individual life history, how best to support the person, what is important to them and what people like and admire about them. Information was also readily documented on what people's life was like before moving into Bowes House. This information helped staff promote the transition from home to a care home and helped them build a rapport with the individual. One person's individual care plan, noted the person 'liked to start their day around 08.00am and enjoyed going for a daily walk. They enjoy quiz shows and good dramas on TV.' Staff told us how they found this information helpful and would also build upon this information, once they got to know people more.

People's individual care needs had been assessed and a care plan written to meet their identified needs. These assessments gave a clear account of people's needs in relation to their medicines, communication, breathing, nutrition, continence, skin integrity, sleeping pattern and mobility. Care plans were detailed but also personal to the individual. One person's communication care plan identified they may experience difficult in understanding others. Guidance available included, 'It is a useful exercise to ask (person) to repeat back what has been said to see if they had clearly understood. When talking to (person), it is important that they are approached from the left side so they can focus on their left side to help reduce the level of left sided inattention.' This enabled staff to provide personalised and individual care to people.

Care staff understood the importance of providing person-centred care. One staff member told us, "This is the only home where I've worked where it's really person centred. They strive to make it person-centred." Care staff told us how they spent time getting to know people, learning about their past and felt this was an important part of their job. One staff member told us, "Learning about their histories and the stories they have is amazing. A lot of people living here are also from the local area and I knew them when they lived at home when I was growing up. I feel that adds to our relationship."

It is important that older people in nursing homes have the opportunity to take part in activities, including activities of daily living that helps to maintain or improve their health and mental wellbeing. People should be encouraged to take an active role in choosing and defining activities that are meaningful to them. At the

last inspection, we found improvements were required to the provision of one to one activities. This was because, there was a significant focus on group activities, but not all activities were meaningful to people.

The provider employed three full time activities coordinators and had a range of bank activities coordinators they could call upon. A wide range of activities were on offer throughout the day. These included; crossword challenge, scrabble, dominoes, review of the paper, hangman challenge, charades and carpet bowls. Throughout the inspection we observed the activities coordinators regularly interacting with people and undertaking group activities. Group activities were well attended. On both days of the inspection, the activities coordinator sat down and had coffee with people in the morning, where they read the morning news and debated about what was going on in daily affairs. People told us they enjoyed coming down to the coffee shop (Lynn's café) for a morning coffee and to discuss current affairs.

Improvements had been made since the last inspection by providing meaningful activities for people. The activities coordinator told us, "We support everyone to complete a life history. From the information provided, we then centre activities around people's individual preferences. A large number of people identified they were interested in the local history. So when we go out on the mini bus, I always give an overview of the local history. I've also done tours on the mini-bus. For example, we've been on a murder mystery tour around Eastbourne, which was successful. We have also been up to Beachy Head, where one person realised they were stationed there, which they didn't realise up until we drove up there. That was a positive experience, as it jogged memories for them and we learnt about their experience of being stationed there." One person told us, "The activity coordinator who takes us out on the bus is fantastic. They designs trips to see places we have not been before and the trips are very interesting and informative, I really enjoy their outings."

Where people had expressed individual hobbies or interests, they were encouraged and supported to pursue those interests. For example, one person used to play the piano on Meadow unit, however, they found they were often distracted. To enable the person to pursue their hobby without being distracted, the piano was brought to Lynn's café for them to continue playing. One person with a keen passion for singing was being supported to set up a choir club. Another person with an interest in art, was also being supported by the activities coordinator to pursue their passion. Where people preferred one to one activities, the activity coordinators spent time with people in their individual bedrooms. The registered manager told us that the activity coordinators would record these one to one sessions in people's daily care notes.

People spoke highly of the activities provided and the opportunity for social engagement. One person told us, "I really enjoy coming down to Lynn's café and spending the day here." A visiting relative told us, "Staff are quite responsive and try to encourage mum to do activities." Some people advised they felt more could be done to provide meaningful activities for them. One person told us, "I'm content here, the staff are friendly and try and make me laugh but I do not have anyone to have an intellectual conversation with, which I miss." This was raised to the management team who agreed that although significant improvements have been made, there is always room for continued improvements.

For people living with dementia a dedicated activities coordinator was employed to provide stimulation and activities specifically for Meadow unit (dementia unit). A wide range of activities was made available to people, such as arts and crafts, sing a-longs and cooking classes. Throughout the unit, various sensory items were available for people to engage with. For example, one wall included an old fashioned clothing peg line with clothes for people to hang up. Books and musical instruments were also available along with a sensory cat. One staff member told us, "The sensory cat is amazing, you walk past it and it purrs or curls up. The residents love it. One person loves picking it up and brushing it." Throughout the inspection, we observed people interacting with the various sensory items which provided them with stimulation and interactions.

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. People also told us they could bring up any concerns and issues at the residents meeting. People and relatives felt they would be listened to and would usually approach the registered manager or deputy manager as they were both available and approachable. We saw evidence that complaints which had occurred had been recorded and responded to appropriately.

Good

Is the service well-led?

Our findings

At our last inspection March 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because documentation failed to record what action had been taken following a change in people's care needs. Care plans were contradictory and failed to provide sufficient guidance for staff to follow.

An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2015. At this inspection, we found improvements had been made and the provider is now meeting the requirements of the regulation.

People were relaxed and comfortable in the presence of the management team. The management team knew people and their relatives by name and made time to engage with people. People and staff praised the leadership of the registered manager. One staff member told us, "She's very approachable." Another staff member told us, "The manager comes out on the floor and sees how we're doing, she's very friendly and open."

At the last inspection, concerns were raised regarding the lack of detail available in people's care plans. Care plans were contradictory and failed to advise what action had been taken where people had lost weight or their care needs had changed. During this inspection, the management team had made significant improvements. Care plans were detailed, up to date and reflected people's current level of need, therefore providing clear guidance for staff to follow. The management team told us, "We've been working extremely hard to ensure that all care plans are now personalised and up to date. Where people were losing weight, we were conducting a monthly weight audit to monitor people's weight and ensured we recorded what action had been taken where people had lost weight. Staff now feel confident this is always recorded, so we have now reduced how often we do this audit. But we do regular checks to ensure staff are regularly recording people's weights and recording what action has been taken where people may have lost weight." Care staff spoke positively about the changes to care plans and felt the level of detail included was positive and reflected the individual needs of the person.

There was a clear management structure in place at Bowes House. This included head of departments, clinical leads, unit managers and team leaders that supported the registered manager who had an overview of the service. The structure had recently been strengthened with the recruitment of a second clinical lead supporting the registered manager and the unit managers. Staff were aware of the line of accountability and who to contact in the event of any emergency. There were on call arrangements in place to ensure advice and guidance was available every day and night if required. All staff were aware of the whistleblowing procedure and said they would use it if they needed to.

People, their relatives, staff and healthcare professionals were actively involved in developing and improving the service. Regular satisfaction surveys were sent out to people to enable them to provide feedback. Care UK (provider) also conducted telephone interviews with relatives to obtain their feedback. The latest satisfaction results from the period September 2015 – February 2016 found that 90% of

respondents felt staff treated their relative with respect, dignity and kindness. Comments included, 'The staff are very good, they're always there for him and keep their eye on him. There's a nice atmosphere, it's like a hotel.' 'Resident' and staff meetings were held on a regular basis. These provided people and staff with a forum for making any suggestions or raising any concerns. Where people had made suggestions, we could see that action had been taken. A feed-back notice board was displayed in Lynn's café which identified that action had been taken following feedback from people. For example, suggestions received from people included 'more trips out', 'somewhere to purchase toiletries' and 'somewhere to have nails and treatment done.' Actions taken by the provider in response to this feedback included 'more bus training for staff.' 'Shop built within the home for people to purchase toiletries and the implementation of the therapy room.'

Feedback from staff indicated a positive culture, with staff feeling motivated and supported. We discussed the culture and ethos of the service with the registered manager and staff. One staff member told us, "We're here to give the best care possible." Another staff member told us, "The best thing about working here is the person centred care we give." Staff said they felt well supported within their roles and described an 'open door' management approach. One staff member told us, "The management team are very approachable." The registered manager told us, "We've made a lot of changes in the past year. We've focused on strengthening the leadership of the home and the structure of the leadership. I've also focused on implementing a non-blame culture, reiterating the importance of honesty, transparency and openness. I want staff to come forward with concerns and worries and we learn from it, rather than a blame culture." Staff members spoke positively about staff morale and felt communication within the home was effective.

There were systems to review the quality of service provided which included a variety of audits and checks. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. Infection control; medication, nutrition, supervision and training and quality assurance audits were taking place on a regular basis. The provider's regional director also visited the home on a regular basis undertaking compliance audits which assessed the delivery of care and treatment. In line with the Care Quality Commissions (CQC) methodology, a key line of enquiry audit took place which considered how the home was meeting the five key questions, is the service safe, effective, caring, responsive and well-led. The provider also organised for an external professional to come into Bowes House and conduct an audit, also based on CQC's five key lines of enquiry. The management team told us, "Having that external auditor as well is extremely useful, they also arrive un-announced and rate the service. It also prepares staff and people for what a CQC inspection looks like. We find it very helpful." Night spot checks were also undertaken by the management team which considered the competency of the night staff and the delivery of care at night. Any action points identified were then transferred onto Bowes House Service Improvement plan. The registered manager told us, "The service improvement plan incorporates all actions from a variety of audits, including the actions from our last CQC inspection. I regularly up-date this to reflect when actions have been done or record the progress we have made."

Documentation was in place for the recording of incidents and accidents. Documentation included the unit where the accident/ incident occurred, the date and time, person involved and nature of the injury. On a monthly and six monthly bases, the registered manager would audit incidents and accidents looking for any trends, themes or patterns whilst also considering how improvements could be made following individual accidents and incidents. The registered manager told us, "From auditing the incident and accidents, I noticed a lot of people were falling at the same time on a regular basis. We therefore implemented a twilight shift which has greatly helped. However, I also questioned whether it was reflected that a lot of people were falling at this time, as this was the time staff were completing the incident and accident documentation, so I've also been exploring that. From the trending, we also agreed to trial pressure alerting cushions and sensor beams instead of crash mats, as a lot of people can step over the crash mat then fall, so their

effectiveness was not great." Effective mechanisms were in place to learn from incidents and accidents and ensure appropriate action was taken.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.