Bowood Care Homes Limited

Bowood Court & Mews

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bowood Court & Mews is a residential care home providing care and support for up to 93 people. The service is split across 2 buildings on the same site, providing support to younger and older adults, some of whom may have a physical and/or sensory impairment. The larger of the buildings is referred to as Bowood Court and the smaller is Bowood Mews, which specialises in providing care to people with dementia. At the time of our inspection there were 51 people were living at Bowood Court and 29 living at Bowood Mews.

People's experience of using this service and what we found
People were not always protected from avoidable harm and abuse. The provider had an inconsistent approach that sometimes put people's safety, health or wellbeing at risk. The provider had policies and procedures about upholding people's rights and making sure diverse needs were respected and met, however, these were not fully understood or consistently followed by staff. Risk management did not always consider the least restrictive option, and this limited some people's control over their lives and their independence.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not fully understood. People and their family and friends were not always included in decision making. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of consistency in the effectiveness of the care and support that people received.

The provider did not have a consistent approach to supporting staff to maintain their knowledge of best practice. The provider monitored people's health, care and support needs, but did not consistently act on issues identified.

The leadership and governance of the service did not always support the delivery of high-quality, person-centred care. Support for staff from management was inconsistent. Quality assurance arrangements were not always applied consistently across the service.

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

Rating at last inspection
The last rating for this service was good (published 09 August 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines and the management of the service. As a result, we undertook a focused inspection to review the key questions

of safe, effective and well-led only.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to people's safety and the leadership of the service at this inspection.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bowood Court & Mews

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors, a Specialist Nurse Advisor and an Expert by Experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, the inspection team consisted of 2 inspectors and a Specialist Nurse Advisor.

Service and service type
Bowood Court & Mews is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post.

Notice of inspection
The first day of inspection was unannounced. At the end of the first day we let the management team know

we would be returning the following day for a second day.

Inspection activity started on 14 October 2022 and ended on 01 December 2022. We visited the location on 17 and 18 October 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people about their experiences of what it was like living at Bowood Court & Mews and 5 visiting relatives. We spoke with 20 staff including the nominated individual, relief manager, care managers, quality assurance manager, senior care workers, care workers, chef and agency care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. 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 reviewed a range of records. This included samples of 9 people's care records and multiple medicine records. A variety of records relating to the management of the service, audits, complaints, compliments and evidence of activities people were involved in and people's overall feedback about the service were also viewed.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management

● Risks to people and their safety were not consistently managed. Risk assessments and care plans were not always personalised or regularly reviewed. For example, we found 1 person had lost weight and their risk assessment had been updated, but not their care plan. This placed people at risk because arrangements for monitoring their weight were not effective.

● People who required textured modified diets were at risk of choking as staff were not sure what support people needed. Without clear knowledge, the provider could not be assured texture modified meals were prepared in line with the speech and language team's recommendations and people's individual preferences of food choice.

● Hazards and risks around the home had not been identified and mitigated. For example, we found the doors to the kitchen and laundry were propped open, allowing anyone to enter despite the known risk of people consuming products that could harm them. We also found exposed hot water pipes, sluice rooms were unlocked, wardrobes not secured to the wall and a window was without appropriate restrictor. This also posed a fire safety risk.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

We discussed the environmental risks and inaccurate care documentation with the management team, who advised they were going to review all care records and will ensure the environmental issues were made safe.

Systems and processes to safeguard people from the risk of abuse

● People were not consistently protected from the risk of abuse. Some staff used language and phrases when talking about people living with dementia, which inadvertently referred to people as childlike. Using negative language in this way increased the likelihood of a person with dementia experiencing stigma or discrimination.

● Staff we spoke with recognised different types of abuse and how to report these. However, staff did not feel confident appropriate action would be taken by the management team to protect people.

● Not all staff had completed safeguarding training. This meant the provider could not be assured all staff would recognise and report safeguarding concerns. We raised this with the management team following the inspection and they told us they would address this immediately.

Staffing and recruitment

● People, relatives and staff shared concerns about staffing levels and felt this impacted on being able to support people with promoting independence and taking part in more personalised activities. For example, being able to go out in the garden.

● Staff worked hard to support people, but they told us they did not have time to sit with people and spend quality time with them. We raised this with the management team at the time of the inspection.

● Safe recruitment processes were not always followed. The provider's policy had not considered how frequently existing staff's Disclosure and Barring Service (DBS) checks were done. Good practice suggests these should be done every three years; however, staff files showed some staff had not had a DBS for 5 years. In addition to this, the provider had no system in place to ensure agency staff had sufficient DBS checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

● Opportunities were missed and communication was ineffective at learning from incidents and or complaints to drive improvement. For example, there had been recent incidents with the laundry and kitchen areas at the home which highlighted the need for the doors to remain closed due to risk. This learning however had not been implemented and we found the doors propped open. This meant people living at the service were exposed to risk of harm.

Using medicines safely

● Medicine management was not consistently safe. For example, we found 1 person had been prescribed medicine to be given covertly. This means when medicines are administered without the knowledge or consent of the person receiving them, for example concealed in food or in a drink. Their care plan did not evidence that a pharmacist had been consulted on safe administration method. We shared our concerns with the management team, and they advised they would speak to the person's GP and pharmacy for advice. Without checking this, the person may be at risk of absorbing the medication quicker than intended and suffer side effects.

● Some medicines were not always stored properly. We found a tub of thickener in an unlocked cupboard. Thickener is added to fluids for some people at risk of choking and must be locked away when not in use. This placed people at harm of risk of eating the powder and becoming unwell.

● Medicines were not always safely managed or disposed of. We found medicines no longer required or out of date were not appropriately managed in-line with National Institute for Health and Care Excellence (NICE) guidance. Medicines for disposal were not stored in an appropriate tamper proof pharmaceutical waste bin and there were no records of items that were waiting to be sent or had been sent for disposal.

● People were at risk of not receiving their medicines correctly as prescribed, because although staff received medicine training and competency assessments, some staff told us they felt the 14-hour day shifts impacted on their ability to safely administer 4 rounds of medication. Staff told us this was because they felt the length of the shift impacted negatively on their ability to fully concentrate on each task. The provider was investigating a number of instances where medicine had been missed.

● Some people were prescribed medicines to be given on an 'as required' (PRN) basis. We found there were protocols for the administration of these which included the maximum dosage in a 24-hour period, indications and frequency of dosage. This meant staff had guidance on how and when to administer these medicines safely.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider had a system in place to ensure people could receive visitors to the home.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- There was a failure to implement the principles of the MCA. Staff lacked understanding about the MCA and there were no processes in place to support MCA assessments and best interest decisions where people were unable to give consent. Staff had not consistently received mental capacity training.
- Some staff sought consent before offering support to people. However, care plans had sometimes been completed without the involvement of the person or their representative. This meant staff following care documentation were at risk of supporting people inconsistently and not in line with people's needs and wishes.
- We found the provider was not working within the principles of the MCA and if needed, appropriate legal authorisations were not always in place to deprive a person of their liberty.
- We found some people had restrictions placed on them without capacity and best interests' assessments being completed. This placed people at risk of being unlawfully deprived of their liberty. For example, we found the majority of people living at the service had a sensor mat in their bedroom and most did not have a corresponding risk assessment or explanation as to why that piece of equipment was needed or if the person had consented to its use.

The provider had failed to follow the principles of the MCA and we could not be assured people had given lawful consent to their care. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People shared mixed feedback about the service supporting them to partake in activities they enjoyed. One person said, "I would like to go out more in the garden than I do, they [management] say there's not enough carers to take me out". One person shared positive feedback and told us, "I am reasonably happy here I just wish I could go out more. If it's really nice they [management] might let us go out".

● Care plans did not always document evidence they had been prepared in consultation with people. For example, care plans were frequently not written from the perspective of the person or signed by them. Relatives told us they were not involved in the reviews of people's care. One relative told us, "I haven't been allowed to look at my [relative's] care plans and I'm not asked what I think. I've tried to share important things, but I don't feel like they [management] listen." This meant people were at risk of receiving care they did not consent to or meet their specific needs.

● Care plans were not always person centred. Care plans lacked details of people's preferences about how they would like their care delivered. For example, there was limited information about people's oral health care needs, peoples likes and dislikes and past histories.

Staff support: induction, training, skills and experience

● Staff had not consistently received supervision and adequate training to meet people's needs. We found some staff had not received training in safeguarding, mental capacity act, dementia awareness and moving and handling. This meant staff may not always have had the skills and training to safely provide care to people living in the home.

● Staff told us they didn't always feet supported in their role. Several staff expressed concern they hadn't been given sufficient training on how to support people who may become distressed. One staff member told us, "We are just expected to get on with it without any back up or support". Another member of staff said, "We work hard to try and maintain a safe and happy environment."

Supporting people to eat and drink enough to maintain a balanced diet

● People did not consistently have the support they needed to maintain a healthy diet. For example, where people required monitoring due to their risk of malnutrition, this was not consistently in place. This meant people were at risk of losing weight and becoming unwell.

● People's mealtime experience varied dependent on which part of the home people lived. A number of people were not given the correct cutlery to eat their meals and a person had to wait over 20 minutes before staff recognised they needed assistance to eat their meal. One person said, "Some of them [staff] walk in and plonk it on the table. You're treated like animals sometimes. I've not finished my meal and they [staff] take it away. I tell them but some just laugh". Other people said, "Food is pretty good but boring, I sometimes wish I could get my own" and "The food is great I like the pudding".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was limited evidence in some people's care records of the provider having worked with other agencies to ensure people's needs were met where there had been a change in their presentation. For example, several people had lost weight however there was no evidence in people's care records this had been discussed with external health professionals, to agree actions to mitigate the risks to people's health needs. This meant people were exposed to the risk of deteriorating health and harm.

Adapting service, design, decoration to meet people's needs

● Although the provider had commenced some updating and decoration, further work was required to ensure the environment was more reflective of people's individual needs.

● People were not always provided with activity or stimulation. There was a lack of interactive or dementia-

friendly resources within the home to provide fun and engaging things for people to do. The provider had recently purchased new resources, however staff told us they hadn't been given any guidance or support on how to use them so most remained in storage.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Quality assurance processes were not effective. The provider's auditing systems had failed to identify and act on some of the concerns we found during the inspection. These audits still required some development to ensure they were effective. This meant opportunities to improve the service were missed.
- The provider had failed to establish effective systems to monitor health and safety in the home. Daily checks of the home environment had not identified potential risks to people from avoidable harm. For example, there were exposed hot water pipes, sluice rooms were unlocked, wardrobes in people's individual rooms were not secured to the wall, a window was without the appropriate restrictor and kitchen and laundry doors were propped open.
- The provider's systems were ineffective at identifying and reviewing staff training and support. For example, there were no plans in place to ensure all staff remained up to date with their mandatory training, such as safeguarding. This meant the provider could not be assured staff were delivering care that followed up to date safe guidance.
- The provider did not have a registered manager in post therefore staff did not have consistent opportunities for supervision. Therefore matters arising and shortfalls in staff's knowledge and learning could not be identified and acted upon.
- The provider's checking systems had not identified that blanket restrictions on people's day to day activities were imposed upon them, without their consent or rationale for doing so. For example, people were being unlawfully restricted without a DoLS in place and, where people may lack capacity to consent, this had not been assessed and there were limited records of decisions taken in people's best interests.
- The provider's governance checks had failed to ensure people were receiving person centred care. For example, assessments and care plans did not take account of people's needs and preferences for nutrition and people told us they were living in a regimented environment.

Continuous learning and improving care

- The provider's systems for continuous learning and improving people's care were not effective. For example, the doors to the laundry room and kitchen remained propped open. This was despite a known risk of people entering and eating cleaning products, such as dishwasher tablets. The provider had failed in an opportunity of learning from previous incidents to show practices had improved to mitigate potential risks to people's safety.
- Opportunities to drive through improvements in people's care were missed. For example, an audit was

undertaken to review the number of people with weight loss each month. However, no further exploration by the management team was undertaken to gain an understanding of why this may be happening to mitigate potential risks to people's health.
● Staff did not have regular supervision. This means staff did not receive constructive feedback on their performance.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● People's views were not always heard. We saw limited evidence individual meetings with people and their relatives were taking place. We were not assured of how the provider involved people and their relatives in reviewing their care. Opportunities for people and their relatives to receive key updates and have an open forum to raise suggestions or concerns did not regularly occur.
● A duty of candour incident is where an unintended or unexpected incident occurs which results in the death of someone receiving support, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident. As part of internal investigations when mistakes had been made, the management team had apologised to people. The management team understood their duty of candour responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Meetings with people living at the home had been held to seek feedback and encourage people's input into the running of the service. However, there was limited evidence of how this feedback was utilised to improve people's care.
● There was a lack of effective quality assurance systems and processes, audits and regular staff meetings. This meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.

Working in partnership with others
● Systems for working effectively with other organisations with responsibilities for people's care were not always embedded. People's health appointments and outcomes were not always recorded fully or accurately. This meant that there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to obtain the consent of the relevant person when providing care and treatment to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people were being monitored and managed safely.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the service was being managed effectively and failed to ensure comprehensive quality and safety monitoring.

The enforcement action we took:

We issued a warning notice