Care Quality Commission

Bowerfield House Limited

Bowerfield House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 19 and 22 October 2015. Our visit on the 19 October was unannounced. The service was previously inspected on 21 August 2013; we found that the service met the standards assessed.

This inspection was brought forward following concerns raised relating to staffing levels and the high number of safeguarding alerts raised with the local authority.

Bowerfield House is a purpose built care home owned and operated by Maria Milliband Group.

The home provides personal care and accommodation for up to 26 older people. It is a two storey building situated adjacent to a larger sister building on the same site.

All bedrooms have single occupancy and some have en-suite facilities. There is a passenger lift providing access to the first floor. There is an enclosed garden area to the rear of the building accessed via a conservatory area. Car parking is available within the grounds.

Summary of findings

When we visited the service there was no 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.

We identified four breaches of the health and Social Care Act 2008 (regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We found that there was a high turnover of staff and there were insufficient numbers of suitably qualified staff to meet the needs of the people who used the service. At busy times staff were unable to meet the demands of the people who used the service, resulting in people having to wait for assistance. There was a reliance on agency and bank workers, meaning services would be provided by staff who did not always know the people well. We saw that the staff who were permanently employed knew people's needs and provided care in a kind and respectful manner.

The responsibilities of housekeeping staff were not clear, and there were no defined roles with domestic staff expected to clean, work in the laundry and in the kitchen. This meant that staff would not be able to focus on a particular duty and would sometimes be called to assist in other areas leaving jobs incomplete.

There was no system in place to provide staff with supervision or appraisal so there was no way to monitor the performance of individual staff members or to allow them to meet formally with their supervisors to discuss any issues or concerns they might have.

Where risks to individuals were identified we saw that detailed risk assessments had been completed with clear plans in place to show how to minimise the risk and that these plans were reviewed on a monthly basis. Where safeguarding alerts had been reported to the local authority incidents were investigated appropriately and protective measures were put into place. However, we saw that recorded incidents were not always followed up as safeguarding alerts. We have made a recommendation about identifying and reporting incidents which may lead to harm.

There were no restrictions in place on people's movement within the home. People were involved in planning their care, and where they lacked capacity to consent to care and treatment the appropriate steps were taken to protect their rights.

People told us they liked the food and we saw meals were fresh and looked and smelled appetising. Their dietary needs were taken into account, and they were given choices of what to eat.

Procedures were in place to manage people's medicines safely.

Recruitment and selection procedures were in place to help ensure that the staff employed at the home were suitable to work with vulnerable adults.

The communal areas of the home were not always clean. Policies and procedures to minimise the risk of infection were followed but there had been no audit of infection control measures for ten months.

People told us they found that the permanent care staff knew them well and were kind and caring. One person told us, "I can't fault the carers who are there. They are brilliant". Care was taken to ensure that individual's privacy and dignity was respected and we observed staff treating people who use the service in a compassionate and kindly manner. Staff were familiar with their needs and wishes. People who used the service were offered meaningful choices about the details of how their service was delivered, and good relationships had developed between staff and the people who lived at Bowerfield House.

We saw that records were detailed and included appropriate information about individual needs. Care plans were instructive and written in a way which reflected the person's abilities and strengths but did not deflect from their needs.

There were systems in place to monitor the quality of the service provided, but these were not always followed regularly, and we saw that some checks, for example, an infection control audit, had not been completed since December 2014.

Summary of findings

Where the home received complaints, there was evidence of an acknowledgement, investigation and follow up report. Where these had been substantiated we saw that apologies were sent, and action was taken to prevent future occurrences.

There has been a succession of six mangers in the past seven years. This turnover of mangers did not lend to consistency and changes in leadership lead to upheaval. The staff we spoke to were positive about the interim manager in place whilst the provider recruited a permanent manager.

An activities co-ordinator was in post who on both days of our inspection had arranged for visiting performers to come in to Bowerfield House to provide entertainment for the people who lived there, but people told us that this was unusual and that there was rarely anything for people who used the service to do.

Summary of findings

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.

There were insufficient or untrained staff which meant that people's changing needs might not be fully met.

Kitchen and laundry areas were clean but communal areas were not always cleaned to a good standard. Some items of equipment such as hoists and wheelchairs were in poor condition.

Risk assessments were completed and actions formulated to minimise risk of harm.

There were effective systems in place for managing medicines and the control of infection.

Where safeguarding alerts had been reported incidents were investigated appropriately.

Is the service effective?

Requires improvement

The service was not always effective.

Care staff had not had supervision or appraisal so there were no quality systems in place for monitoring the performance of individual staff members.

People told us that they enjoyed the food on offer, and we observed that there was a regular supply of snacks and choice of hot and cold drinks throughout the day.

People were supported in a way they had agreed. Where they were unable to consent to care and treatment relatives were asked for their views prior to making any decisions about their care and treatment.

The manager and care staff were aware of the Mental Capacity Act 2005 and supported people's abilities to make choices and their human rights.

People were supported to see their General Practitioner (GP) and other health care professionals as required.

Is the service caring?

Good

The service was caring.

Care staff were kind and caring and knew people's needs. They provided care at a pace people could respond to.

People were supported to make choices and to be involved in decisions about their care.

Care staff were polite and respectful and showed warmth and friendship to people who used the service.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

Records and care plans seen were written in a way that reflected the person's abilities and strengths but did not deflect from their needs.

Staff were attentive to people's needs.

Where complaints were received about the service these were followed up and investigated.

Is the service well-led?

Requires improvement 

The service was not well led.

There has been a high turnover in staff and managers, and there was no registered manager in post. Frequent changes in management had led to poor oversight and leadership.

Quality audits were not always completed, and deadlines for completion of actions had been missed.

People told us that they had confidence in the interim manager.

Bowerfield 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.

Before our inspection we were told that there had been a high number of safeguarding concerns raised and that there had been a number of different managers employed at the home. For these reasons we brought our inspection forward. We reviewed the information we held about the service including notifications the provider had sent to us. We contacted the local authority safeguarding and commissioning teams. We also noted concerns relating to staffing levels raised directly to the CQC through our 'share your experience feedback.' This is a web based form which allows members of the public to inform us of any concerns or compliments they might have about a specific service.

As we had brought forward our inspection we had not requested the service to complete a provider information return (PIR); this is a document that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make

The inspection took place on 19 and 22 October 2015 and involved two adult social care inspectors. The first day was unannounced.

During the inspection we observed how staff interacted with people using the service and how care and support was being provided in communal areas. We spoke with three people who used the service and three visitors. We also spoke to the registered manager, and four people who worked in the home.

We looked at a range of records relating to how the service was managed; these included four people's care records, recruitment files and training records.

Requires improvement

Is the service safe?

Our findings

Prior to this inspection we received some information of concern relating to insufficient staffing levels and of young inexperienced staff being left to run the units. We were also informed that there had been a high number of safeguarding alerts raised with the local authority with 19 separate incidents raised between July and August 2015.

One visitor said to us "the staff are very good, but there aren't enough of them". Another said "the staff are fantastic, but they are pulled out". A person who used the service said "[The staff] are always too busy; they could do with at least another person".

The interim manager informed us that there had been a high turnover of staff in recent months and that the home was in the process of recruiting new staff. In the interim this meant that they relied on agency workers and bank staff; these are people who are not directly employed by the service but can be called upon to cover working shifts when the regular staff are unavailable. We were told that normally four care workers worked during the day and two at night. A nurse would be on duty at all times. We asked the manager to confirm the staffing levels for each shift, we were told that during each day there were four care workers and a nurse on duty and at night two care workers and a nurse.

When we looked at the staffing rotas for the three weeks prior to our visit we saw that this was not always the case. On some days there were only three care workers, and on the weekend prior to our inspection, only two care workers were on shift, one of whom was a bank worker, and the nurse on duty during the Saturday shift was also an agency worker.

The rotas reflected the need for 24 hour qualified nursing cover, but there was no consistency in who would be working from one day to the next. Additionally numerous changes had been made to the rota, reflecting late changes in planning. We saw an over reliance on agency and bank workers who would be unfamiliar with the layout of the home or the people who lived there. This meant that the staff would not always know the people who used the service and would be unfamiliar with their needs and routines.

We observed lunchtime on the upstairs unit on the first day of inspection. The staff had difficulty supporting all the people who needed assistance, as there were only two staff to support fifteen people. This meant people needed to wait for assistance and the mealtime was not a pleasant experience for people who used the service.

For long periods people in the main lounges were left unattended or supervised by the activities co-ordinator as staff on duty were assisting others with personal care needs.

When we spoke to the manager about how staffing levels were determined, she explained that there was no clear method for determining staffing levels and agreed that the level of staff required did not reflect the needs of the people who used the service. She advised that she was looking to review dependency levels and increase the ratio of staff to service users based on the needs of individuals rather than numbers.

There were other staff employed such as an activities co-ordinator, who had recently been appointed, and housekeeping staff. However, the responsibilities of housekeeping staff were not clear, and there were no defined roles with staff expected to work in the laundry and in the kitchen. This meant that staff would not be able to focus on a particular duty and would sometimes be called to assist in other areas leaving jobs incomplete. For example we spoke to one member of domestic staff who told us that there used to be one person working in the laundry with two cleaners, but staff have left and not been replaced. The expectation was that in addition to laundry and cleaning duties the domestic staff would also help in the kitchen with meals, and so she would have to leave jobs before she had a chance to complete them fully. The chef informed us that at weekends there was no kitchen assistant. As part of their duties night staff would assist with laundry, but we were informed that this did not always happen and consequently laundry was always behind.

When we spoke to the interim manager we were told that they had reviewed the domestic schedules, and looked at separating the housekeeping and laundry roles. They had discussed this with the relevant staff and were in the process of implementing a new system to ensure more efficient use of resources.

Requires improvement

Is the service safe?

This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Insufficient numbers of suitably qualified competent skilled and experienced persons to meet the requirements.

There were policies and procedures to minimise the risks of infection to people. There were hand washing facilities and suitable personal protective equipment, such as disposable gloves and aprons, around the home which we saw staff accessing and wearing.

During this inspection we undertook a tour of the home including some bedrooms, communal toilets and bathrooms and all the communal areas of the home. We were informed that the home had recently been redecorated. Communal bathrooms were decorated in pastel shades with pictures on the wall and ornaments on the window sill, which gave a homely feel to them.

Resident's bedrooms were generally clean and tidy but communal areas were not always cleaned to a good standard, increasing the risk of infection to people who used the service. We also noticed that mobility equipment was generally in poor condition, for instance we saw wheelchairs were poorly maintained, some were missing footplates. It is important peoples feet are supported when using a wheel chair.

The kitchen and laundry areas were clean, with procedures displayed on the walls, although there was a build-up of linen in the laundry room waiting to be washed.

We also noticed that the laundry area had been left unattended, which could cause a safety risk to people who are living with dementia as there were cleaning materials in this area which could be mistaken for drinks.

During our tour of the building we saw that the home followed the national colour coding scheme for cleaning materials to minimise risk of cross contamination. For example, mops and buckets were colour coded so different ones were used in the kitchen areas, bathrooms and laundry areas.

We saw that Fridge temperatures were monitored and recorded to ensure food was stored correctly, and that there was a temperature probe to ensure hot food was served at the right temperature.

When we looked in the communal bathrooms we saw that on the first floor one bathroom did not have any paper towels or hand wash. There was a pedal bin for disposal of waste, but this was not lined with a yellow sack to indicate hazardous waste. A lack of appropriate equipment to help maintain hygiene could place both people using the service and staff at risk of potential infection and cross contamination.

These identified issues were breaches of regulation 12(2)(b)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home had a safeguarding policy available, stating that "the company is committed to the highest standards of openness, probity and accountability."

We asked two members of staff about their understanding of safeguarding procedures and they informed us that they had received training, and they demonstrated an awareness of what might constitute a safeguarding alert. They were also able to explain the procedures they would follow when they suspected abuse was occurring.

When we reviewed safeguarding records we saw that where safeguarding alerts had been reported, incidents were investigated appropriately. In three incidents we reviewed the protective measures put in place and actions taken were proportionate and disciplinary action and outcomes were reported to the appropriate authorities.

However, when we looked at individual case files we found one allegation made by a person who used the service relating to physical abuse by another. We noted that this incident had not been recorded in the accident file and there was no evidence of a follow up investigation. When we spoke to the interim manager about this she agreed to look into the incident and to follow up any required actions.

We looked at the accident file and noted that there were 36 recorded accidents or incidents in one recent calendar month. When we looked at these incidents we saw some inconsistencies in response, for example, one person had a series of falls and the records showed that appropriate action was taken to investigate the cause of these falls and to put measures in place to mitigate the risk, for example, by using sensors and crash mats. However, on other occasions there was no record made of any action taken following the incident; one person had two unwitnessed falls fairly closely together but there was no evidence of any follow up for either incident.

Requires improvement

Is the service safe?

We recommend that the home reviews the pathway for identifying, reporting and following up incidents which may constitute abuse to ensure that people are properly safeguarded from the risk of abuse and to avoid any potential serious incidents being overlooked.

There were clear recruitment procedures in place to help ensure that new staff were of good character to provide care to vulnerable adults. The procedures were in line with regulations. Application forms included previous work history and we saw that satisfactory references were sought prior to new staff starting work at the home, and identity checks made. Further checks through the Disclosure and Barring Service (DBS) ensured that there were no criminal convictions. The DBS is a service that identifies people who may be barred from working with children and vulnerable adults and informs the service provider of any criminal convictions recorded against the applicant. These checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people.

When we walked around the building we saw it was secure and that entry to the home was managed, to ensure the safety of people using the service. There was a secure and well maintained garden area which people could walk or sit in safely and enjoy fresh air. Bedrooms were numbered, and had names and pictures on the doors. This ensures that when entering, staff or visitors who might be unfamiliar with the person, would recognise that they were seeing the correct person and reducing the risk of mistakes.

The home had a call bell system in place so people could summon help when needed and we saw records that the bells were tested on a regular basis to ensure they were in good working order.

We saw evidence that equipment such as the lift, fire safety equipment and alarms, bed rails and mattresses were serviced on a regular basis which helped reduce unnecessary risk to people. We noted that the latest service of the lifting hoist used on the upstairs floor had led to this being taken out of service. This meant that people who needed to be hoisted were reliant on staff bringing the hoist from downstairs to help lift them reliant on being hoisted until a new hoist could be provided.

An 'emergency kit' was kept by the main entrance including flashlight and first aid kit, and a copy of the individual emergency evacuation plan for each person. This details any special needs the person might have and assists the emergency services to identify how best to help them out of the premises in the case of an emergency

Where risk was identified there was evidence that risk assessments were carried out, action put in place to minimise the risk, and reviewed on a monthly basis. Where changes were noted this led to a change in the care plan, which was detailed and instructive, for example we saw one care plan which stated that staff must talk to the person whilst providing support and advise what they are doing step by step to relieve their anxiety.

We looked at four case records, which showed that detailed risk assessments had been completed, for risks such as falls, moving and handling, pressure relief and nutrition, with clear plans in place to show how to minimise the risk. These were reviewed on a monthly basis. We observed staff supporting people in a way that kept them safe, for example, we observed a care worker safely supporting a person to get out of their chair and offering an arm to help them to mobilise safely.

People who use the service told us that the care staff were attentive to their health and social care needs, and that they received their medication as prescribed.

Medication was stored in locked medication trolleys in a locked treatment room when not in use to ensure only authorised people could access them. The nurse on duty would hold the keys to the treatment room, and we observed the night nurse handing over keys to the nurse coming on duty when shifts changed. Room and fridge temperatures were checked to ensure that medicines were stored at the right temperature, and a daily record was kept up to date. Controlled drugs were stored in a separate locked cupboard.

The home operated a Monitored Dosage System (MDS). This is a system where the dispensing pharmacist places medicines into a cassette containing separate compartments according to the time of day the medication is prescribed. Some medication was not included in this system and was dispensed in separate bottles or boxes.

We carried out a check of stock and found it corresponded with the balances recorded on individual medicine record sheets.

Requires improvement

Is the service safe?

There was also a signed log of all returned unused medicines to the pharmacy. However, we saw a jar of topical cream (E45) which was out of date. When we pointed this out to the nurse she agreed to remove it from stock.

We observed one medication round during our inspection. This was carried out by the nurse on duty. They checked the dosage and that they were for the right person before placing the tablets into a small pot. Each person was given their medicines individually ensuring that the right person was given the correct medication. They approached the person, addressed them by name and explained what they were doing. They then checked the person had a drink to help them take the medicines. Once taken, this was recorded on the medication administration record (MAR) sheet. MAR sheets included a photograph of the individual, and the records we checked were accurate, up to date and matched the medicines in stock. There were no gaps in signatures.

Administration of creams and ointments were recorded on separate sheets known as Topical Medicine Administration Records (TMAR) which were kept in a separate file which included guidelines for staff to apply creams appropriately.

Requires improvement

Is the service effective?

Our findings

The people we spoke with believed that the carers were competent and knowledgeable. One person who used the service told us, "Once they are settled, the staff get to know us and what we need. They are really good at what they do". A relative who was visiting told us the staff were "really good with [my relative]. They know what to do and they really understand him".

We were shown a copy of the training matrix which indicates what training staff had received. This showed that there was opportunity for regular e-learning in a variety of subjects including safeguarding adults, dementia awareness, infection control, manual handling, mental capacity, food safety, fire awareness, health and safety procedures, and first aid. Over 80% of permanent staff had completed this training, although bank and agency staff did not. Given the reliance on agency staff we were concerned that service delivery was supplied by staff who did not have access to the training opportunities given to permanent staff.

When we spoke with members of staff they told us that when they started at Bowerfield House they had an induction to their role where they received on the job training, and shadowed more experienced workers. The care staff were able to demonstrate what they had learned and how they had put their learning into practice. We saw one care worker, for example, using disposable gloves and aprons to assist a person with their personal care and disposing of waste appropriately and when we spoke with this person afterwards they were able to give a good account of why they followed these procedures. However, they expressed a wish for more training, for example in dementia care as they believed that they lacked confidence to fully support people living with dementia

Staff were also supported to undertake professional training in line with Skills for Care qualifications, and the staff we spoke to had NVQ qualifications in Care. When required the manager informed us that they will provide specialist training, for example, for catheter care.

When we looked at the master supervision file we saw that this was not up to date and the majority of staff had not had a formal supervision within the past calendar year. Whilst we accepted that the service has had a number of changes in management, the service provider should have ensured that staff were receiving supervision in line with organisational policy. This meant that there were no quality systems in place for monitoring the performance of individual staff members or for allowing collective understanding of issues or concerns

The interim manager informed us that they had begun to address this issue and were arranging to meet all workers individually to give them the opportunity to discuss care practice and areas for development.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staff must receive support, training, supervision and appraisal in order to perform their duties

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA. The interim manager was able to demonstrate a good understanding of the legislation to help ensure that people's rights were protected, including pathways to reach best interest decisions. She was able to give us an example of where they had considered the rights of the individual and balanced this alongside duty of care and maintaining the person's independence. Where it was appropriate authorisations for DoLS had been requested and people were assessed by appropriate health and social care staff. Training records showed that 95% of the permanent staff team had undertaken the Understanding the Mental Capacity Act [MCA] and DoLS training. At the time of our visit there had been 18 DoLS applications made of which 5 had been authorised and 13 were awaiting a full

assessment. A matrix was kept detailing dates of application and authorisation, and where appropriate the date of expiry to alert the manager to the possible need to seek an extension.

People told us that staff supported them in the way they had agreed and that they asked for the person's consent before carrying out care and support tasks. We observed this in practice, for instance, when giving out medicines we saw that as the nurse approached one person he was still finishing his meal, so agreed to come back at his request. After five minutes or so they returned, checked the person was ready and then gave them their tablets. Relatives of people using the services told us that they were consulted with regard to any changes in care plans and we saw evidence in case files that communication with relatives was recorded. We also saw that when people did not have capacity relatives were asked for their views prior to making any decisions about their care and treatment.

The care files we looked at showed that attention was given to people's nutritional needs and skin integrity. We saw that Malnutrition Universal Screening Tool (MUST) charts were used to accurately monitor and chart any changes. MUST is a screening tool which helps identify adults who are at risk of malnutrition or obesity.

People were weighed on a monthly basis to ensure that they were maintaining weight. We noted that where there were concerns about a person's weight they had been referred to the dietician for further advice and support and their weight was then monitored on a weekly basis.

We saw that people enjoyed their food which looked and smelled appetising. We observed one person at breakfast was asked what they would like. The person asked for scrambled egg on toast, which was freshly made and served promptly. When we asked this person about the food they told us that "they feed us well. I have nothing to complain about".

We saw that mealtimes were not well organised. Where people had chosen to get up late they had a late breakfast, and some people were still eating their breakfast at 11 o'clock with their main meal at 1.00 p.m., which meant that meals overlapped. We saw that staff would 'keep back' anyone's main meal until later if they had had a late breakfast, and they would try to remain flexible about the times people would eat.

Meals were served at tables in separate area adjacent to the main lounges on each floor. On the downstairs floor meals were unhurried and relaxed, but upstairs the staff were pressed to meet individual's needs for support with eating, and there was insufficient room to seat everyone.

There were no menus displayed on the menu board; we were informed by the interim manager that these had been taken down during the redecoration, and had not yet been put back up. When people were offered a choice for lunch we saw that care staff offered choice in a meaningful way and used pictures as necessary to assist with choice.

We saw people who needed help with eating were supported, and safety measures were put in place to protect people, such as clothes protectors, and equipment to help maintain independence, such as plate guards and adapted cutlery.

All food was cooked on the premises, and people were offered a choice of main meals on the day it was to be cooked. There was a four week rotating menu which showed a good variety, and the chef tried to encourage healthy eating. A main meal was served at lunchtime, and tea would generally be soup and sandwiches or pizza. Kitchen staff would also leave out sufficient food for suppers, and showed a good understanding of the likes and dislikes of the people who used the service. Notes on specific diets were kept in the kitchen, such as soft pureed or diabetic diets; allergies and personal preferences. The chef was also aware of specific needs for build-up drinks and fortified diets and how to ensure individuals received appropriate nourishment. Drinks and snacks were offered throughout the day and residents had facilities to help themselves to juice and biscuits.

People told us, and we saw documentation in care files to confirm that people were supported to see other health professionals when required. The name and address of the General; practitioner (GP) was recorded in case files and we saw evidence in the files of regular GP visits as well as referrals to health professionals such as Speech and Language Therapists. A chiropodist visited regularly and there were notes in case files we looked at to show recent visits by an optician. Where people were admitted to or from hospital there was evidence of good communication between Bowerfield House, the hospital and relatives; we saw for instance the notes of one Discharge Planning meeting which was attended by the manager of the home to liaise with medical staff to ensure good communication.

Requires improvement

Is the service effective?

The communal areas were free of clutter and obstacles and allowed for some social interaction. However, there was very little space particularly in the upstairs unit to allow for entertaining visitors or for larger gatherings. Both lounges and the corridors had recently been redecorated which gave a bright and fresh feel to the home. There was a safe garden accessible through a conservatory, well maintained by a regular gardener. Communal areas and bedrooms were personalised according to individual's tastes, were bright and clean and well maintained.

Good

Is the service caring?

Our findings

People told us they found that care staff knew them well and were kind and caring. One person told us, "I can fault the carers who are there. They are brilliant". Another said "They are so caring. I feel they are really unappreciated for the work they do".

When we arrived at the care home at 8.00 a.m. most people were still in their rooms and the night staff were starting to support those people who wanted to, to get up. One person had just got up and was wearing pyjamas and a dressing gown. There were no set rising times, and people were being assisted to get up in their own time. We observed breakfast taken to some people in their rooms.

We saw that people were addressed by their preferred names and spoken to in a friendly manner making eye contact and touch where appropriate. Interactions between care staff and people who used the service were respectful and caring. For example during the day we saw one person greeted by name by a care worker who then offered support. The person explained he needed the toilet, so the care worker offered to escort him but asked to sit down whilst they "just popped some gloves on".

Throughout our visit we observed positive and meaningful interactions between staff and people who used the service. Care staff were polite and respectful, for example, they would knock on doors before entering and close doors when attending to personal care needs.

The care workers we spoke to showed a good knowledge of the people who used the service, their lives likes and past histories. One care worker told us for example, how they responded to one person who used the service who was: "Not a morning person. I take my time helping to get them up, and give them time to come round. Later in the day they are more chatty but need their own time and space". Another told us that they will often share jokes with the people who live there and their relatives. This person spoke of the importance of understanding facial expressions and hand movements, especially with people living with dementia, and of sharing knowledge with other care staff.

People were supported to maintain relationships with family and friends. Feedback from visitors was positive about the care provided, and the relatives we spoke with had no issues about the quality of care. There were no restrictions on visiting and those visitors we spoke with told us that they were always welcomed and supported when they visit. They informed us, and we saw that staff knew them and greeted them by name. A relative told us that the staff were always available, friendly and knowledgeable.

All the people in the home were clean and well presented. Care was taken to support people with personal needs. People told us that the staff take time to ensure they are well groomed and that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported. One staff member told us, "We can have a laugh with the people here, but they've all got their own ways." We saw staff interacting well with people who used the service, for example we overheard friendly conversations between staff and people about their plans and other arrangements.

The home had an equality and diversity policy, and the staff we spoke with had a good understanding of what this meant and gave examples of how they would respect people's individual beliefs, culture and background.

At the time of our visit nobody was on end of life care. However, there was evidence in the care files we looked at that personal wishes had been considered, and individual plans made for this aspect of care, including DNAR records. A DNAR (do not attempt resuscitation) form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR).We asked staff how they would support a person who was nearing the end of their life and they were able to explain how they would consider their needs, but acknowledged that they would like further training in this aspect of care. Further training in this area will support staff to delivery high quality end of life care in a compassionate and understanding manner.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs and provided them with support when they required it. One visitor to the service said to us "The staff are busy, but they are always attentive, and won't leave anyone on their own."

There was a calm and unhurried atmosphere for much of the day and we saw that in general people were not left unattended. However on one occasion we noticed a person who used the service enter the eating area downstairs looking for a cup of tea. She was unable to find anyone to help her, but she chose to help herself to a glass of juice instead.

For each new person being admitted into Bowerfield House a generic pre-admission assessment was completed to begin to build a picture of the individual. This included physical and mental health, skills and abilities and activities of daily living. We saw in care records we examined that these plans included assessments from other health and social care professionals. On admission staff would get to know the individual and a full care plan would be drawn up

We looked at care files for four people who used the service. These were detailed and included a generic assessment along with details about past history and service user details prominent to allow new or agency staff to read a summary of the person's needs. Records and care plans seen were written in a way which reflected the person's abilities and strengths but did not deflect from their needs.

Throughout the files there was evidence of involvement and communication with the individual and their relatives and their wishes were recorded. We saw evidence in a care file that the person had agreed to, and signed their care plan. We saw that staff showed a good understanding of people, their likes and dislikes and interests. We saw one carer talking to a person about touring in this country, asking for advice on good places to visit.

On both days of our visit the activities co-ordinator had arranged for visiting performers to come in to Bowerfield House to provide entertainment for the people who lived there. On the first day of our visit, a singer performed and interacted with the people who used the service, encouraging them to join in with choruses, and getting some up to dance. This was very well received by the people who used the service.

However, the feedback we received from visitors was that this was unusual, and we were told that there is rarely anything for people to do. On visitor commented "Like busses, nothing for ages then two come along at once!" The interim manager recognised that there were issues around activities and informed us that the last activity co-ordinator had left. A replacement had recently been appointed. Much of the focus was on working with individuals but the organiser had planned further events and entertainment for the coming months. This will help to stimulate and promote the well-being of people who use the service.

There was a minibus, which was shared with the adjacent sister home and people told us that they would occasionally be taken out on a ride, although one person felt that this did not happen as often as they would like. We observed people in the lounges and saw good interaction between people who used the service and the staff. People were happy to converse with each other.

We looked at the complaints procedure and reviewed the complaints file. We saw that where complaints are made there was evidence of an acknowledgement, investigation and follow up report. Where complaints had been substantiated we saw that apologies were sent, and action was taken to prevent future occurrences.

Requires improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service is registered with the Care Quality Commission. 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. When we visited, however, there had been no registered manager in place since November 2014, but an interim manager had been appointed by the service provider, and had been working at the home for less than three weeks.

We asked some staff about their experience of working at Bowerfield House. One person told us that "when the staffing is right it's been brilliant, but when it's not, it's dispiriting." This person believed that this had accounted for the high number of people leaving and told us that there was no discussion on the impact of a new member of staff or how this affected people who used the service. Another told us that teamwork and consistency are essential, but some people work better with some staff. This person felt that some communal tasks were not always done as no single person had responsibility to complete the task, so it was important to recognise a team approach.

We spoke with the interim manager about the culture and management of the home. She recognised that the frequent changes in management had led to poor oversight and leadership but was very positive about the future of Bowerfield House. She recognised her responsibility to drive improvements forward but did not see her role as a long term position. The Interim Manager was supported by the provider to introduce changes, particularly with regard to staff roles and care staff numbers. This would include regular staff supervision and appraisal sessions to monitor staff competencies, actively recruiting staff to make sure people's needs could be fully met and addressing the issues around hygiene and cleanliness in the home.

She had also begun to make attempts to promote a culture which valued the views of people who used the service, and seek the views of people who lived in the home and their relatives. We saw that a relatives meeting had been organised for the week following our visit. The last relatives meeting had been held in April 2015, issues raised at this meeting had not been actioned.

When we spoke with the provider we were informed that plans to recruit a new manager were underway. We were told that there had been six managers in the past seven years, and that the current interim manager was the third person this year to manage Bowerfield House. This had led to inconsistencies in management style a lack of clear direction and leadership; one member of staff told us "we need a settled manager", but another informed us that they were used to the management changes: "changes in management don't make a difference; I do what I have to do".

Staff were positive about the interim manager, believing she was approachable. They echoed a view that she was "firm but fair". One person said "she is showing some ownership of the home. We have a strong manager who is directive and seems to be getting things done". However, relatives of people who used the service had mixed views; one told us that "she seems to be making a difference" whilst another said "the only time they have spoken to us was when [my relative] was admitted". When we spoke with people who were living at the home they were complimentary about the way the home was being run.

The care staff we spoke to said that they would be confident that if they had a problem or concern they could speak to the interim manager and that she would listen and take action, and recognised their responsibility to share any concerns about the care provided to people who used the service.

Although the interim manager had only been at the home for a short while she had begun to implement changes. She had reviewed the staffing rota based on dependency of the people who lived at Bowerfield House rather than numbers, and recognised the need to increase staffing, and was in the process of recruiting extra staff to cover key hours such as mornings and mealtimes. She had looked at the domestic tasks, revising roles and responsibilities to provide a more efficient and effective service, for example by changing the working hours to times more convenient for the people who lived in the home, and reviewing roles to provide greater accountability.

Requires improvement

Is the service well-led?

The provider had systems in place for daily exchanges of information about people's care and support needs between staff. We witnessed a handover between the night staff and the day staff, which included hand written notes. Information about any issues of concern were raised, but this briefing did not cover any plans or priorities for the day. Moreover, these handover meetings were the only opportunity for staff to meet together formally; we looked at a file that contained notes from general staff meetings, but there had only been two meetings; one in September 2014 and the last in January 2015 prior to the new interim manager taking up her post. The latter was held for the last manager to introduce herself and outline her proposals for the home, including reintroducing supervision, but there was no evidence to show that these plans had been followed through. There had also been a 'nurse's forum' but this was poorly attended. This meant that there was little opportunity for staff to formally meet and discuss ideas, issues raised and or discussion about individuals or care issues.

We saw that there were corporate policies and procedures in place to support the daily running of the home. Staff had access to these procedures and were clear about their duties when they were involved with aspects of people's healthcare and wellbeing. Current and up to date policies and procedures are critical to ensuring compliance with relevant legislation and regulatory requirements at the home ensuring people who use the service receive appropriate and safe care.

We saw that the manager had begun a process of auditing individual case files. We looked at one case audit and cross checked this with the case file. We saw that where gaps had been identified these had been addressed following the audit.

There were some systems to regularly audit the quality of the environment and equipment used in the home such as health and safety, presentation, infection control and medication. Where issues were identified we saw evidence that action had been taken to resolve the concerns. However, we noted that some of these checks had not been completed for several months, for example the infection control audit had not been completed since December 2014. The most recent medication audit did not pick up on the storage of out of date creams, which if applied could be ineffective. Whilst maintenance checks were regularly carried out the condition of some items of equipment was poor, this had not been noticed through audits, for example, wheelchairs missing footplates but no action had been taken to address the shortfalls identified.

The provider had produced an on-going action plan, which identified a number of issues to be addressed within the home. It is not clear when this action plan was implemented, and whilst there was evidence that the plan is regularly monitored, actions needed had not been completed, with deadlines for completion of actions passed, rescheduled and missed again.

This meant that the provider did not operate systems to effectively monitor and manage the governance of the service to ensure the quality and safety of service provided.

This was a breach of Regulation 17(1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance. Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not do all that is reasonably practicable to mitigate risks to the safety of people who used the service, ensure that equipment was safe and used in a safe way or control the risk of infection Regulation 12(2)(b)(e)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not operated effectively to assess, monitor and improve the quality and safety of the services or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk Regulation 17(1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of competent, skilled and experienced persons employed. Persons employed by the service did not receive appropriate supervision and training to carry out their duties Regulation 18(1) (2)(a)