Ideal Carehomes (Number One) Limited

Bowbridge Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 17 and 19 April 2018. The inspection was unannounced. Bowbridge Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bowbridge Court accommodates up to 54 people in one purpose built building, which is split across three floors. On the day of our inspection 41 people were living at the home.

Bowbridge Court was rated as inadequate at our last two inspections which were in April and December 2017. During this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staffing, consent and governance. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

During this inspection we found people were not always protected from risks associated with their care and support. Risks were not always identified, assessed or managed and this placed people at risk of harm. There were not always enough staff to ensure people's safety and meet their needs. Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them.

People told us they felt safe and improvements had been made to protect people from abuse and improper treatment. Medicines were stored and managed safely and this meant people received their medicines as required. The home was clean and hygienic and effective infection control procedures were in place.

People's rights under the Mental Capacity Act (2005) were not respected. People were subject to restrictions upon their freedom but their capacity to consent had not been assessed.

People could not be assured they would receive effective support in relation to their health. Health professionals were not always contacted quickly when people required specialist support and the advice of health professionals was not always followed. People had enough to eat and drink. However, improvements were required to ensure people's needs and preferences were met.

The physical environment had been adapted to meet people's needs and people had been involved in the decoration of the home. Improvements were planned to ensure the design and decoration of the home met the needs of people living with dementia. People were supported by staff who had training and supervision.

Staff were kind and caring in their approach and treated people with dignity and respect. People were involved in and consulted on day to day decisions about their care and support. There were links with local advocacy services to enable people to express their views if needed. People told us most staff understood what was important to them. This was not always reflected in care plans, but work was underway to make improvements. People's right to privacy was respected and they were encouraged to maintain their independence.

Care plans did not always reflect people's needs and preferences, improvements were underway to address this. People were given opportunities to get involved in meaningful activity and further improvements were planned to ensure people's individual interests were taken into account. People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Improvements to management and governance systems were underway but further work was required to ensure this was effective and sustainable. Systems to monitor and improve the quality and safety of the service did not consistently ensure risks were identified and addressed in a timely manner. People and staff were involved in giving their views on how the service was run. The management team were passionate about making improvements and had a positive impact on the quality of the service. They were open to feedback and took swift action to respond areas of concern raised during our inspection.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected from risks associated their care and support.

There were not always enough staff to ensure people were provided with safe support that met their needs. Safe recruitment practices were not followed.

Improvements had been made to protect people from abuse and improper treatment.

People received their medicines as required. The home was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights under the Mental Capacity Act (2005) were not respected.

People could not be assured they would receive effective support in relation to their health.

People had enough to eat and drink, further improvements were required to ensure people's needs and preferences were met.

People were supported by staff who had training and supervision.

The physical environment had been adapted to meet people's needs, improvements were planned to ensure the design and decoration of the home met the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People felt involved in day to day decisions about their care.

People told us most staff understood what was important to them. Improvements were underway to ensure this was reflected in care plans.

People were encouraged to maintain their independence.

People were treated with dignity and their right to privacy was respected.

Is the service responsive?

Good

The service was responsive.

Care plans did not always reflect the support people required, however improvements were underway to address this.

People were given opportunities to get involved in meaningful social activity.

Complaints were addressed in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements to management and governance systems were underway but further work was required to ensure the effectiveness and sustainability of the processes.

Systems to ensure the quality and safety did not ensure that risks associated with people's care and support were responded to in a timely manner.

People and staff were involved in giving their views on how the service was run.

The management team were passionate about making improvements to the service and had had a positive impact on the quality of the service. Action was taken to address areas of concern raised during this inspection.

Bowbridge Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We inspected the service on 17 and 19 April 2018. The inspection was unannounced. The inspection team consisted of two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit we spoke with 11 people who lived at the home and the relatives of six people. We also spoke with four members of care staff, a member of the catering team, a member of the domestic team, the maintenance person, the deputy manager, the care manager, the registered manager and the nominated individual. The nominated individual is a person who is nominated by the provider to represent the organisation.

To help us assess how people's care needs were being met we reviewed all or part of 10 people's care records and other information, for example their risk assessments. We also looked at the medicines records of seven people, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also 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 did not request a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what they do well and improvements they plan to make. However, on the day of inspection we gave the provider the opportunity to share this information.

Requires Improvement

Is the service safe?

Our findings

At our past three inspections in August 2016, April 2017 and December 2017 we found concerns with how risks associated with people's care and support were managed. This resulted in an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, some risks associated with people's care and support were still not safely managed.

Risks associated with people's care and support were not always identified, assessed or managed. For example, one person had recently suffered a seizure resulting in a hospital admission. Despite this, there was no care plan or risk assessment in place in relation to this and there were no measures to reduce the risks to the person. A member of staff told us they had been advised by health professionals this may be linked to the person having infections. The person had an infection at the time of our inspection but the risks and potential impact of this had not been considered. This placed the person at risk of harm.

We were not assured that action had been taken to protect people from the risk of falls. Care plans and risk assessments had not always been reviewed in response to serious incident. One person had recently sustained a serious injury as a result of a fall. However, their risk assessment and care plan had not been reviewed or updated in response to this and consequently we were not assured all reasonable steps had been taken to reduce the risk of the person sustaining further injuries from falls.

Furthermore, records did not demonstrate people received care that met their needs. For example, records showed some people were only assisted to go to the toilet twice in a 24 hour period. Where people were at risk of poor fluid intake fluid records did not evidence they were offered sufficient amounts of fluids. This meant we were not assured people received the required support. We discussed this with the nominated individual and registered manager who believed this was recording issue rather than an issue with staff practice. They advised us they would address this with the staff team.

There was a risk people may not be provided with safe support in relation to their behaviour. For example, records showed one person often became anxious and distressed when being assisted with personal care. However, their care plan for personal care did not have any reference to their resistance to personal care and consequently did not provide staff with guidance for staff about how best to support them. This placed people at risk of inconsistent and potentially unsafe support. In addition, there was no system in place to learn from people's behaviours to develop and improve the support they received. Charts used to record people's behaviours were not used to learn about triggers to behaviours and how best to support them. Records showed one person frequently called out for support, behaviour charts had not been analysed and consequently there was limited guidance in their support plan to inform staff support. Records showed and our observations confirmed that staff responded to this in a dismissive manner, often telling the person to stop shouting or use their call bell. We observed the person shouting in a communal area, a member of staff intervened saying, "Stop shouting, everyone is looking at you." This was not a supportive or constructive way of dealing with the behaviour.

Although we found some improvements had been made to record and learn from adverse incidents, further

improvements were required. Incidents, such as altercations between people living at the home, were not always reported to the management team which meant investigations had not been undertaken. In addition to this, investigations of incidents were not always undertaken in a timely manner.

The above information was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to meet people's needs and ensure their safety. Feedback from people and their families was mixed. While some people told us there were enough staff, others commented there were insufficient numbers of staff. One person told us, "There is not enough staff, no way. I can wait a long time (for help) sometimes." A relative told us, "There aren't enough staff but the turnover (of staff) isn't too bad." Feedback from staff was also varied but most staff told us that there had been recent improvements in staffing levels. One member of staff commented, "There are enough staff now, not like in the past." We reviewed staffing rotas and found there were not always enough staff deployed to meet people's needs and ensure their safety. The registered manager told us six staff were required at night to ensure people's safety. However, recent records showed occasions where only three or four staff were deployed on night shifts. In addition, during our inspection we observed occasions where there were not effectively deployed to ensure people's safety. For example, we saw one person, who required support to stand, attempting to stand up from a sofa. There weren't any staff available to assist. This placed the person at risk of falls.

The above information was an ongoing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them. Pre-employment checks designed to help providers ensure staff were suitable to work at the service were not always completed. All of the recruitment files we looked at had shortfalls in safe practice. For example, applications forms for two staff had not been fully completed and were missing information about the staff member's employment history or their reason for leaving previous posts. Another two staff files were missing references from previous employers. This meant that the provider did not have all the relevant information to make a decision about the suitability of the staff members to work at the service. The registered manager assured us they would take action to address this and we observed this in action on the second day of our inspection, they had found DBS checks and were in the process of sourcing references.

At our April and December 2017 inspections we found action had not been taken to safeguard people from harm. This was a breach of the legal regulations. During this inspection we found that improvements had been made and there was no longer a breach of the legal regulations. Since our last inspection the provider had implemented new systems and provided staff with additional training and guidance to increase staff skill and decrease the risk of incidents not being reported and addressed. People told us they felt safe. One person said, "I'm alright. Yes I like it here, of course I do. We are all friends. I'm not frightened." Another person commented, "I am safe." Processes were in place to minimise the risk of people experiencing avoidable harm or abuse. Staff and managers were clear about their responsibilities to protect people from the potential risk of abuse; they had a good knowledge of safeguarding processes and felt confident any issues they reported would be acted on appropriately. The registered manager had taken action to protect people from abuse by conducting investigations relating to concerns raised and making appropriate referrals to the local authority safeguarding adults team.

At our April and December 2017 inspections we found the home and equipment were not clean and hygienic

in all areas. This was a breach of the legal regulations. At this inspection we found the required improvements had been made and there was no longer a breach of the legal regulations. The provider had recently recruited a member of staff to improve standards of cleanliness within the home and this had a positive impact. The home was clean and hygienic and effective infection control and prevention measures were in place. During our inspection we observed bedrooms, communal areas and equipment were cleaned to a sufficient standard. Staff were trained in the prevention and control of infection and had access to personal protective equipment, such as gloves and aprons, to ensure good infection control practices. Regular audits of the environment were completed to identify issues and ensure good practice.

At our December 2017 inspection we found medicines were not managed safely. At this inspection we found improvements had been made in this area. Since our last inspection the provider had employed a consultant to help them improve their medicines management systems. They had also provided staff with additional guidance and implemented new audits and checks. As a consequence of these improvements we found that people received their medicines as required. People told us they got their medicines when they needed them. Medicines systems were organised and records were completed accurately to demonstrate that people had been given their medicines.

People were protected from risks associated with the environment. There were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal evacuation plans detailing how each person would need to be supported in the event of an emergency and the majority of staff had been trained in health and safety.

Requires Improvement

Is the service effective?

Our findings

People could not be assured that they would receive effective support in relation to their health. For example, one person had been identified as being at risk of a health condition which required regular monitoring and intervention to prevent it worsening. Although monitoring took place this information was not used to inform administration of medicines to prevent the condition from worsening. This meant there was a risk changes in the person's health may not be identified and addressed.

Timely action was not always taken to enable people to access support from external health professionals. During our inspection we observed one person had an infected wound. Staff had not taken action to seek medical advice about this until we raised it with them. This posed a risk of the person's health deteriorating. In additional to this saw records of two recent complaints which raised concerns that people had not been assisted to access health care professionals when their health had deteriorated.

Guidance from health professionals was not always incorporated into care plans. For example one person had recently collapsed. Advice given by the hospital was to monitor the person closely after meals to reduce the risk of further collapse and subsequent injury. However this advice had not been incorporated in to their care plan and we observed staff did not follow this guidance during inspection. This placed the person at risk of harm.

This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (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.

At our April and December 2017 inspections we found that people's rights under the Mental Capacity Act (2005) (MCA) were not respected. This was a breach of legal regulation. At this inspection we found that although some improvements had been made further improvements were required to ensure people's rights were fully respected.

Mental capacity assessments and best interest decisions were not always in place as required. This meant we could not be assured support was provided in people's best interests. For example, people's capacity to consent to restrictions upon their freedom, such as movement sensors, was not always assessed when their capacity was in doubt. Capacity assessments were also not in place for people who could not consent to decisions made on their behalf to refuse certain types of medical intervention. Where mental capacity assessments were in place some were not sufficiently detailed. For example, one person had been assessed as lacking capacity to consent to decisions about their personal care and records showed they often became upset and agitated when being supported in this area. The associated best interests decision and

care plan stated staff should undertake personal care tasks in the persons 'best interests'. However, there was no further information about what assisting in the person's 'best interests' meant or details of how to assist if the person became upset and resisted care. Consequently records showed staff continued to assist the person with personal care even when they were highly distressed. Thus we could not be assured that decisions made in people's interests were the least restrictive option and posed a risk that their rights under the MCA may not be protected.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Although applications for DoLS had been made as required, when people had DoLS in place, conditions imposed to ensure their rights were protected were not always met. For example a DoLS had recently been granted for one person. The condition stated that the person should be provided with regular opportunities to go out in the local community. We spoke with the care manager about this who said it this was not happening as the activities coordinator had only just started in post, they said the person went out in the garden but not in the community. Another DoLS specified that mental capacity assessments must be completed for the person; we viewed their care plan and found that capacity assessments had not been completed as directed. This did not respect people's rights and did not ensure that people were supported in the least restrictive way possible and meant they were not meeting their legal duties under the Act.

The above information was an ongoing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our April and December 2017 inspections we found staff did not always receive adequate training or supervision. This was a breach of the legal regulations. During this inspection we found the required improvements had been made and the service was compliant with the legal regulations.

People were supported by staff who had the skills and knowledge to provide good quality care and support. This was supported by feedback from people living at the home and their relatives. One person said, "The staff are well trained." Records showed staff had received the relevant training to equip them with the knowledge and skills they needed, such as dementia awareness, first aid and end of life care. Staff were positive about improvements in training. One member of staff told us, "We get the training we need now, we didn't always. Every time we get a new piece of moving and handling equipment we get more training." Since our last inspection the majority of staff had received enhanced training in supporting people whose behaviours could pose a risk to others. The management team had also attended advanced safeguarding and mental capacity training to ensure they had sufficient knowledge in these areas.

New staff were provided with an induction period when starting work at Bowbridge Court. Induction took place over a 12 week period and included the training staff required to provide safe and effective support. The induction covered the main components of the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe and compassionate care and support. Improvements had also been made to ensure staff were provided with supervision and support. Staff told us they felt supported and records showed they had regular supervisions to discuss any concerns and identify any training and development needs. Supervision had also been used to address specific areas for improvement; for instance, they had focused on safeguarding to try to improve staff knowledge and awareness and we saw this had a positive impact.

People told us that, overall, they enjoyed the food and said they had enough to eat. People were offered a choice of meals and if people did not want what was on offer alternatives were made available. People's dining experience differed across the different floors, some meal times were sociable friendly occasions, whereas others were quiet and lacked interaction. Staff ate with people living at the home to create a homely atmosphere. However, we observed one occasion where staff ate their own meal before offering support to a person who had not eaten any of their meal. Some people were provided with adapted cutlery and crockery to enable their independence, but this was not consistent. For example, a relative told us it had been identified that their relation would benefit from an adapted plate, but told us this was not always made available for them. Staff did not consistently demonstrate knowledge of people's individual needs and preferences. Some people had expressed a preference to be served smaller portions, this guidance was not always followed and we saw everyone on one floor was served the same portion sizes. This failure to serve people appropriate portion sizes posed a risk that people may be discouraged to eat .

When people required specialist diets these were provided and the catering staff had clear information about people's dietary needs. People were offered drinks and snacks throughout the day. Risks associated with eating, drinking and weight loss had been identified and were managed by staff. People's diverse dietary needs were identified and catered for. For example, one person followed a particular diet and specific products had been purchased to meet their needs.

Systems were in place to share information across services when people moved between them. For example, the electronic care planning system was used to generate a hospital pack which provided a summary of people's needs if they went into hospital. Assessments were conducted prior to people moving into the home to inform their care plans and when people moved on to other services information was shared with the new provider to ensure a smooth transition.

People and their families were positive about the home environment. Bowbridge Court is situated in a large purpose built premises. Consideration had been given to people's physical needs in the design of the building; the home had wide, well-lit corridors to enable people to mobilise around the building freely. People's privacy had also been considered, as well as a large dining and lounge areas on each floor there were smaller lounges where people could sit quietly or have privacy and every room had accessible en-suite facilities. Since our last inspection some improvements had been made to cater for the needs of people living with dementia such as the use of dementia friendly signage. Further improvements were planned to ensure the consistent use of dementia friendly signage throughout the home. Since our last inspection some areas of the home had been redecorated and people living at Bowbridge Court spoke proudly about how they had chosen the wallpaper and colours. The registered manager had also sought advice from a specialist in dementia to ensure the decor was appropriate to people's sensory needs.

Good

Is the service caring?

Our findings

At our December 2017 inspection we found people's right to privacy was not always respected. This was a breach of legal regulation. During this inspection we found that action had been taken to ensure people's right to privacy was respected and there was no longer a breach of regulation.

Overall, people told us that staff treated them with dignity and respected their privacy. However, some people commented that staff did not always knock on their bedroom doors before entering. Staff we spoke with were able to describe how they respected people's privacy. One member of staff told us, "We make sure we close the door when we are providing care and make sure we talk quietly to people so the whole room does not here if they want to toilet or have stomach ache." Throughout our inspection we observed that staff treated people with dignity and respected their privacy.
People were provided with kind and caring support. People and their relatives were positive about the staff team and the overall atmosphere of Bowbridge Court. A relative told us, "I'm happy with the care and the staff are lovely. I love them all. I have no concerns at the minute and visit most days." Another relative commented, "It's a lovely friendly atmosphere." People's relatives also told us they felt welcome at Bowbridge Court. A relative told us, "I can visit at any time and I usually visit about three times a week." Staff were positive about working at the home and told us they cared about the people they supported. One member of staff said, "It is important to remember that each person is a person first and foremost and not just someone who lives here." Another member of staff commented, "Some days you might be the only person that comes to visit the resident so it is important to make sure you spend five minutes just having a chat with them, it makes their day and they look forward to me coming to see them." Throughout our inspection we saw that staff treated people with respect and were patient in their approach. For example, one person required assistance and encouragement to eat, the member of staff was calm and very patient and gently persisted until the person had eaten an adequate amount.

People told us they felt staff knew them. One person said, "They (staff) know my family history." A member of staff commented, "We know people well. When [name] did not look right I knew something was wrong and called for assistance." Work was underway to improve the quality of all care plans, to ensure they fully respected people's life histories and preferences.

Overall people were involved in decisions about their support. People's relatives told us they were also consulted about their loved one's care and support and some said they had been involved in care planning. Staff we spoke with had an understanding of their role in ensuring that people had choice and control. A member if staff told us, "We ask them what they want and they make their own decisions, that didn't happen in the past." During our inspection we saw that staff checked with people about their preferences for care and support and offered people choices. Most care plans contained information about people's communication needs, further improvements were required to some care plans to ensure this information was accurate. Despite this we found staff had a good understanding of how people communicated.

The registered manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the home. Advocates are trained professionals who support,

enable and empower people to speak up. One person was using an Independent Mental Capacity Advocate (IMCA) at the time of our inspection. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.
People were supported to maintain their independence. Throughout our inspection we observed staff promoting people's independence, for example by encouraging people to walk rather than using a wheelchair. Staff were patient and encouraging in their approach. Most people's care plans contained details of where people were independent and areas where they required support. In addition the environment enabled people to maintain their skills. Each floor had a kitchen area and we observed people and their relatives using these throughout our inspection.

Good

Is the service responsive?

Our findings

Each person who used the service had a care plan which detailed their individual needs and preferences. The quality of information in care plans was variable. The provider was in the process of implementing an electronic care planning system. Paper based care plans which had not yet been transferred on to the new system did not always contain adequate detail for staff. In contrast, care plans on the new electronic system were detailed and comprehensive. The registered manager and the nominated individual assured us the remaining paper based care plans would shortly be redeveloped and put on the new system and we saw this work in progress during our inspection.

Staff were very positive about the introduction of the new system and said it enabled them to spend more time with people. One member of staff told us, "The care plans are really good for getting to know people. The computerised ones are much better than the paper ones. You have the information you need and can look things up straight away without having to go and find a file in another room." Another member of staff explained that the system flagged up when people required routine support. They went on to say, "When there are no flags we can go and sit and talk to people."

People were provided with caring and compassionate support in their last days of life. People had been given the opportunity to discuss their wishes for the end of their lives and this was sensitively recorded in their care plans. When people were coming towards the end of their lives there were clear plans in place to ensure their wishes were respected and to make sure they got appropriate support and pain relief. People's families were also supported at this difficult time and were free to stay with their loved one in the last few days of life. The registered manager told us they were "astonished" with the compassion and care staff showed towards people at the end of their lives. They described staff coming in when they were not on shift so that they could spend time with people in their last few days.

People were provided with a range of opportunities for meaningful activity. Although we received mixed feedback about the range and quality of opportunities for activity, we found people were provided with options and the provider was in the process of making further improvements. The provider had very recently employed a full time wellbeing coordinator who had responsibility for planning and facilitating opportunities for people in the home. They told us they were working on getting to know people to make sure they were provided with opportunities which were based upon their interests. For example, a relative told us their loved one had previously enjoyed gardening and staff supported them to do some gardening at Bowbridge Court.
Throughout our inspection we observed people were offered wide variety of ways to spend their time. Some people watched a film in the cinema room, newspapers were delivered daily and some people chose to spend time quietly reading or taking part in arts and crafts. There were also a range of organised events and entertainment options available to people. During our inspection we saw people taking part in an exercise class, the instructor took time to engage and involve people. A member of staff told us this had a positive impact on people. They said, "We have movement today. People really look forward to it. It is good as it keeps them moving. Sometimes, if you put the same music on the next day, you can see people sitting and doing the movement actions." Later in the day we saw people enjoying a singer. People were dancing and

staff joined in as well. There was lots of smiling and laughter and many people joined in with the old tunes. People who previously appeared quiet and withdrawn were singing happily.
People's diverse needs had been identified and accommodated. For example, people's religious and spiritual needs were identified and recorded in care plans. People who wished to practice their religion were provided with opportunities to do so at Bowbridge Court or in local places of worship. The staff team also provided sensitive support to people in personal relationships, ensuring they had privacy and were free from discrimination whilst also maintaining their safety.
We spoke with the manager about how they ensured they met their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. The registered manager told us they had considered this and would take action to meet people's information access needs by producing information in different formats if the need arose. The provider had an accessible information policy in place which provided detailed information about how they ensured people had equal access to information.
There were systems and processes in place to deal with and address complaints. People told us they would feel comfortable raising complaints or concerns. A relative told us, "I know who the manager is and I have no complaints. It's a very good home." Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the registered manager would act upon complaints appropriately. There was a complaints procedure on display in communal areas informing people how they could make a complaint. We reviewed records of complaints and these had been investigated and responded to in a timely manner. For each complaint, there was a written note of the response made to the complainant outlining the actions taken to resolve the issue and apologising. This was in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

At our past three inspections in August 2016, April 2017 and December 2017 we found concerns with the governance and leadership at Bowbridge Court. This resulted in an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found improvements were underway but further work was needed to ensure the effectiveness and sustainability of the new systems and processes.

The need for continued improvement and consistency was reflected in feedback about the service. Relatives spoke about the consistency of the quality of the service provided at Bowbridge Court. One relative told us, "It's very up and down here. Things will be ok for a couple of months and then it goes off for a couple of months." Another relative said, "At first when my relative moved here it was very good, but now it's not so good." We spoke with the registered manager and nominated individual about how they planned to ensure improvements were sustained. They told us this would be achieved by improved systems, consistent management and ongoing learning.

The implementation of new systems had been prioritised over the requirement to have accurate and up to date records of people's care and support. Following our December 2017 inspection the provider had started to implement an electronic care planning system. As a consequence of this some care plans had been rewritten as they were transferred to the system, these care plans were detailed and accurate. However, the care plans which had not been transferred to the electronic system were still of poor quality and did not reflect people's needs as these had been 'left' until they were transferred on to the new system. Consequently we found that care plans were of variable quality and this had placed people at risk of inconsistent support. In addition to this there had not been any recent audits of the paper based care plans which meant there was no system in place to ensure these care plans were up to date and adequately detailed.

Systems to ensure the quality and safety of the service did not ensure that risks associated with people's care and support were responded to in a timely manner. Audits were completed on a monthly basis, at the end of the month. This, combined with staff failure to report incidents quickly, had resulted in action not being taken to mitigate risks in a timely manner.

Further developments were needed to ensure systems were robust and well organised. During our inspection we found the system in place to evidence safe recruitment practices was not well organised. For example, there were multiple gaps in staff files which meant we were unable to ascertain if safe recruitment practices had been followed. The registered manager told us they thought checks had been completed but were unable to evidence this due to changes in personnel which meant the required documents had not been filed appropriately. This meant the provider could not demonstrate compliance.

The above information was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our December 2017 inspection we found the provider had not ensured that we were notified of incidents at the service, this was a breach of the legal regulations. During this inspection we found we had not received the majority of notifications from the provider due to an administrative error. We spoke with the care manager who advised us they had resubmitted all notifications and following our inspection we confirmed this to be the case.

There was a registered manager in place who was passionate about their role. People, their relatives and staff alike spoke favourably about the positive impact of her on the quality of the service. A relative told us, "The [registered manager] is very good." A staff member commented, "The (registered) manager is doing wonders here. I hate change, but the changes we have had here have been great and were well needed." Staff told us they felt supported by the registered manager and had confidence she would address any concerns raised in an appropriate manner. There were regular staff meetings, these were used to share news and information with staff and to raise and address issues of concern. Records showed staff had recently raised concerns about staffing levels. The registered manager told us they were aware of the pressures on the staff team and said they were recruiting and using agency staff in the interim to ensure safe staffing levels were maintained.

Throughout our inspection the management team were responsive to feedback and took swift action to address areas of concern, ensuring immediate risks were reduced and planning changes to systems to reduce future risk.

Plans were in place to better involve people living at the home and their families in the running of the home. Social committee meetings were held for people using the service and their relatives. Meetings had been infrequent but plans had recently been put in place to make improvements and we saw a schedule of planned meetings. Records of a recent meeting showed that topics such as activities, food, concerns and suggestions for improvement were discussed. The outcomes of the meetings were displayed in the reception area, this demonstrated improvements had been made based upon people's feedback. For example, people had asked for more healthy food options, consequently there had been a meeting with the kitchen manager who had committed to providing more options for people. People and their relatives had also been invited to share their feedback in regular quality assurance surveys. The results of these surveys had not yet been collated or analysed.

Other than the concerns referred to above, there were effective systems and processes in place to monitor and improve the quality of the service. The management team conducted a wide range of audits including the environment, medicines, catering and infection control. Regular audits were also carried out by the provider. Action plans were developed as a result of audits and there was also an overall action plan documenting how they were working towards compliance with the legal regulations. The registered manager had collated evidence to demonstrate how the planned actions had been implemented.

The management team told us they were given the resources they needed to develop and improve the quality of the service provided. Since our December 2017 inspection, the provider had invested increased resources to make improvements at the home. For example, they had employed two consultants who had been asked to improve care plans, medication processes and other areas of care. This had a positive impact on the quality of the service. For example, medication storage and administration had improved since last inspection. Learning was shared across the organisation. We saw evidence that changes and improvements had been made as a result of complaints, incidents and other events in the service and across the wider organisation.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online

where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the home and on their website.

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 People's rights under the Mental Capacity Act (2005) were not always respected. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks associated with their care and support 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety did not ensure that risks associated with people's care and support were responded to in a timely manner. 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff available to meet people's needs and ensure their safety.

18 (1)