Bowerfield House Limited

Bowerfield House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 23 and 24 October 2017 and was unannounced on the first day.

We last inspected the service on 5, 6 and 8 December 2016 when we rated the service as inadequate. At that time we found the service was in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, these were in relation to person centred care, dignity and respect, need for consent, safe care and treatment, meeting nutritional and hydration needs, good governance and staffing. At that inspection we made one recommendation, which was in relation to how the provider handles informal complaints.

Due to the concerns we identified during that inspection, we wrote to the provider and requested they take a number of voluntary actions. This included ensuring all care plans and risk assessments be reviewed by the end of January 2017, reviewing staffing levels, assessing staff competence, keeping CQC informed about the recruitment of a suitable deputy and sending CQC an action plan. We requested the provider sent us evidence of the completed actions, and we would review this to inform our decision making as to whether any formal enforcement action was required. The provider agreed to take these actions.

This inspection was to check improvements had been made following the last inspection and to review the ratings.

Bowerfield House is a purpose built care home owned and operated by Maria Mallaband Group. The home provides nursing and personal care for up to 26 older people living with dementia. It is a two storey building situated adjacent to a larger sister home located on the same site. All bedrooms are single occupancy and some have en-suite facilities. There is a passenger lift providing access to the first floor, an enclosed garden area to the rear of the building and car parking is available within the grounds. At the time of our inspection there were 24 people living at Bowerfield House.

On entering the home we were met by the registered manager who was eager to show us the improvements they had made following the last inspection.

Systems to make sure the safekeeping and administration of medicines were followed and monitored were in place and reviewed regularly. Medicines were stored safely in locked clinic rooms and were administered by designated trained nurses. Any specific requirements or risks in relation to people taking particular medicines were clearly documented in their care records.

Risk assessments were in place for people who were at risk of falls and in relation to people's skin integrity. Additional risk assessments were in place to meet people's individual needs for example specific dietary requirements.

Staff we spoke with confirmed they had received safeguarding and whistleblowing training (raising a

concern about a wrong doing in the workplace) and knew who to report concerns to if they suspected or witnessed abuse or poor practice. Records showed care workers received regular supervision to help make sure they were carrying out their duties safely and effectively.

Records in relation to the Mental Capacity Act 2005 were complete and up to date. Any restrictions were deemed to be in people's best interest and the least restrictive.

People were supported by sufficient numbers of care workers and nurses. Staff we spoke with told us they had undergone a thorough recruitment process and undertaken employee induction and training appropriate to their job role. This helped to make sure the care and support provided was safe and responsive to meet peoples identified needs.

We saw people who required encouragement and prompting to eat and drink receive the required level of staff support at meal times. We saw staff offered people a choice of meals as displayed on the menu.

We saw positive and caring interactions between care workers, nurses and people who used the service, which helped to make sure their dignity and privacy was respected and their wellbeing was promoted.

End of life care procedures were person centred and aimed at supporting the person to have full control about decisions relating to their future care and end of life needs.

People lived in a clean and well maintained environment. Appropriate equipment and health and safety checks were carried out to help maintain a safe environment for people to live in.

People who used the service and their relatives were complimentary about the care and support provided and the attitude of the staff. They felt that the overall care provided was good.

Complaints were addressed and recorded appropriately. People's relatives told us they knew how to make a complaint and felt confident to approach any member of the staff team if they had any concerns.

Accurate and complete records in respect of the care and treatment provided to people were being maintained. Systems were in place to monitor the quality and safety of the service provided to people living in the community.

The provider was conspicuously and legibly displaying their CQC rating at the premises and on their website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems to ensure medicines were stored, recorded and administered safely by suitably trained nurses were in place

Clear procedures and practices were in place to protect people from potential abuse and unsafe care. Staff we spoke with knew how to protect people from the risk of abuse.

Staffing levels were adequate to provide a good standard of support to people as identified and needed.

Risks to people were identified and detailed in their care records. Written information showed how to mitigate any risks to people.

Is the service effective?

Good

The service was effective.

All staff received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

People had access to external healthcare professionals, such as specialist nurses and General Practitioner's where risks had been identified.

Staff were aware of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's nutrition and hydration was monitored to ensure their nutritional needs were being met. Food options and refreshments were available throughout the day.

Is the service caring?

Good

The service was caring.

People received care and support from nurses and care workers who knew them well and understood their needs.

We observed positive interactions between staff and people who used the service which showed that people were valued.

People's care records were stored securely to respect their privacy and dignity and maintain confidentiality.

Is the service responsive?

Good

The service was responsive. □

People's needs were assessed prior to them moving into the home and a system of continuous assessment and evaluation was in place to identify any changes in how people's care and support was to be provided.

The provider promoted a person centred approach to help make sure people's needs and preferences were met.

Care records identified risks to people's physical health, mental health and well-being. Specialist guidance was included in people's care plans to address their health needs.

People were encouraged to engage and participate in a range of activities, hobbies and interests.

Is the service well-led?

Good

The service was well-led.

A manager was in place and was registered with the Care Quality Commission to manage Bowerfield House. They promoted a service ethos and culture that was transparent, open and honest.

Systems were in place and were being fully utilised in order to monitor the quality of the service and demonstrate continual improvement.

People who used the service, their relatives and care workers spoke positively and expressed their confidence in the management team.

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.

This inspection took place on the 23 and 24 October 2017 and was unannounced on the first day. The inspection was carried out by two adult social care inspectors, a pharmacist specialist advisor, a nursing specialist advisor (SpA). SpA provide specialist advice and input into the Care Quality Commission's (CQC's) regulatory inspection and investigation activity to ensure CQC's judgements are informed by up to date and credible clinical and professional knowledge and experience.

Before the inspection, we reviewed the information we held on the service including notifications we had received. This included safeguarding and incident notifications which the provider had told us about. A notification is information about important events such as accidents or incidents which the provider is required to send to us by law. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Following the inspection we received information about the service from the local authority and the National Health Service (NHS) Clinical Commissioning Group (CCG). They made positive comments about the quality of the care and support provided to people living at Bowerfield House and had no concerns.

During our inspection we spoke with six relatives of people living in the home, one visitor, the registered manager, a nurse, two care workers, the activities coordinator, three kitchen staff, the regional director, the office administrator, and the head of clinical standards.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed five staff personnel files including registered nurses recruitment checks, records of staff training

and supervision and the care records of seven people living in the home. We also reviewed a sample of medicine records, records relating to the servicing/ maintenance of premises and equipment, safety audits, a sample of the service's operational policies and procedures and the service's clinical governance audits.

Good

Is the service safe?

Our findings

People's relatives told us they felt their relatives were safe living at Bowerfield House and made positive comments about the care being provided to them. One person said, "Yes I feel [Person] is quite safe."

At our last inspection in December 2016 we found that medicines had been stored insecurely in a conservatory accessible to people living at the home. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

We found there were appropriate arrangements in place to help maintain the safe management of medicines at the service. The service used a monitored dosage system (MDS) and medicines were provided in blister packs by a supplying pharmacy. MDS is used to help keep track of what medicines are administered. This system can help to reduce the risk of medicine errors and make sure that people receive the correct medicine as prescribed by their general practitioner (GP). When we checked how medicines were being managed in the home we saw there was clear segregation of medicines being stored and medicines trolleys which were located in designated locked rooms on both floors of the home. Records showed that medicines delivered to the home had been checked in by nurses. Medicines, including thickening agents, were stored in appropriate key-coded cabinets, trolleys and a medicines' fridge. The codes to the key pad locks were handled securely by nurses. The temperature of the clinical rooms and the fridges were monitored and recorded.

Each person had a comprehensive administration chart that included their photo, allergy status and other relevant information which helped to assist nurses and care workers in identifying them.
Medicines were administered by a registered Nurse and the medicines administration records (MAR) were completed appropriately. Any excess medicines were stored in locked cupboards within each room. We saw skin creams and medicines prescribed to be taken as and when required had been appropriately recorded on individual medication administration records (MAR). Instructions for MAR coding, for example the use of an alphabetical letter to indicate when a person has refused their medication were in place. An up to date nurse verification signature sheet containing the names of authorised medicine handlers was in place and had been signed by designated nurses.

At our last inspection in December 2016 the provider was not able to demonstrate that a best-interests decision making process had been followed for people receiving medicines covertly. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation. Three people had their medicines administered covertly and there was appropriate documentation in place to support this process. The general practitioner (GP), pharmacist and registered manager had been involved in the assessment process for each person and people's relatives had been consulted. We reviewed the records for three people who were administered medicines covertly and saw the peoples' GPs had agreed the decision, as had a pharmacist. Best-interests decisions and appropriate evidence that other people involved in the peoples' care such as a family member or advocate had been consulted was in place. This meant the service was able to evidence that the decision to administer medicines covertly were only considered in exceptional circumstances and best interest meetings were held prior to providing medicines

covertly.

Controlled drugs are prescribed medicines frequently used to treat conditions such as severe pain. These medicines are liable to abuse and for these reasons there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations. These controls require services to make entries of any controlled drugs stored and administered in a separate register as well as on the MAR sheets. We saw that the provider was following these regulations.

Controlled drugs (CD) daily checks were in place to help ensure that the provider's protocol for CD's had been followed. When we checked the CD cabinet we found the CD's could be accurately reconciled with the amounts recorded as received and administered. We saw that the CD record book contained the CD's remaining balance and this had been signed alongside the person's MAR to confirm these medicines had been administered. When we carried out a medicines stock check we saw that regular audits were being undertaken by the provider. This meant that the systems in place in relation to the recording and storage of medicines were being used and followed correctly.

At our last inspection in December 2016 staff expressed concerns about their ability to provide adequate supervision of people at potential risk of falls at all times of the day. At that inspection we observed that people did not always receive support in a timely manner, including at meal times and in the mornings. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

A recruitment and selection procedure was in place. We saw that staffing numbers had increased because additional care workers had been recruited within the home. We looked at five care worker personnel files and found that they had been recruited in line with the regulations, including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults.

We spoke with five staff who described their recruitment to the service. They told us that after completing an employee application form and attending a face to face interview to assess their suitability for the job the provider carried out the necessary pre-employment checks. When we examined the care worker induction records we saw evidence that they were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

People we spoke with told us that they had noticed an increase in staffing levels and felt the atmosphere within the home had improved. From our observations we saw there were sufficient care workers and nurses to safely meet the needs of people living in the home and particularly at meal times. This was confirmed when we checked the staff roster which showed staffing levels were reviewed daily to ensure appropriate staffing levels were in place to meet people's identified needs. This meant the provider was able to ensure that the care provided to people was safe and consistent.

The service had a safeguarding policy and procedure and systems to help protect people from the risk of abuse were in place. The procedure was in line with the local authority's 'safeguarding adults at risk multi-agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records which showed the provider had suitable procedures to help make sure any concerns about people's safety were appropriately reported.

Care workers and a nurse we spoke with were knowledgeable and confident about the services safeguarding

procedures. They were able to give a good account of the risks associated to vulnerable adults, the safeguards in place to minimise those risks and explain how they would be vigilant about poor practice in order to recognise and report suspected abuse. They confirmed they had received safeguarding and whistleblowing training and understood the service's whistleblowing policy (the reporting of unsafe and/ or poor practice). Nurses and care workers knew how to protect people from the risk of harm. Care workers we spoke with said, "If we had a Safeguarding, we would contact the Safeguarding Team and they will tell us what harm level it is and what we need to do regarding a referral. Referrals will be done by the Deputy Manager."

At our last inspection in December 2016 we found that peoples' risk assessments had not been regularly reviewed. Also health professional guidance in relation to a person identified as being at risk of choking was not being followed. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

We saw records to show that risk assessments were in place for people who were at risk of falls, at risk of choking and in relation to people's skin integrity. Additional risk assessments were in place to meet people's individual needs for example specific dietary requirements or behaviours that might challenge the service. Where necessary body maps had been completed for particular people in order to highlight any bruising, pressure sores or skin tears, we saw records to show that people's skin checks were carried out by all staff that carried out any personal care intervention for people. From the risk assessments we examined we saw they contained enough detail to fully identify the risk and strategies to manage and minimise the risks.

Environmental risk assessments had been undertaken using a system for documenting and recording any maintenance work required. Records and audits for Legionella water checks had been carried out by an external contractor. Health and safety audits were carried out on a regular basis by the services maintenance person. Checks on windows and window restrictors, doors, lighting and heating had been carried out and were up to date. We examined additional records that showed regular checks had been undertaken on electrical appliances and portable appliance testing. This helped to make sure that any environmental risks to people were minimised. Records we examined indicated that fire equipment checks and fire drills were carried out frequently.

The service operated a deep clean programme. This meant that all bedrooms were cleaned on the day of the month that corresponded to each bedroom number, for example room one is deep cleaned on the first of the month, room 23 on the 23rd of the month. The domestic worker spoken with told us this meant there was plenty of time to thoroughly clean other areas of the home.

Records to show all of the people living at Bowerfield House had a Personal Emergency Evacuation Plan (PEEP) were in place. These plans detailed the level of support a person would require in an emergency situation such as a fire evacuation. In addition to this a PEEP box was located in the foyer of the home. The box contained essential items such as up to date copies of people's evacuation plans, a torch and a mobile phone. These items were accessible for use in the event of an emergency. Staff training records showed that all staff had undertaken fire safety training at regular intervals.

An accident/ incident policy and procedure was in place. Records of any accidents and incidents were recorded and analysed to check if there were any themes. Appropriate notifications had been made to the Care Quality Commission (CQC) and the local authority adult social care safeguarding team where necessary.

We saw that nurses and care workers had access to personal protective equipment (PPE) to help reduce the

risk of cross infection and was being used when providing personal care to people. Staff we spoke with knew to use disposable gloves and aprons provided for them. This helped to protect them and people using the service from the risk of cross infection whilst delivering care. They were aware of the need to make sure they used the protective equipment available and confirmed to us there was always plenty of PPE available for them to use.

Good

Is the service effective?

Our findings

At our last inspection in December 2016 we found staff did not offer people a choice of meals despite there being two choices on the menu. There were concerns about the support provided to people, and meeting peoples' preferences in relation to food and drink. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation. People living in the home had choice about what they wanted to eat and where required we saw they were supported to eat their meals with prompts from care workers. We observed the meals served were well presented, looked appetising and were nutritionally balanced. We examined the menu and saw that a variety of meal options were available at different times of the day. People were assisted or supported to eat their meals or with prompts from care workers. Dining tables were set for each meal time and where people preferred to eat in their rooms they were supported to do so. We saw people were frequently offered a variety of drinks to maintain their hydration and snacks were available throughout the day.

People's individual meal preferences were recorded in their care plans. A whiteboard was used in the kitchen to show the names of people living in the home and any food allergies, preferences and special diets or food textures required. Staff told us this was updated by a nurse when people came to live in the home or when their preferences or needs changed. This meant the cook could prepare food that suited the requirements of people living in the home.

Dietary risk assessments were also in place for people with specific dietary requirements. These risk assessments contained enough detail to fully identify the risk and strategies for care workers and nurses to manage and minimise those risks to ensure people's safety. For example people identified as being at risk of choking were provided with a pureed diet or a thickening agent was added to their food and drink to prevent the risk of choking. This meant people could enjoy their food because any specialised food and dietary needs were known and any risks were mitigated.

Care records and daily records we examined showed attention was paid to people's dietary requirements and what they ate and drank. We examined people's daily observation and weight records which indicated the type and amount of food people had eaten. This meant people's nutrition and hydration was monitored to ensure their nutritional needs were being met. Care workers, nurses and the cook were aware of the need to follow the speech and language therapist (SALT) instructions. For example making sure that people at risk of choking received a soft or pureed diet.
SALT provides treatment support and care for people who have difficulties with communication or with eating, drinking and swallowing.

Care records we examined showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses and general practitioners (GP's). Notes of such visits were included in people's care plans. Other care records showed attention was paid to people's general physical and mental well-

being, including risk assessments. For example where people were at risk of developing pressure sores this had been identified and recorded and appropriate health care support, such as a district nurse, was requested. Care records that recorded people's weight, dental and optical checks were also in place and reflected the care being provided to people.

The registered manager told us that care workers and nurses had received additional training in appropriate topics such as dementia awareness and falls awareness to meet people's specific health and wellbeing needs. This was confirmed when we examined the staff learning and development plan. This helped ensure that people were supported by suitably qualified, skilled and experienced care workers/nurses. Care workers and nurses we spoke with said about the staff training provided, "We have the usual things such as first aid, catheterisation, dementia awareness, safeguarding, Mental Capacity Act, venepuncture, tissue viability, moving and handling and Deprivation of Liberty Safeguarding. The training is always useful and helps us to do our job safely." When we spoke with visiting relatives they made positive comments about the care workers and nurses' ability to provide people with the care and support required.

There was an ongoing annual staff appraisal and a system of regular staff supervision in place. The system was used at regular intervals to discuss and evaluate the quality of care workers and nurse's individual performance and where best practice was in place. Care workers and a nurse we spoke with confirmed they received an annual appraisal and supervision at least every three months. We examined five care worker supervision and appraisal records which showed that care workers and nurses supervised and appraised regularly. Staff supervision provides the worker with the opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. Nurses and care workers we spoke with said, "We have staff meetings every couple of months and [staff member] does our supervision. It's too soon for our appraisals because we've just had them."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

The registered manager told us that DoLS applications were required for 10 people living at the home and had been submitted to the supervisory body (the local authority). We saw a tracker was in place to monitor when applications had been made to the supervisory body, when any applications had been authorised and the DoLS expiry date. The registered manager, nurses and care workers we spoke with were knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them. The registered manager was aware of the needs to notify the Care Quality Commission once the application had been approved.

We examined five care worker training records we saw that some care workers had obtained a National Vocational Qualification in Health and Social Care and new care workers had received training via the Care Certificate. This is a national recognised qualification that aims to equip health and social care workers with the knowledge and skills they need to provide safe and compassionate care. We saw that care workers had undertaken mandatory induction training in topics such as fire evacuation, safeguarding, food hygiene and infection control. This induction was followed by a two week period of shadowing (working under the

supervision of an experienced care worker) within the home. This gave the new care worker/nurse the opportunity to get to know the people who used the service. A probationary period of six months could be extended if the care workers/nurses performance did not meet expectations or the care worker/ nurse felt they required additional time to develop their skills.

We saw there was sufficient and suitable equipment in place to promote people's mobility such as handrails, hoists and wheelchairs. Appropriate raised seating was provided and pressure relieving equipment were well maintained and in good condition. Corridors were wide enough for wheelchairs and other mobility aids to manoeuvre adequately.

The service maintained a homely environment to enable people's planned activities, routines and lifestyles to be supported effectively by care workers and nurses.

Good

Is the service caring?

Our findings

At the last inspection in December 2016 we found there were lapses in the way people were being treated in relation to dignity and respect around their bedding and clothing. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation. During the inspection we saw staff interact with people living in the home in a pleasant, respectful and caring way. Care workers engaged people in conversations that were interesting and meaningful to them. For example we saw them showing warmth and empathy towards people at meal times, when serving meals. We observed staff asking if they were enjoying their meal and if they had eaten enough at that particular mealtime. They shared friendly conversation with people and we observed them speaking respectfully with people whilst supporting them to mobilise around the home within the person's capabilities.

People we spoke with and their relatives told us they were happy living at Bowerfield House and felt they were receiving good care and support from the care workers and nurses. People we spoke with gave good examples about the care workers, their approach and their attitude towards them and felt they were being treated respectfully. A relative told us how the service respected a person's preferences by carpeting their bedroom as most rooms had laminate flooring. They said, "[Person] didn't feel at home without a carpet." Another relative told us that the provider had also fitted a safety gate on a person's bedroom doorway so that they could leave their door open and other people living in the home could not walk in, at the suggestion of relatives. They told us that the person was able to open the gate if they wanted to leave the room.

Relatives said, "All the staff are lovely" and "They stop and talk with [Person]" and "They are very kind." We observed one carer who knew people very well and used a variety of techniques to engage with them and prompt them to eat or to distract people when they became distressed.
When we spoke with the care worker they told us they had received training in behavioural techniques in relation to caring for people with autism and had adapted the technique to use with people living with dementia.

Another care worker discussed with us how they encouraged people to do as much for themselves as they were able to and how they helped people to make choices each day. They described one person living in the home who enjoyed fashion, make up and jewellery and told us how they helped the person choose what to wear each day. A visiting relative said, "Staff are kind considerate and compassionate, they know [Person] inside out".

The atmosphere at the home was relaxed. We observed good interpersonal relationships between care workers/nurses and people who used the service. When we spoke with two care workers and a nurse about people's individual needs they were able to demonstrate their knowledge about people very well and gave good examples of how people preferred their care and support to be given. These details had been

accurately reflected in people's care records.

We saw care workers had developed a good rapport and understanding of the people who used the service and treated them and their belongings with respect. They and the nurses had good knowledge about how to provide care to people and we observed people being given choices for example in relation to meals, drinks, activities, daily living and where they wanted to sit in communal areas. All staff were aware of people's personal preferences and this information was contained in people's care records, such as their likes, dislikes, whether people preferred to have a bath or a shower or the time they preferred to get up in the morning. This showed that nurses and care workers had a good understanding of the person when providing care and support to them.

The registered manager, nurse and care workers were aware of how to access a local advocacy service to ensure that people could request independent advice and support when needed. An advocate is a person who represents people independently of any government body. They are able to assist people in ways such as, acting on their behalf at meetings and/or accessing information for them.

We looked at the services End of Life (EoL) care policy and procedure which considered the national guidance 'Ageing mental Health'. This was person centred and geared towards helping the person, and their relatives to have full control about decisions relating to the person's future care and end of life needs. In addition to this training the Namaste Care programme had been provided to two nurses and it is intended for all staff to receive this training in the near future. This programme aims to improve quality of life and provide more compassionate and dignified care to older people with advanced dementia at the end of life.

We saw records that confirmed where people were receiving end of life care meetings were held to discuss and agree with the person and/ or their relatives the person's medication, hydration/nutrition, personal care needs, pressure area and comfort. The registered manager told us that where people living at Bowerfield House were receiving end of life care they would follow the services policy and procedure. Interventions were based around an advanced care plan (ACP). At this stage discussions would take place to make sure the person's wishes were considered and planned at all times. Any additional issues raised would be discussed with the registered manager and nurses where necessary.

We saw that people's records and any confidential documents were kept securely in secured rooms that could only be accessed by designated staff and no personal information was on display. This ensured that confidentiality of information was maintained.

Good

Is the service responsive?

Our findings

At the last inspection in December 2016 we found the provider had not carried out an adequate assessment of people's needs and preferences, which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

At this inspection we found people's needs had been assessed before they moved into Bowerfield House. Needs assessments showed people and their relatives had been included and involved in the assessment process wherever possible. Care records were up to date, complete and showed that care workers and nurses used information from the initial needs assessment to develop detailed care plans. Associated records highlighted people's abilities, dependency level, support required to maintain their independence and the desired outcome following the support given. This meant care workers and nurses were enabled to provide care to people in a person centred way. For example needs assessment identified where people had a history of falls and clearly detailed potential risks to each person. Written information for care workers and nurses to follow showed that falls monitoring records were in place. These records identified the equipment to use to reduce the risk of the person falling and environmental considerations.

People's care records were reviewed, actioned and evaluated monthly or more frequently if the person experienced any health or support changes. Care reviews help to monitor whether care records are up to date and reflect people's current needs so that any necessary changes can be identified and actioned at an early stage. We saw that care records contained a detailed personal history and gave clear guidance for care workers and nurses to follow in order to support the needs of people who used the service. Records showed attention was given to people who were at risk of weight loss and instructions for care workers/nurses to follow were clearly documented. Monthly weight management reviews were held to ensure care workers and nurses were aware of any observations required in relation to people's weight.

We reviewed seven care plans and found them to be very detailed and person centred. A section entitled 'My Story' had been completed and included photographs of places, experiences and things that had been part of the person's life before moving into Bowerfield House. Staff we spoke with told us that 'My Story' was used in one to one meetings with each person to stimulate reminiscence and memories. People's relatives were given the opportunity to attend and contribute to the review meeting. One relative commented, "I fully agree with all the plans agreed and appreciate the time, consideration and care that has been given. Time to voice my concerns and express my knowledge of [Person] has given me confidence in the home."

Care workers and nurses we spoke with were able to demonstrate their understanding about person centred care. They told us that it was important to make sure people's care was delivered to them to help maintain or increase their independence and people should always be included in decisions about their care. Information relating to people's care was consistent with what the care workers told us. This showed that people using the service received identified and appropriate support when required to ensure their care and treatment needs were being met.

Activities were organised by an activities coordinator who consulted people individually about their preferences before completing the activities programme. The activities coordinator told us that people were supported to take part in hobbies and interests and individual or group daily leisure activities were always provided. Activities records and risk assessment highlighted where there were potential risks when people were involved in particular activities such as leaving the home and involvement in outside activities. The activities coordinator said, "We are proactive with activities offered. There is always something for everybody because we researched people's interests and hobbies before providing activities. People's participation in daily activities was recorded. We saw a game of skittles in progress although creative drawing had been scheduled. The activities coordinator told us they had changed the morning activity in response to the people who wished to take part that day.

People and visiting relatives we spoke with told us they knew how to make a complaint if they had any concerns and guidance telling people how to make a complaint was displayed on notice boards around the home. A complaints policy which allowed for a full investigation into the complaint and for all complaints to be taken seriously was in place. The policy allowed complaints to be escalated to the Local Government Ombudsman if the complainant remained dissatisfied with the outcome. We saw actions to complaints had been recorded and the complaint resolved to the person's satisfaction.

All of the relatives we spoke with said they had been given information about how to make a formal complaint and the registered manager was very responsive to issues or suggestions. One relative said, "If I've got any concerns, her [manager] door is always open." They informed us of issues they had discussed with the manager which had led to positive changes for the person. For example, a person had been afraid of using the lift and their bedroom was on the upper floor. After discussing this with the manager a downstairs bedroom was redecorated "In her [Person's] favourite colours" and the person had moved into the room. Another relative said, "The manager listens, they are very reassuring and acts on concerns. They sort it out right away."

Good

Is the service well-led?

Our findings

At the last inspection in December 2016 we found that accurate and complete records of care provided were not being kept and care records contained insufficient detail to provide personalised care and treatment to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At this inspection we found that improvements had been made and the provider was now meeting the requirements of the regulation. We found staff were now consistently maintaining accurate records in relation to the care and support provided to people. This is discussed throughout this report.

At that inspection, we also found systems in place to monitor and improve the quality and safety of the service were not implemented effectively. At this inspection we found that improvements had been made and the provider was now meeting the requirements of the regulation.

The service had a manager who was registered with the Care Quality Commission (CQC) in December 2016. They were present at both inspection days. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager also managed the neighbouring care home, 'Bowerfield Court', which is a 40 bed nursing home that is also part of the Maria Mallaband Care Group. The registered manager is a qualified nurse, has significant experience working with older people and was supported by deputy manager's and a regional management team to provide managerial oversight of the day to day running of the services and service delivery.

Discussions with care workers, nurses and relatives of people who used the service confirmed the registered manager was always present in the home. All of the people we spoke with made positive comments about the management team and felt people's needs were being met by a sufficient number of competent care workers and nurses. Care workers and nurses understood their role and responsibility to the people living in the home. They felt the registered manager was supportive and responded well to their needs and those of the people living at Bowerfield House. Care workers spoke positively about the culture at Bowerfield House and said, "The home is well led. The culture is caring and open", "Things get discussed and sorted out" and "We have good teamwork."

Since the last inspection in December 2016, the registered provider had focused on service improvement and was working collaboratively with external agencies. Throughout the inspection it was apparent that the registered manager and staff team were committed to providing an improved service to people. They used opportunities to consistently review and evaluate how to maintain a good service to benefit people. They promoted a person centred approach to help make sure people's needs and preferences were being met.

The service completed clinical indicator reports in order to provide comparative information about the quality of the service provided at Bowerfield House. This information was also shared with the National Health Service (NHS) Clinical Commissioning Group (CCG) and local authority quality monitoring team. We examined a sample of reports which highlighted any patterns that emerged, for example in relation to hospital admissions, people's weight loss, the number of modified diets, infections, deaths, falls and pressure sores. Information gathered was reported and reviewed at regional director level where actions would be identified and recorded on an audit action plan. The registered manager described the action plan as a 'live' document which was updated daily. Information from this document was analysed in order to assist in anticipating seasonal trends and risk planning prior to a potential health or environmental events.

We examined records that showed the registered manager had addressed and actioned identified issues to make sure there was no delay in maintaining or improving the health, safety and welfare of people using the service. This ensured appropriate remedial action could be taken to address any identified issues in a timely way to ensure people received safe care and treatment. Internal quality audits and action plans for areas such as infection control, environmental and care records identified good practice and where improvements were required. The registered manager carried out daily walk arounds at the home to check and record on people's health and safety and the safety of the environment. This meant good provider oversight of service delivery and quality was ongoing.

In order to ensure good service continuity a business contingency plan was in place. This plan identified potential risks and threats to service provision and the provider's actions should they occur. The registered manager said, "This is where we as a company ensure systems and processes are being reviewed regularly to ensure consistency. The regional director also carries out night visit checks at the home to ensure people's night time care experience is safe and person centred." Night check records we looked at confirmed these visits had taken place and any issues were reported and actioned.

Records to show that meetings were held with people who used the service and their representative or relatives were in place. People were given an opportunity to say what they liked about Bowerfield House but also what, if any, improvements could be made. We saw that notes of the meetings were kept to ensure an accurate account of people's verbal contribution was maintained. This system helped to drive forward service improvement and maintain good quality service provision.

The registered manager shared with us copies of the various organisational policies/ procedures such as, complaints and suggestions, safeguarding, accidents/ incidents, medicines management and staff recruitment. Policies and procedures help the provider to guide the actions of all individuals involved in the service and provide consistency in all practices carried out in the home. Policies we looked at were being kept under review.

We checked our records before the inspection and saw that accidents and incidents that the Care Quality Commission needed to be informed about had been notified to us by the registered provider. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

The registered provider recognised staffs caring attributes through observations of staff practices and behaviours and operated an employee reward scheme to acknowledge staff loyalty. This helped the staff team to feel valued and maintain a good standard of care.