Bowerfield House Limited

# Bowerfield House

## Inspection report

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08 December 2016

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## Ratings

| Overall rating for this service | Inadequate |
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| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 05, 06 and 08 of December 2016 and was unannounced on the first day. We last inspected Bowerfield House on 19 and 22 October 2015 when we rated the service as requires improvement overall and identified breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had not been made and the service remained in breach of the regulations.

Since our last inspection we had received a number of concerns that related to areas including sufficient staffing, staff turnover, activities and management of the home. We identified breaches of seven of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which 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. We made one recommendation, which was in relation to how the provider handles informal complaints.

Due to the concerns we identified during our 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. The provider agreed to take these actions. We requested the provider sends us evidence of these completed actions, and will review this to inform our decision making as to whether any formal enforcement action is required. We will update the section at the end of this report once any enforcement action has concluded.

Because of our concerns, we also raised a number of safeguarding alerts with the local authority. These were not progressed formally under safeguarding, but were passed to the local authority's quality assurance department to follow-up.

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 building 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 23 people living at the home.

We found medicines were not being kept safely, which presented a risk to people living at the home. On our arrival at the home we found a large quantity of medicines received from the pharmacy had been kept in the conservatory area of the home, which was accessible to people living at the home. We also observed one occasion when the medicines trolley was left open and unsupervised in the clinic room. Entry to this room was restricted only by a door guard that some people living at the home may have been able to release. We also found thickening agent was kept in an unlocked cupboard in the ground floor lounge/dining area, which presented a risk of asphyxiation if people inadvertently consumed this.

Staff had not regularly reviewed risk assessments in relation to areas including malnutrition, falls, and pressure sores. This meant the provider could not be certain that appropriate measures were in place to reduce such risks. We also found staff were not following guidance in one person's care plan in relation to reducing their potential risk of choking.

Numbers of staff providing direct care and support to people had not increased since our last inspection, despite the interim manager at that time recognising that staffing levels at particular times of the day required review. The provider had started using a dependency tool, which indicated there were sufficient numbers of staff. However, this tool did not consider factors such as the layout of the building, or the times of the day when additional staff support might be required. We observed that people did not always receive the support they needed in a timely manner, including support to get up in the morning, use the toilet, and to eat and drink. Staff and relatives expressed concerns that staffing levels did not always allow for sufficient supervision of people who may be at risk of falls.

We observed that people who required encouragement or prompting to eat and drink did not always receive the support they required as staff were engaged supporting people on a one to one basis or providing other care to people who required two staff to support them. On one occasion we observed two people had been sleeping with their meals in front of them uneaten, which were then removed by staff with no apparent encouragement or prompting provided for them to eat and drink. The provider changed the process for mid-day meals during the inspection to provide two sittings, which meant additional staff were available to provide support. However, we found there were on-going issues around the provision of support at breakfast and in the evening.

Care plans, including a care plan for a person receiving end of life care had not been regularly reviewed, and were not always reflective of peoples' current support needs. The provider was in the process of carrying out comprehensive reviews of the care plans that had been completed for two people. However, this meant other care plans had not been regularly reviewed, which meant there was a risk care would not be planned to meet individuals' needs and preferences.

We observed staff interactions with people living at the home were caring, patient, and empathetic. However, due to pressures on staff members' time, interactions were often task based. Other than a pantomime on the first day of the inspection, we did not observe any attempts by staff to engage people in activities or other stimulation.

Systems and processes in the home were not always effective at ensuring people were treated with dignity and respect. We found one person was left for at least one hour without access to a call bell with their finished meal in front of them and wearing a clothing protector. We were informed by relatives that another person had been left without a duvet on their bed overnight as this had been taken to the laundry and not returned. Another relative told us that despite improvements in the laundry service, they would still find their family member wearing other peoples' clothes.

Since our last inspection staff had started to receive regular supervision, and we saw training was carried out in a range of areas including safeguarding, moving and handling and infection control. The registered manager had identified areas where additional training was required, and had taken steps to ensure training that met specific learning needs was provided.

Relatives told us there had been a large turnover of staff, and this was also reflected in the information shared with us by the provider. Although relatives felt longer-term staff knew their family members well, it was felt that the regular use of agency staff and the turnover of staff had effected the consistency of care

provided, as well as effective communication within the home.

Since our last inspection a registered manager had been appointed who was responsible for the management of Bowerfield House and the neighbouring care home, Bowerfield Court. 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.

Staff and relatives were positive about the registered manager's management of the home. They told us the registered manager appeared to be working very hard to try to improve the home. We received mixed reports about effective communication between relatives and staff at the home. Whilst some relatives were confident to approach staff or the registered manager, other relatives told us due to the registered manager managing two homes they felt they were not always accessible.

Record keeping at the home was poor. We found gaps in records of care provided and records, including records of food and fluid intake were not always updated in a timely manner. Record keeping in relation to wound care was poor, and although there was no evidence of actual harm as a result of this, we found staff were not clear about the care needs of one person with a wound.

There were systems and processes in place to help the registered manager and provider monitor and improve the quality and safety of the service, but these had not always been completed consistently and had not been effective at addressing identified concerns in a timely way. For example, we saw issues in relation to meal-time support had been identified in audits by both the registered manager and provider, and this issue had also been discussed at a relatives meeting. However, we found no effective actions had been taken to address this area of concern at the time of our inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in 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?

**Inadequate**

The service was not safe.

Medicines were not kept securely. A large quantity of medicines received from the pharmacy had been stored insecurely in a conservatory accessible to people living at the home.

Peoples' risk assessments had not been regularly reviewed. We found staff were not following one persons' care plan and guidance from a health professional in relation to their risk of choking.

Staff expressed concerns about their ability to provide adequate supervision of people at potential risk of falls at all times of the day. We observed that people did not always receive support in a timely manner, including at meal times and in the mornings.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

We observed people who required encouragement and prompting to eat and drink did not always receive the required level of staff support at meal times. Staff did not offer people a choice of meals despite there being two choices on the menu.

Since our last inspection the new registered manager had started to ensure staff received regular supervision.

The provider was not able to demonstrate that a best-interests decision making process had been followed for people receiving medicines covertly.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

We observed positive and caring interactions between staff and people using the service. However, there had been lapses in processes, which meant people had not always been treated with respect and dignity.

We found the care plans for one person receiving end of life care had not been reviewed for approximately six months. This meant the provider could not show this person's changing needs and wishes had been considered and that care was being provided in accordance with their preferences.

Relatives told us they felt longer-term members of permanent staff knew their family members well. However they told us there had been a high turnover of staff, which impacted on how well staff knew their family members.

## Is the service responsive?

**Inadequate**

The service was not responsive.

Care plans had not been regularly reviewed and did not always accurately reflect the support people required. This meant there was a risk care provided may not meet peoples' needs and preferences.

Complaints had been recorded, investigated and responded to within reasonable time scales. However, we found actions taken to resolve 'informal' complaints had not always been sustained effectively.

We saw a pantomime had been arranged on the first day of our inspection. Other than this we did not observe any other activities taking place. Interaction from staff was often task-based.

## Is the service well-led?

**Inadequate**

The service was not well-led.

A registered manager had been appointed who managed Bowerfield House and the neighbouring home. Whilst staff and relatives felt the registered manager was working hard to try to improve standards at the home, they felt issues such as the turnover of staff had prevented positive progress from always being made.

Systems in place to help monitor the quality and safety of the service had not always been implemented effectively. The provider had failed to ensure there was sufficient and sustained improvement following our last inspection.

We found some records of care provided were missing and other records were not updated in a timely manner. Daily records were not always completed in sufficient detail to allow other

professionals to gain an accurate picture of peoples' current presentation and support needs.

# 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 05, 06 and 08 December and the first day was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed information we held about the service. This included previous inspection reports, the providers' action plan following the last inspection, information shared with us via 'share your experience' forms completed on our website and other information shared with us via email and phone to our contact centre. We also reviewed notifications that the provider is required to send to us in relation to safeguarding, serious injuries and other significant events and the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from Stockport safeguarding, Stockport Healthwatch, commissioners of the service, Stockport's local authority quality assurance team and the care home officer from Stockport's clinical commissioning group (CCG). We received feedback from Stockport's quality assurance team and the CCG care home officer who shared reports of their most recent monitoring visits. We considered this information as part of the planning process for this inspection.

During the inspection we spoke with 13 members of staff. This included the registered manager, the regional director, five care staff, three nurses, the quality assurance manager, the head of nursing and the chef. We spoke with two health professionals, seven relatives who were visiting at the time of our inspection and two people who were living at the home. 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 carried out observations around the service and reviewed records in relation to the care people were receiving. This included six care files; medication administration records (MARs) and daily records of care. We also reviewed records in relation to the running of a care home. This included records of servicing and maintenance, audits, action plans, records of training and supervision and three staff personnel files.

Inadequate

# Is the service safe?

## Our findings

At our last inspection of Bowerfield House on 19 October 2015, we found there were not sufficient numbers of suitably qualified and competent staff on duty. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found there had not been sufficient improvement in this area, and the provider remained in breach of this regulation.

Since our last inspection, staffing levels for care and nursing staff had remained the same. The registered manager told us, and rotas we looked at confirmed that there was always one nurse on duty. In addition, there were four carers on shift in the day, and two care staff at night (from 8pm to 8am). The provider had introduced a 'dependency tool'. This is a tool that helps providers and managers determine how many staff are required to meet the needs of the people they are caring for, based on those individuals' needs. The dependency tool indicated that staff hours provided were above those expected based on the needs of people living at the home. However, the tool used did not take into account factors such as the layout of the home or give an indication as to staffing requirements at different times of the day. The provider told us there was a high ratio of staff to people using the service during the day when the total staffing complement, including ancillary staff (such as kitchen and domestic staff) were considered. However, our observations were that the deployment of staff providing direct care to people was not adequate to meet peoples' needs in a timely way across both floors of the home, and particularly at busier times of the day such as when people were getting up from bed or being supported with breakfast or other meals.

Relatives and staff told us there had been a high turnover of staff, with a group of staff having left the home since our last inspection. Relatives felt this impacted on the care provided as agency staff were used to cover gaps in the rotas, who did not always know their family members so well. We observed that some of the agency staff working at the home were limited in the interaction and support they provided to people. The registered manager told us they had recently recruited more nursing staff and were awaiting their pre-employment checks to be completed. There were vacancies for approximately three full time care staff at the time of our inspection, which equated to approximately 40% of the total staff team hours. Relatives told us the registered manager always ensured permanent staff were working alongside agency staff, which they felt helped ensure a degree of consistency.

Staff and relatives were consistent in telling us they did not think there were sufficient numbers of staff on duty to meet peoples' needs in a timely manner. One relative told us; "I think staffing levels are a struggle as [the home is] on two floors. It's often relatives who assist people. I think dementia care needs have increased and more people need assistance with eating and drinking, with no increase in staffing." Another relative told us they choose to assist their family member to eat meals, but also said they did not think their family member would receive the level of attention they needed if they didn't attend the home due to the high level of support needs of other people at the home. Two relatives told us they were not always able to find staff and said communal areas were frequently left unsupervised. Our observations during the inspection confirmed these reports.

Staff told us they found it difficult to provide support in a timely manner due to pressures on their time, and

said they felt staffing levels were not always safe as they were not always able to adequately supervise people who were at risk of falling. For example, staff told us the night before the first day of our inspection there had been two people who did not go to bed until approximately 5am through choice. They told us these people were 'wandering' and at risk of falls. We confirmed this by checking the daily records of care. Staff told us many people required two staff to assist them to bed or with personal care, and that the nurse was often engaged in duties in relation to medicines. They told us this meant they were not always able to provide adequate supervision and support to these people.

We found items including a box of juice drink in the first floor bathroom toilet, which staff told us another person must have done when not observed by staff. During the day we found the communal areas were frequently left unsupervised as staff were required to assist people with personal care or other care needs in their rooms. On the first and second days of our inspection, staff were still supporting people with breakfast at 11:30am, which they told us in some cases was due to pressures on staff time in assisting people to get up, rather than individuals' preferences. On the second day of the inspection, we found staff were still supporting people to get up from bed at 11:30am.

We observed one person had to wait 20 minutes following their first request to staff to be supported to the toilet as they required two staff members to assist them. After waiting 13 minutes, we overheard them telling a staff member; "I have got to go to the toilet or I will deliver it on the floor." We also found issues in relation to the deployment of sufficient numbers of staff had an impact on the support provided to people to eat and drink, activities and interaction. For example, during the breakfast period on the last day of our inspection we saw there were two care staff on the first floor of the home. One staff member left the lounge for approximately 45 minutes whilst they went to provide assistance to a person receiving care in their room. This left one staff member to assist six people in the dining area with their breakfasts, which they struggled to do alone. We have discussed these areas of concern in more depth later in this report.

There were not sufficient numbers of staff deployed to ensure people's needs were met consistently. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in October 2015 we found areas where there were short-falls in the cleanliness of the home, and one of the bathrooms we went in did not have paper-towels or hand wash available. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found sufficient improvements had not been made, and the home remained in breach of this regulation.

Relatives informed us that cleanliness at the home had improved following the appointment of domestic staff to cover the home seven days per week. We also saw there were adequate stocks of personal protective equipment (PPE) such as gloves and aprons, and the bathrooms were stocked with hand towels and soap. However, we continued to find areas where cleaning had not been adequate to effectively control the risk of spread of infection. We saw carpets in the downstairs lounge were stained, and observed there was dried faeces on one of the downstairs toilets. We saw one person sat in a specially designed wheeled chair that had stains from a drink on the arm, and there was a piece of dried food on the frame of the chair. This was still present two days later, and we observed another person living at the home pick the piece of dried food off the frame and place it on the arm of the chair. The home had had a new heating system fitted, which had left gaps in the flooring where water ingress was possible. The provider had identified this risk and was awaiting repair of the flooring, having obtained quote for the relevant work to be carried out.

When we visited the kitchen we asked the chef about the length of time food could be kept in the heated

soup kettle before it became unsafe to eat. He said, "I am concerned about the breakfast porridge being served to people after two hours in the soup kettle. Although the soup kettle temperature is always set at 80 degrees centigrade, if the temperature drops below 76 degrees centigrade, after two hours bacteria will begin to grow. We send the soup kettle up to the first floor at 8.30am and the porridge is still being served at 11.30. If the porridge is served too hot for people, staff will often cool it down by adding cold milk. This encourages bacteria to grow and increases the risk of food poisoning." A risk assessment was not in place to highlight the risks of food served to people at the incorrect temperature.

The provider was not demonstrating that they were meeting criterion two of the 'Code of practice on the prevention and control of infections' by providing and maintaining a clean and appropriate environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Records in relation to medicines provided staff with the information they needed, to help ensure people received their medicines as prescribed and in accordance with their preferences. For example, we saw care plans outlined how people liked to be supported with their medicines, and there were protocols in place that detailed when staff should administer 'when required' (PRN) medicines, the intended effect of these medicines and any possible side effects to be aware of. Medications administration records (MARs) we reviewed indicated that people had received their medicines as prescribed.

One relative we spoke with raised a concern that their family member did not always receive their medicines in a timely manner. They told us their family member took medicines four times per day, and said it would be difficult to ensure adequate spacing between doses as they sometimes did not receive their medicine until late in the morning. One nurse completed the medicines round on both floors of the home, and we observed that the morning medicines round took until 11am to be completed. The nurses we spoke with confirmed that it was normal that the medicines round would take until this time to complete. The nurses informed us the night nurses would administer people their medicines if they required medicines that needed to be given earlier in the morning before breakfast. They also informed us that medicines would be administered first to anyone requiring medicines multiple times in the day to help ensure there was an adequate gap between subsequent administrations.

We found medicines were not always kept safely. On arrival at the home on the first day of our inspection we saw a large quantity of medicines that had been delivered from the pharmacy were being kept in the conservatory that adjoined the downstairs communal lounge, and had been left in this area over the previous two days. This included both tablet and liquid medicines, and we saw the conservatory was accessible without restriction to people using the service. We sat in the conservatory and saw the communal lounge was left unsupervised, and one person using the service entered the conservatory where the medicines were located during this time. We raised this concern with staff on duty and requested that the medicines were moved to safe storage. There was a risk that people using the service may have inadvertently taken the loose medicines, or the medicines could have been stolen or moved without staff knowledge. We also observed the medicines trolley on one occasion was left open in the treatment room, with the treatment room door open. Although there was a door guard that would restrict access by people unable to release the guard, this was also poor practice and presented a potential risk of people accessing the medicines inappropriately. We found thickening agent, used to thicken some people's drinks had been stored in an unsecured cupboard in the kitchenette area of the ground floor lounge. A patient safety alert was issued by NHS England in February 2015 in relation to risk of asphyxiation through accidental ingestion of thickening agents. We handed the thickener to the registered manager to move to safe storage.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines.

Staff we spoke with were able to tell us how they would identify and report any potential safeguarding concerns. We saw the registered manager kept a log of any safeguarding alerts they made to the local authority. This showed that the home was identifying potential safeguarding concerns and sharing this information with the local authority, and CQC when required. From our discussions with the registered manager, we found they were aware of the progress of any safeguarding investigations being carried out, and any recommendations that had been made as the result of such investigation. However, we found timely actions had not always been taken to act on recommendations. For example, the manager told us that following investigations into a concern raised about wound care, the home had been advised to improve record keeping in relation to care in this area. However, we found on-going issues in relation to effective wound care management and documentation. We have discussed this concern further in the well-led section of this report.

Assessments were in place that considered potential risks to people's health, safety and well-being. This included risk assessments in relation to falls, skin integrity and malnutrition. We checked whether measures identified in risk assessments and care plans were being followed, and found that in most cases they were. For instance, we saw where care plans identified the need for equipment such as pressure mats to detect falls from beds that this equipment was being used. Where people had been identified at risk of pressure sores and requiring special mattresses to reduce the risk of sores developing, we saw these were in place, and there were frequent checks recorded to help ensure the mattresses were set up and working correctly.

However, in four of the six care plans we reviewed, we found risk assessments had not been reviewed on a regular basis. This would increase the likelihood that risk assessments would not be effective at identifying appropriate measures to reduce the likelihood of harm occurring, and would not identify a change in an individual's risk in relation to areas such as falls or malnutrition as their care needs changed. We found one person's risk assessments had not been reviewed since September/October 2016. This was despite their risk assessments identifying them as being at 'high risk' or 'very high risk' in areas including risk of skin breakdown and falls. Another person's care plan stated monthly review of the risk assessments was required to help maintain their safety and this had not been done. We reviewed the risk assessments of a third person, who we were informed was approaching the end of their life, and therefore had frequently changing needs. Their falls risk assessment had not been reviewed from June to October 2016, and their Waterlow score had not been reviewed since June 2016, despite the last calculated score placing them at high risk in this area. A Waterlow score gives an estimated risk for the development of a pressure ulcer developing.

We spoke with a relative who raised concerns that their family member would eat food whilst lay down in bed, which could present a risk of choking. They told us they had asked staff on several occasions to either encourage their family member to sit up, or to supervise them whilst they were eating. They told us despite these repeated requests that this was not always done, and they had recently found their family member lying down eating in bed without staff supervision. We reviewed this person's care file and saw guidance issued by the speech and language therapist (SALT) instructed staff to supervise this person whilst eating, to encourage them to sit up if eating in bed and to avoid toast. We asked two members of staff what support this person required with eating and drinking, and neither staff member showed an awareness of these guidelines. We asked one of the staff members specifically whether staff were required to supervise this person whilst they were eating, and they told us this was not the case. We also saw staff had left toast in this person's rooms for them to eat for breakfast. This would place the individual at increased risk of choking as staff were not aware of the measures identified to reduce this potential risk. The provider told us they thought the SALT guidelines were no longer entirely relevant, but the care plan had not been updated to reflect any change in needs and a re-referral for updated guidance was not sought until we raised this issue.

These issues in relation to the assessment of risk and taking appropriate actions to reduce risk was a breach

of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We reviewed records relating to the maintenance of the building and equipment. Records showed the required inspections and servicing of equipment such as hoists, lifts, fire alarm, gas, electrical and water systems had been carried out as required. Entrances to the home were secured by keypads, which would prevent unauthorised entry or people who were subject to authorised deprivations of liberty from leaving without staff knowledge and support.

During the inspection we saw the environment was not always kept safe for people living at the home. On the first day of our inspection we saw a razor had been left in the communal bathroom, and a pair of scissors had been left in the conservatory area. These items were removed when staff were informed of their presence. We also found on the first day of the inspection that a cupboard containing cleaning chemicals (COSHH) in the kitchenette area of the ground floor lounge was freely accessible to people living at the home as the restriction mechanism fitted was defective. We raised this issue with the registered manager and the restrictor was mended later that day. One relative we spoke with raised concerns that items such as kettles in the lounge/dining areas were accessible to people and may put them at risk as these areas were frequently left without staff supervision.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as reasonably practicable measures had not been taken to ensure the environment was safe for people using the service.

The provider followed procedures designed to ensure staff recruited were of suitable character to work at the home. There was a document in place to track the status and return of staff disclosure and barring service (DBS) checks. DBS checks show whether an applicant has any criminal convictions or is barred from working with vulnerable people. This helps employees make safer decisions when recruiting staff. The recruitment records we viewed showed that a DBS check had been received prior to an offer of employment being confirmed. There was evidence that other checks including obtaining references from former employees, and proof of identity had been received as is required. The provider had checked that nursing staff held the required qualifications and had a current registration to practice.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in October 2015 we found staff had not received regular supervision during a period of change in management at the home. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the supervision of staff had improved, and the requirements of the regulation were being met in relation to staff supervision. A supervision matrix was in place that recorded staff supervisions back to June 2016. Since recording had started we saw most staff had received supervision approximately every other month. We reviewed records of supervisions, which consisted of brief notes and showed topics of discussion had included dementia care and safeguarding. Newly recruited staff were subject to a probationary period and we saw the registered manager held regular discussion with new staff during this period to review their performance and competency. Relatives we spoke with told us they felt staff had the competence required to provide the care and support their family members needed. One relative said; "The staff deal with mum well," and another said; "They do a lot for [my relative] and I feel their needs are being met."

Records of training indicated 85% or more of the 23 listed staff had completed training in a variety of topics including; fire awareness, moving and handling, first aid, safeguarding, infection control, dementia and the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw the registered manager reviewed training requirements at the home, and had for example arranged training in tissue viability to improve staff competence in this area. They told us the training staff attended had not covered all areas they had hoped it would, and they had arranged further training in this area to help address these gaps.

We observed the support provided to people over breakfast, mid-day and evening meals. There were not always sufficient staff to ensure people received the assistance and prompts they required to ensure they ate and drank sufficient amounts. On the first day of our inspection we observed that there were two care staff supporting people with meals in the upstairs dining area. Both staff members were engaged in providing one to one support to people who required this level of assistance, as well as continuing to carry out tasks such as answering the phone and collecting meals. This meant that other people, whom it was apparent required encouragement and/or supervision when eating and drinking did not receive this support. For example, we observed two people asleep with their meals in front of them. We did not observe any attempts by staff to encourage these people to eat, and their partially eaten meals were removed approximately 40 minutes later.

Following our feedback to the registered manager and regional director on the first day of the inspection, the process for providing support over the mid-day meal was changed so that there were two sittings provided. This meant more staff were available to provide support to people who required assistance over the meal time. On the last day of our inspection we saw additional support was provided by staff, including a member of administrative staff from the home next door. We were informed the administrative staff member from the neighbouring home would not usually be present to provide support over meal times, but that they were at the home that day to support a new member of administrative staff at Bowerfield House at the time

of our inspection.

Despite these changes, we found some on-going issues around the support provided to people over meal times. We found breakfasts were still being served at 11:30am on the last day of our inspection, which staff indicated was due to pressures at this time in supporting people to get up from bed as well as providing support with breakfasts. We saw staff had to regularly leave the dining area unsupervised during the breakfast period to attend to other duties, which meant there was not sufficient support available at this time. We saw one person was left asleep with porridge and then toast, which were then later removed uneaten. At another point we observed a person take and eat a piece of toast from another person's plate whilst the dining area was unsupervised. We spoke with one relative who told us they always came in to support their family member eat meals. They told us this was their choice, but that they felt staff would not have the time to provide the level of attention their family member needed during meal times if they did not come, due to the number of people requiring a high level of support at meal times.

We saw that two options for the main meal were recorded on a menu that was available in small print text. This would have been difficult for people to read if they had any visual impairment, and we observed one person trying to read the menu and commenting that they were unable to. One relative told us they brought food in for their family members' breakfast as they were only offered toast or porridge, which was not in accordance with their preferences. Another relative reported that no choice of meals was offered, although alternatives were provided if they went and requested them from the kitchen. They told us; "There isn't really a choice of food and it is repetitive. [Family member] won't always eat the kind of food offered." One person living at Bowerfield House told us they liked the food offered, whilst another person said they couldn't always 'stomach' the food and so would sometimes go without. We asked the provider to look into this concern. During our inspection we did not observe any choice of meal being offered, and staff confirmed that everyone had received the same option from the menu. We spoke with kitchen staff who told us communication with care staff was poor, and that although options were available, care staff only requested the first choice from the menu.

These concerns in relation to the support provided to people, and meeting peoples' preferences in relation to food and drink was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, and had been submitted for all people living at the home. We saw a tracker was in place to monitor when applications had been made to the supervisory body (the local authority) and when any applications had been authorised. We saw one person had had an authorised DoLS in place that had expired before the provider had submitted a request to renew the authorisation. This meant that the DoLS had lapsed, and there would have been a risk that this person was being deprived of their liberty without lawful authority.

The registered manager told us two care files had undergone a recent full review. We looked at the care plan in one of these revised care files and saw there was a good level of detail in relation to the reason for any DoLS being in place, details about any conditions in relation to the DoLS and what this meant in relation to the care staff provided to this person.

We asked one person living at Bowerfield House if staff asked for their consent before providing any care. They told us; "Yes, but I can't understand them [the staff] sometimes." During the inspection we observed staff asking peoples' permission before providing any support or assistance. Staff told us they would always ask for a persons' consent before providing support, and would look for non-verbal signs of consent through facial expression or behaviour if the person was unable to communicate consent verbally. Staff we spoke with demonstrated a reasonable understanding of the principles of the MCA and DoLS. For example, one staff member told us that where a person lacked the capacity to consent, any decisions they were able to take on a persons' behalf should be in their best interests. We saw evidence of capacity assessments and recorded best interests decisions in peoples' care files.

The registered manager showed us that they were in the process of requesting evidence of any 'lasting power of attorney' (LPA) that relatives' held in relation to their family members' care. An authorised LPA can provide another person with a legal right to make certain decisions relating to either finances or health and welfare on a person's behalf. It is important that providers have evidence of any LPA so they are aware of any legal right a family member has to make decisions in relation to their relatives' care.

We were informed several people were administered medicines covertly. This means their medicines were given without the person's knowledge, such as by disguising it in food or drink. A judgement by the Court of Protection in July 2016 clarified the steps required in relation to the administration of covert medicines. This judgement indicated that that covert medicines can be considered in exceptional circumstances, but that a best interests meeting should be held prior to providing medicines covertly. We reviewed the records for two people who were administered medicines covertly and saw the peoples' GPs had agreed the decision, as had a pharmacist. However, there was no documented best-interests decision, or evidence that other people involved in the peoples' care such as a family member or advocate had been consulted. This meant the service was not able to evidence that the decision to administer medicines covertly had been taken in the individuals' best interests and was the least restrictive option available.

This meant the service was not acting in accordance with the MCA and was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of adaptations that had been made to the environment to make it more accessible to people living with dementia. This included some people having photos on their bedroom doors, which would help them locate their room and retain independence. There were also contrasting colours used for hand rails and toilet seats for example, which makes such items easier to locate for people who have a visual impairment. Other adaptations included a 'fiddle board', which contained a variety of items that may be a distraction to people living with dementia. We also saw some people had ''empathy dolls' they looked after. Empathy dolls may have a range of positive outcomes for certain people living with dementia, including outcomes in relation to communication and positive behaviours. We saw staff had undertaken basic training in dementia, and the registered manager told us they would be booking the newer staff onto the externally provided training that the home used. Two relatives we spoke with told us they felt the comparatively small size of the home was beneficial for their family members as it allowed them freedom to retain independence in an environment that they got to know well.

The registered manager told us there was a regular weekly round carried out by a GP from the local surgery.

This would help ensure advice in relation to any developing health concerns could be addressed promptly. One relative commented; "The access to the doctor is great. They come weekly and really know Mum." Records in peoples' care files showed advice had been sought from a range of health professionals in relation to peoples' care. This included GPs, speech and language therapists (SALTS) and dieticians. However, in some instances, such referrals by the home could have been more proactive. For example, the home felt the needs of one person weren't reflective of the advice in their SALT assessment, but no re-referral had been made until concerns around the support this person received with eating and drinking were raised by the inspection team. One of the nurse reviewers present during our inspection also advised for referrals to be made to a tissue viability nurse and dietician for another person living at the home.

Requires Improvement

# Is the service caring?

## Our findings

Despite observations of some positive and caring interactions, we found times when there was limited interaction between staff and people living at the home. For long periods throughout the days of the inspection, we observed that staff were primarily engaged in task based interactions, such as supporting people with personal care, one to one support with eating or serving meals. There were also occasions when there were missed opportunities for staff to engage with people living at the home. For example, at one point in the inspection we observed a member of agency staff sat in the ground floor lounge watching the TV but not interacting with people. These observations were supported by reports from a relative who commented that there were rarely staff with their family member and that interactions were limited and focussed on meeting 'basic needs.' We also saw a concern had been previously raised with the registered manager about staff being on their mobile phones in the lounge area rather than engaging with people using the service.

We found instances where processes in place at the home had resulted in lapses in the provision of care that upheld peoples' dignity and ensured they were treated with respect. During the inspection we visited one person who had been given their mid-day meal to eat in their room. This person was able to eat independently, but was not able to mobilise independently. When we visited them, they had finished their meal and were sitting with a clothing protector on and their dirty plates were in front of them. When we visited this person's room approximately one hour later we found the plates had still not been removed and the person was still wearing their clothing protector. Although there was a call bell in this person's room, it had not been positioned so that they would be able to use it to call for assistance should they need this.

One relative had raised a complaint with the registered manager as they had found staff had taken their family member's duvet to the laundry but not ensured a replacement cover was put in place. This meant this person had spent the night without a proper cover on their bed, and staff had either not noticed or not acted upon this omission. We discussed this with the registered manager who told us additional covers had been ordered and that this had been addressed with staff. At our last inspection in October 2015 we identified issues in relation to the effective running of the laundry at the home. Relatives we spoke with told us the laundry service had improved since the last inspection, but that there were some on-going issues. For example, one relative told us their family member was wearing another person's trousers at the time of the inspection, and that this was a regular occurrence despite items of clothing having the person's name in.

These issues show there were lapses in treating people with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us no particular model of end of life care provision was followed, and we did not see any evidence of any specific training in this area. The providers' head of nursing told us there was a staff member employed at a nearby care home in the Maria Mallaband group who specialised in end of life care and would provide additional support and training to staff at the home as required. We reviewed care plans, including those for people receiving end of life care. Some care plans contained information on the care people would want to receive when approaching the end of their life, including their preferences and

wishes, whilst in others this information had not been recorded. One care plan contained information on a person's end of life care needs, and showed there had been discussion with others' involved in their care such as family members. However, we saw this care plan, including the information on end of life care wishes, had not been reviewed since June 2016 and the information contained in it was not always up to date or reflective of this person's current needs. For example, the medicines and food and nutrition care plans did not reflect the actual support this person required or staff were providing at the time of our inspection. The registered manager told us, and we saw that peoples' current care needs were also recorded in summary on sheets located in the inside of peoples' wardrobes. This would help ensure staff were aware of key points in relation to peoples' care. Staff we spoke with also demonstrated an awareness of this person's current needs, which they told us, was gained during shift handovers. However, the lack of regular review of their care plan would increase the risk that end of life care would not meet this person's needs or preferences.

The provider had not carried out an adequate assessment of needs and preferences, which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When asking relatives about their experience of the service, all mentioned areas where they either had concerns or felt improvements were required. Despite this, most relatives we spoke with reflected that there were also positive aspects about the home, including the caring approach of permanent staff. For example, one relative raised a number of concerns with us, but went on to say; "I know the staff care." Another relative also raised a number of complaints, but went on to say; "There are lots of excellent things too, good carers," and a third relative said; "The staff love the people who live here and treat them all as family."

Relatives told us that there was a high turnover in staff, and this was also reflected in the information on staffing provided to us in the providers' information return (PIR) they sent us in June 2016. One relative who visited the home on a regular basis said; "There is a churn of staff. There are only a couple I recognise now." During the inspection we saw agency nurses and carers on duty on all three days of our inspection. Although the provider booked agency staff on a regular basis whenever possible, relatives' felt this had an impact on how well the staff team knew their family members.

It was apparent from our discussions with permanent staff that they knew people well and had a good understanding of their needs, preferences, and interests. For example, one member of care staff told us; "I get the newspaper for [person] as they like to read. [Person] likes to dance and sing." One relative talking about the permanent staff told us; "The staff know Mum and me really well."

During the inspection we saw that interactions between staff and people living at the home were respectful and caring. For instance, we observed staff supporting people to adjust their clothing and supporting people in a patient way at a pace comfortable to the individual. At other times we heard staff engage people in conversation about their care needs or topics of interest to them. We overheard a staff member speaking gently and with kindness to a person who used an 'empathy doll'. We heard the staff member ask the person if they could look after the doll while the person ate their breakfast. The staff member reassured the person not to worry, that she would feed, change and look after the doll. After the person had eaten breakfast the staff member returned the doll to the person and explained how they had cared for the doll in the person's absence.

We asked one person whether they found staff respected their privacy. They told us; "Yes, to a point." During the inspection we saw staff would knock before entering people's rooms and spoke discreetly with people when offering assistance with personal care. Staff also told us they would ensure doors and curtains were closed when providing personal care. We saw records such as care plans were kept securely in lockable

cabinets.

We observed that staff communicated clearly and effectively with people, and used touch when appropriate to help offer people reassurance if needed. Care plans contained information in relation to people's communication support needs. For example, one care plan we looked at stated that staff should speak slowly and clearly and use the person's preferred name. A second care plan informed staff it was important to use a 'cheerful tone of voice' when communicating and providing support to the person. This information would help ensure staff were able to communicate effectively with people and provide them with information about their care.

Inadequate

# Is the service responsive?

## Our findings

At the start of our inspection the registered manager told us they had recognised that care planning at the home needed to be more 'thorough, robust and person centred'. As a result they showed us they had begun to put together a file of feedback from care staff detailing peoples' preferences in relation to how staff provided them with care and support. They also had a tracker to show when comprehensive reviews of the care plans had taken place. At the time of our inspection, staff had completed these reviews for two people's care files and the action plan in place indicated the remainder of the reviews should be completed by February 2017.

Care plans indicated peoples' abilities, needs and desired outcomes in relation to a range of areas including mobility, food and nutrition, medicines and sleep. We found care plans recorded people's preferences in relation to the care they received. For example, one person's care plan noted they liked a warm drink before bed and preferred to be assisted to shave rather than have a beard. We reviewed one of the revised care files and saw this contained a good level of detail about the person's needs and preferences and it had been regularly reviewed. Some people's care plans contained information about their social history, including people and events that were important to them, although this was not present in two of the care files we reviewed. Information on social histories can help staff get to know people and understand their interests and preferences better.

We found there were significant gaps in reviews carried out of other care plans that had not been through the thorough revision. As discussed in the caring section of this report, one person's care plans had not been reviewed since June 2016 and did not accurately detail their current care needs. We found other examples where care plans had not been reviewed since July and September 2016. One of these care plans did not accurately reflect advice provided by the GP in relation to the person's diet. We also spoke with two visiting health professionals who were carrying out reviews of people's care. Both professionals told us that they had found the care plans were not reflective of the people's current needs. One professional told us for example that the person's needs in relation to their mobility, dementia and communication had changed and the care plan did not reflect this. The second health professional noted that the care plan for the person they were carrying out a review for was out of date and did not provide them with the information they required around the person's memory loss or cognition. This was despite this person only having been resident at the home for a relatively short space of time.

We reviewed the care plan for another person and found a form titled 'review of accidents'. This form was dated 05 October 2016 and stated that staff should carry out daily clinical observations, including records of blood pressure and oxygen saturation. However, the form had no observations recorded on it. We asked a member of nursing staff about this, they were unaware of any need to make such observations for this person. They told us a former staff member had written the instruction, but not passed on this information to other staff. As this person's care file was not up to date, there was a risk they were not receiving appropriate care and support.

These shortfalls in the review of assessed needs would increase the risk that people would not receive care

that met their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found permanent staff were aware of people's preferences, likes and dislikes. For example, one staff member told us; "[Person] likes sweet coffee and biscuits. They usually like to have their TV on in their room, but will tell you if they don't." Staff told us they were not under any pressure to support people to get up or go to bed at any specific times. However, we found choice in relation to this was also restricted due to the availability of staff to support people to get up in the mornings. As previously mentioned in the effective section of this report, we also found there was a lack of active promotion of choice in relation to food at meal times. One person we spoke with told us they could request support with bathing or showering at a time to meet their preferences, but that they had to 'book' this in the day before and it was not always possible for staff to meet their preference.

We saw the registered manager kept a log of complaints made, which would help ensure they were responded to in a timely way. The log would also help the service to monitor the outcome of any complaints. Records showed that concerns raised had been investigated and responded to appropriately. For example, we saw apologies had been issued when appropriate, and the registered manager had recorded the actions taken to resolve any complaint.

One relative we spoke with told us they had previously raised a formal complaint and had been satisfied with the outcome and handling of their concern. They told us they felt confident to approach the registered manager or other senior staff and said; "I've raised complaints before, but they're all resolved now." However, two relatives we spoke with expressed some frustration about what they saw as on-going concerns and lack of improvement in relation to some of the concerns they had in relation to communication, staff turnover and other issues related to their family members' care., One relative told us; "I keep raising it again and again." Their concern that their feedback had not been acted upon effectively had resulted in them then raising a formal complaint. We also saw evidence that actions taken to help resolve informal complaints or concerns were not always sustained. For example, one person's relative was concerned they were not being supported with personal care as frequently as required, and as a result a record of personal care support had been placed in their en-suite. However, this record had not been update by staff since mid-October 2016.

We recommend the provider reviews the way informal complaints are identified and managed.

The registered manager told us the home employed an activity co-ordinator who worked 30 hours per week at Bowerfield House, although we did not see them during our inspection. On the first day of our inspection we saw people attended a pantomime that had been put on in the ground floor lounge. Other than this, we saw no further activities or attempts by staff to arrange or encourage participation in activities during the course of our inspection. Records of activities kept in peoples' care files did demonstrate there had been recent provision of activities, which had included exercise sessions and a visit from a singer. One relative told us activities had improved since the previous inspection. However, two other relatives we spoke with commented that they rarely saw activities taking place, which was also our observation during the inspection. One relative told us they were aware the home had resources such as 'activity boxes'. They said they would have liked to have had access to these resources to support activities when they visited, but were not aware where they were kept. The provision of activities and meaningful stimulation is an important aspect of meeting peoples' needs in relation to social interaction, health and mental wellbeing.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection in October 2015 there had been no registered manager in post for approximately 11 months and we were informed there had been three acting managers at the service over the past year. It is a condition of Bowerfield House's registration that a manager registered with CQC manages the service.

At the time of the current inspection, a registered manager was in post who had registered with CQC at Bowerfield House in July 2016. 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. There was no deputy manager in post at Bowerfield House at the time of our inspection and the provider told us they would be appointing an interim deputy internally until they were able to recruit a suitable deputy on a permanent basis.

Relatives and staff we spoke with were positive about the management of the home by the registered manager, and told us they thought the registered manager was working hard to try to improve the home. One relative said; "[Registered Manager] is working their socks off. They are very good." However, it was also felt their efforts to make improvements were limited by issues such as staff turnover. One staff member told us; "The manager seems good," and another said; "Turnover [of staff] is the trouble. We need a good management team. It is getting better." A relative told us; "[Registered Manager] is trying hard to turn things around, but there are on-going issues, including with staffing." We also received mixed reports in relation to communication from staff at the home. One relative told us; "[Registered manager] is receptive, calm and finds time to talk to you to try and resolve things. She is always available and I can go next door or ring her mobile if she is not here." However, two other relatives commented that the registered manager was often not visible, which they felt limited effective communication. One relative also told us they were not always kept informed about changes in their relatives care and were not certain who to approach to ask about such changes as they did not know many of the staff due to high staff turnover.

The registered manager told us she split her time between the two homes based on changing priorities, and said she had an 'open door' policy. We saw 'resident and relatives' meetings were scheduled to take place every other month. Minutes from recent meetings showed topics of discussion had included activities and consultation in relation to the home environment. The service sought the views of relatives and people using the service through surveys, including a survey conducted by an independent research company. This would help the provider and registered manager understand where improvements were required.

We found staff were not consistently keeping accurate records in relation to the care and support people received. At the start of our inspection the registered manager informed us that one person had a pressure sore that was being treated. When we checked the wound care records for this person, we found staff had not recorded any assessment of the wound, nor recorded that the dressing on the wound had been changed for over two weeks. The entries on the wound care record also did not evidence that the dressing had been changed as frequently as the care plan stated was required. We spoke with two nurses who were both aware of the wound, but were not able to tell us when the dressing had last been changed. We requested that the nursing staff determine the condition of the wound, and whether the dressing needed to be changed during

our inspection. Shortly after the inspection, the provider sent evidence that the wound had healed. However, the poor documentation and poor tracking by the nursing staff about the current condition of the wound showed management was poor in this area.

We found other gaps in care records, including records of food and fluid intake, records of accidents, and daily records of care provided. Staff had not updated records, including food and fluid intake records in a timely manner. For example, we saw no intake of food and fluid had been recorded for one person at 3:15pm, although staff assured us this person had been supported with food and drink that day. Staff told us another person received regular two hourly checks. However, we found no entry had been made in this person's records for over three hours when we visited their room. This meant we could not always tell what food and fluid intake people had had that day or that they had received appropriate care. Records of care also lacked detail. For example, a relative discussed two recent events in relation to their family members' care with us, and we found no mention of these events in the daily records of care. This meant that care records did not always reflect the day to day events from the person's point of view, and so did not allow for opportunities to provide a more person centred approach to care.

Both visiting professionals we spoke with also told us they found care notes were not reflective of the care delivered as described by staff, and did not provide an accurate picture of peoples' current presentation. Records of weights were not always recorded in people's care files, which would make it more difficult to monitor their health appropriately. We also saw an entry made by a visiting health professional in one person's care notes in October 2016 that stated care staff had been unable to locate weight records more recent than July 2016 for that person. It is important accurate records in relation to care are completed and accessible when required to ensure people's needs can be properly monitored and assessed.

These issues in relation to the failure to keep accurate and complete records of care were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection in October 2015 we found systems in place to monitor and improve the quality and safety of the service had not been effective. This included the finding that actions identified in action plans had not been completed by the identified dates, and had been repeatedly rescheduled. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection, we found an on-going breach of this regulation.

Bowerfield House was rated requires improvement at our last inspection, and the provider had failed to ensure sustained improvements were made to improve the safety and quality of the service. One relative we spoke with told us they had read the last inspection report and did not feel the home had moved on since this time. We found evidence of on-going and multiple breaches of the regulations at this inspection.

There was evidence of a culture at the home where staff did not take responsibility or the initiative to help ensure a safe and person-centred service was provided to people. For example, we found medicines had been left unsecured in the conservatory area of the home over the weekend. Despite this clear risk to peoples' safety, no staff member on duty had taken action to ensure the medicines were moved prior to us requesting this action was taken. Reviews of care plans had lapsed, which the regional director had suggested was the result of agency nursing staff not taking ownership and completing the reviews as required. Our observations during the inspection also showed that despite some caring and person-centred interactions, such an approach was not consistent across the staff team. Relatives also felt there had been a negative impact on the quality of care due to a high turnover of staff resulting in a reliance on the use of regular agency staff.

The registered manager and quality assurance manager told us they had identified a number of the issues we raised and showed us an action plan they had produced as a result. This included actions in relation to infection control, care plans and medicines. The action plan had identified deadlines for completion of actions of between 21 December 2016 and 21 February 2017. However, as found at our previous inspection, we saw some of these actions had not been completed by the initially identified deadlines and had been rescheduled. This meant we could not be confident that the provider would complete their action plan in a timely way.

There was a system of checks and audits in place, but we found these had not always been consistently completed, or had not been effective at ensuring timely action had been taken to address concerns. For example, we were given copies of three 'daily home manager audits' from October 2016. We requested, but did not receive more recent copies of this audit. The registered manager acknowledged that this audit had not taken place on a daily basis. We saw that a mealtime audit completed by the registered manager in October 2016 had highlighted that due to staff being engaged in provision of one to one support that other peoples' meals went cold and it was also noted that people were not made aware of choices. Similar issues had been identified by the provider in an audit they carried out in September 2016. This recorded that people had been sat at dining tables at 11:30am with 'cold, soggy toast' and that staff had not encouraged people to eat or offered alternatives. The minutes of the October 2016 residents and relatives meeting also documented discussion around the possibility of 'staggering' the meal time to ensure the needs of people requiring higher levels of support were met. Our last inspection report also noted that the interim manager had recognised the need for additional staff support at key hours such as mornings and mealtimes. Despite awareness of these issues, no clear actions had been taken to address these concerns, and we found the provision of adequate support to people over meal times to be an on-going issue at this inspection.

The providers' and registered managers' audits had identified other issues such as the lack of regular review of care plans and risk assessments. Whilst we found action was being taken to conduct a thorough review of care plans, we raised concern that the regular review of specific care plans and risk assessments had ceased whilst the full reviews were being awaited.

These issues in relation to the effective implementation of systems to monitor and improve the quality and safety of the service were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had not carried out an adequate assessment of peoples' needs and preferences that was reviewed on a regular basis.<br><br>Regulation 9(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Systems in place did not ensure people were always treated with dignity and respect.<br><br>Regulation 10(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was not acting in accordance with the Mental Capacity Act 2005 by following a best interests decision making process.<br><br>Regulation 11(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider was not taking adequate steps to control the spread of infection. |

Medicines were not managed safely.

The provider had not taken reasonably practicable steps to assess and mitigate risks to people using the service.

The provider had not ensured the environment was safe for people using the service.

Regulation 12(1)

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>People did not always receive the support they required to eat and drink. Preferences in relation to food were not met.<br><br>Regulation 14(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems in place to monitor and improve the quality and safety of the service were not implemented effectively.<br><br>Accurate and complete records of care provided were not kept.<br><br>Regulation 17(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not sufficient numbers of staff deployed to meet peoples' needs in a timely way.<br><br>Regulation 18(1) |