Ideal Carehomes (Number One) Limited

Bowbridge Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Bowbridge Court on 25 and 27 April 2017. The inspection was unannounced. Bowbridge Court is a situated in Newark in North Nottinghamshire and is operated by Ideal Care Homes (Number One) Limited. The service is registered to provide accommodation for 54 older people who require personal care. There were 49 people living at the service on the day of our inspection. The service is split across three floors, each with communal living spaces.

We inspected this service on 30 August 2016 and the service was rated as requires improvement with multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the required improvements had not been made and found ongoing concerns in relation to the quality and safety of the service. This resulted in us finding new and ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safeguarding service users from abuse and improper treatment, consent, safe care and treatment, staffing and good governance. We also found an ongoing breach of regulation 18 of the Care Quality Commission (Registration) Regulations) 2009. You can see what action we told the provider to take at the back of the full version of the report.

There was no registered manager in post at the time of our inspection, our records showed that the previous registered manager had left the service in October 2016. 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. There was a service manager in place during our inspection who had taken over responsibility for the day to day running of the service in November 2016. They informed us that they would be submitting an application to register as manager for the service. We will monitor this.

During this inspection we found that the systems in place to reduce risks associated with people's care and support were not always effective and this exposed people to the risk of harm. Risks in relation to people's care were still not planned for appropriately to ensure people received safe care and people's care records did not contain sufficient guidance for staff to minimise risks to people.

Although people felt safe in the service, they were still not always protected from the risk of abuse and information of concern was not always acted upon or shared with the local authority. People did not always receive their medicines as prescribed and medicines were not always managed safely. Equipment used to support people was not always clean.

There were enough staff to provide care and support to people. However safe recruitment practices were not always followed. Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs and were not provided with regular supervision and support.

People's rights under the Mental Capacity Act (2005) were not respected. People could not be assured that restrictions imposed upon their freedom were appropriate or in their best interests. However, people told us they felt involved in day to day decisions about their care and support.

People's day to day health needs were met, however, there was a risk that people may not receive appropriate support with specific health conditions due to a lack of information in care plans. Most people were supported to have enough to eat and drink. However a small number of people were placed at risk of malnutrition as action was not taken to monitor their weight.

People were not provided with consistently kind and caring support and they could not always be assured that they would receive support that was based upon their individual interests and preferences.

People could not be assured that they would receive the support they required as care plans did not all contain accurate, up to date information about people's needs. People were not always offered the opportunity to be involved in the planning or reviewing of their care plans.

People were encouraged to be as independent as possible and staff treated people with dignity and respected their right to privacy. People were given opportunities to get involved in social activity and were supported to maintain relationships with family and friends.

There was a continued lack of appropriate governance and leadership and this resulted in us finding ongoing breaches in regulation and negative outcomes for people who used the service. Systems in place to monitor and improve the quality of the service were not effective and timely action was not taken in response to known issues.

People who used the service and staff had limited opportunities to give their views on how the service was run. Despite this people and staff felt able to share concerns with the management. There were systems in place to respond to complaints.

The management team were responsive to feedback and developed an action plan in response to the most significant concerns identified during this inspection.

Given the issues identified above 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.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Action was not taken to protect people from the risk of harm and abuse.

Systems in place to reduce the risks associated with people's care and support were not always effective and this exposed people to the risk of harm.

Medicines were not managed safely and people did not always receive their medicines as prescribed.

Equipment used to support people was not always clean and hygienic.

There were enough staff to provide care and support to people. However safe recruitment practices were not always followed.

Is the service effective?

Inadequate

The service was not effective.

People's rights under the Mental Capacity Act (2005) were not respected. People could not be assured that restrictions imposed upon their freedom were appropriate or in their best interests.

Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs. Staff were not provided with regular supervision and support.

People's day to day health needs were met, however, there was a risk that people may not receive appropriate support with specific health conditions.

Most people were supported to have enough to eat and drink. However a small number of people were placed at risk of malnutrition as action was not taken to monitor their weight.

Is the service caring?

Requires Improvement

The service was not always caring.

People could not be assured that they would be provided with consistently kind and caring support.

People were not always offered the opportunity to be involved in the planning or reviewing of their care plans. However people felt involved in day to day decisions about their care and support.

People could not always be assured that they would receive support that was based upon their individual needs and preferences.

People were encouraged to be as independent as possible. Staff treated people with dignity and respected their right to privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive the support they required as care plans did not all contain accurate, up to date information about the support people needed.

People were given opportunities to get involved in social activity and were supported to maintain relationships with family and friends.

People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was a continued lack of appropriate governance and leadership and this resulted in us finding ongoing breaches in regulation and negative outcomes for people who used the service.

Systems in place to monitor and improve the quality of the service were not effective and timely action was not taken in response to known issues.

People who used the service and staff had limited opportunities to give their views on how the service was run. Despite this people and staff felt able to share concerns with the management.

The management team were responsive to our feedback and developed an action plan in response to the most significant concerns identified during this inspection.

Bowbridge Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 30 August 2016 inspection had been made, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We inspected the service on 25 and 27 April 2017. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection visit we spoke with eight people who used the service and the relatives of three people. We spoke with six members of care staff, members of the catering and housekeeping team, the deputy managers and the service manager.

To help us assess how people's care needs were being met we reviewed eight people's care records and other information, for example their risk assessments. We also looked the medicines records of five people, three staff recruitment files, training records and a range of records relating to the running of the service.

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.

Inadequate

Is the service safe?

Our findings

During our August 2016 inspection we found that people were not adequately protected from risks associated with their care and support. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the required improvements had not been made which meant that people were still exposed to the risk of harm.

People were not adequately protected from the risk of developing a pressure ulcer. Equipment in place to reduce the risk of pressure ulcers was not always used effectively. Records showed that one person had developed a grade two pressure ulcer. A specialist mattress was in place to reduce the risk of further skin damage and promote healing, however we found that the mattress was not set to a level appropriate to the person's weight. This resulted in the mattress being too firm and would have reduced its efficiency in preventing further skin damage. In addition to this we found two further examples where there was a risk that pressure mattresses may not be set to the correct settings for the person's weight as they had not been weighed recently. This put people at risk of developing pressure ulcers or the deterioration of existing ones.

Guidance to promote the management and healing of pressure ulcers was not always followed. One person had developed a pressure ulcer and their care plan stated that they should be positioned completely off the affected area 'at all times'. During the first day of our inspection we observed that they were positioned on this area on two occasions and records showed that this was regularly the case. Despite raising this with the service manager during our inspection, we found the person was again positioned on this area on the second day of our inspection. This failure to position the person as directed put the person at risk of harm due to further deterioration of the pressure ulcer.

Pressure ulcer risk assessments had not been not completed regularly or to reflect changes in people's needs. Records showed another person had recently developed a pressure ulcer. We reviewed their risk assessment and found that this had not been completed to take account of this change in their skin integrity. This meant we could not be assured that all practicable steps had been taken to reduce the risk of the pressure ulcer worsening.

People could not be assured that risks associated with their health conditions would be managed or responded to appropriately. Care plans did not contain detailed information about the risks associated with people's health conditions and staff we spoke with did not always have adequate knowledge of these risks. For example one person who used the service had a condition which caused them to have seizures. Despite a recent history of seizures, hospital admission and known non-compliance with medicines, there was no seizure risk assessment and their care plan contained basic information about their condition. On the second day of our inspection we observed that the person was resting on their bed, a member of staff informed us that the person was checked by staff approximately every hour. We asked them how staff would know if the person had a seizure in their room and they informed us that they would not know until the next check or if they heard them. This failure to assess and manage risks put the person at risk of physical harm or injury. We spoke with the service manager and deputy manager about the lack seizure risk assessment and control measures and they were unaware of this issue. Following the inspection visit we were informed

that control measures had been put in place to reduce the risk to this person.

People were not adequately protected from the risk of falls. The quality of risk assessment, care planning and recording in relation to falls management was variable and put people at risk of harm. Care plans relating to falls did not always contain sufficiently detailed information for staff about the risks associated with people's care. For example one person had been assessed as being at high risk of falls and had a motion sensor in place to alert staff should they move around in their room. Records showed that the person suffered from regular infections which affected their mobility and could increase the risk of falls. However this had not been included in the falls risk assessment and the person's care plan contained no guidance in relation to signs and symptoms of infection or additional precautions to be taken to reduce the risk of falls should the person have an infection. This placed the person at increased risk of falls and resultant injury.

We found that falls were not always recorded appropriately and were not effectively analysed and investigated to identify any trends or patterns. There had been no investigation into the circumstances surrounding falls since January 2017, including those which had led to serious injury. Records showed that one person had sustained a fracture as the result of a recent fall. No investigation was conducted into this fall and the falls risk assessment was not updated following this fall. Records showed that this person fell again two weeks later, although no injury was sustained we did not see evidence that all practicable steps had been taken to reduce the risk of falls. We saw that some of people had a high number of repeat falls and but evidence of actions taken to reduce the risk of future falls were limited. This lack of action put people at risk of harm as a result of falls.

Safe techniques to assist people to mobilise around the home were not always in place and people were placed at risk of harm due to a lack of risk assessment of and guidance related to safe moving and handling. Although we observed staff using safe techniques to support people to mobilise there were no moving and handling risk assessments in place for people who required support with mobility which placed people at risk of not receiving safe support. This was lack of risk assessments was confirmed by the service manager who informed us that they were aware that work was required in this area.

One person was assisted to transfer using a hoist and sling. Their care plan did not contain a risk assessment or any up to date guidance for staff about how to ensure safe practice, there was also no information related to the equipment used. Although staff we spoke with told us they knew how to assist the person safely this did not provide assurances about the knowledge and skill of all staff at Bowbridge Court. We spoke with this person who told us that staff did not always know how to position them correctly in the sling and this resulted in discomfort. This lack of risk assessment and guidance related to moving and handling put people at risk of harm resulting from poor or unsafe moving and handling techniques.

In addition to this we observed that communal wheelchairs were in use. We spoke with a member of care staff about this who told us that people had wheelchairs they preferred to use but confirmed that wheelchairs are not allocated to specific individuals. Care plans did not contain any information to demonstrate that the suitability of the equipment or the risks of this approach had been considered.

The above risks were exacerbated by the fact that due to recent high staff turnover. Many of the staff team were new or had recently commenced employment at Bowbridge Court and consequently were reliant upon care records and the knowledge of other staff to inform the care and support provided. This increased the risk of people receiving unsafe, inconsistent support that did not meet their needs.

During our last inspection we found that people could not always be assured that they would receive their

medicines as prescribed. During this inspection we found that the required improvements had not been made in this area and we identified multiple areas of concern.

People could not be assured that they would be given their medicines as prescribed. Records showed that two people had not received a pain relieving medicines in line with the prescriber's instructions. One person was prescribed pain relief to be taken every 72 hours, we found two occasions in the two weeks prior to our inspection visit when the medicine was not given at this frequency. We found that another person had not been given their pain relieving medicine as prescribed because they were out of the service. This failure to administer pain relieving medicine at the required frequency put people at risk of unnecessary pain and distress.

When people were prescribed medicines to be taken as and when they required them (known as PRN) there were not always written protocols in place detailing what these medicines had been prescribed for or when they should be taken. This meant that staff did not always have clear information about when to give people these medicines. For example, one person had been prescribed medicines to relieve their anxiety, there were no details of when this medicine should be administered which put the person at risk of suffering unnecessary anxiety and upset.

Medicine records were not always accurately completed. We found a number of occasions where medicines had been signed for but not administered as the medicines remained in the packets. When people were prescribed creams for topical application there were not always clear details of how, where and why these creams should be applied and staff did not always record the application of these creams. We also checked the expected stock levels of medicines and found occasions where these did not match the actual amount in the service. In addition to this, a significant number of medicines had not been booked in correctly when they entered the service. This made it difficult to check and audit medicines. All of the above issues increased the risk that people may not be given their medicines as prescribed.

People could not be assured that medicines were managed or stored safely. Medicines were not always well organised and we found more than one box of the same medicine in use. This increased the potential of a medicine error. Medicines were not always dated when opened. This meant it was not possible to determine whether the medicine was being used within the manufacturers recommended shelf life. In addition to this people could not be assured that medicines were stored within the recommended temperature range for safe medicine storage. Neither the temperature of the medicines fridge or room had been regularly monitored since February 2017. This posed a risk that variations in temperature may not be detected which could have had an impact on the efficiency of medicines.

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

Feedback from people who used the service about medicines was variable. Some people we spoke with told us that they received their medicines as prescribed. However other people told us that had been occasions where their medicines had run out and times when they had been given their medicines late. One person told us, "You get it (medicine) on time more or less," whereas another person commented, "Sometimes it (medicine) is late, (it) can vary, can be up to an hour late at night time." We observed that the morning medicines round was still being carried out after 11am as the staff member was subject to regular interruptions. The manager told us that any time specific medicines were administered by the night staff before they finished work so that this did not impact on administration of medicines later in the day.

During our previous inspection we found that people were put at risk as the systems and processes in place

to safeguard people from harm were not always followed. During this inspection we found improvements had not been made in this area and this placed people at risk of harm.

Steps had not been taken to safeguard people from the risk of harm or abuse. Although the staff we spoke with told us that they understood how to report safeguarding concerns and felt able to speak with the management team about this we found that in practice the correct processes were not always followed. Repeated physical altercations between people who used service had been documented on behaviour records, however the manager was not aware of these incidents and action had not been taken to prevent the likelihood of recurrence and safeguard people from harm.

Prior to inspection we were notified of a recent incident between two people who used the service which had been referred to the local authority safeguarding adults team. This incident had resulted in physical injury and consequent hospital admission. Despite this known risk, during our inspection visit we saw four records of recent physical altercations between one of the above people and others who used the service. No action had been taken to investigate the incidents or report them to them to the local authority safeguarding adult's team. We also observed that the person's support plan did not contain clear guidance for staff on how to support the person to safeguard them and others. This lack of action exposed people to the risk of physical harm.

People could not be assured that they would be supported in the least restrictive way possible. We were informed by the service manager that no physical interventions were used in the care and support of people at Bowbridge Court. However two members of staff told us that they used a form of restrictive physical intervention whilst supporting a person with their personal care. The members of staff explained that this was to prevent injury to the person and others. There was no care plan related to the person's resistance to personal care nor did it contain any instruction that staff should use physical intervention to support the person. The use of physical intervention placed the person at risk of harm as a consequence of potentially unsafe practices and did not respect their rights to be supported in the least restrictive way possible.

The above information was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider informed us that physical inventions were no longer being used to support anyone at Bowbridge Court.

Despite the above people we spoke with told us they felt safe living at Bowbridge Court. One person said, "I am very safe here." Another person told us, "Yes I feel safe here, especially at night, there is always someone about."

People could not be assured that good hygiene practices were followed. Although we found that on the whole the environment was clean and hygienic, effective cleaning procedures were not in place for some items of equipment used in people's care and support. We observed staff using communal wheel chairs with communal pressure cushions during our inspection visit. A member of the housekeeping team informed us that although it was their responsibility to clean the pressure cushions this was done on an ad hoc basis, they went on to tell us that the cushions were 'not cleaned every day'. This meant that these communal pressure cushions were not routinely cleaned between different people using them. This was an unhygienic practice which meant that people were potentially using equipment which was not clean.

We also observed that some equipment such as hoists and wheelchairs were sticky and dusty. A member of the housekeeping team informed us that care staff were responsible for cleaning this equipment. However

this system was not effective in ensuring its cleanliness. These practices did not ensure the service was sufficiently clean.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
During our August 2016 inspection we found that people could not always be assured that there were enough staff to meet their needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that whilst improvements had been made to staffing levels, people who used the service still provided mixed feedback in this area. One person told us, "There's not enough staff, they're kind and thoughtful but they get tired out." Another person told us, "There's not enough staff - they're rushing about all the time." The relative of third person told us, "There's not enough staff, they're under pressure. There's not enough time for staff to give [relation] one to one care." Despite this feedback we did not find any evidence to suggest that staffing levels had an adverse impact on the safety of the service.

The service manager told us that they had flexibility in their staffing levels and could increase this based upon the number of people using the service and the complexity of their support needs. Staff we spoke with told us that the service was staffed to the level determined by the provider and that any last minute absences were normally covered by the staff team. During our inspection visit we observed that staff were generally able to respond to people's needs in a timely manner. The staff we spoke with felt that the staffing levels were sufficient and enabled them to spend time chatting with people who used the service and facilitating group and one to one activities.

The management team were open about recent high staff turnover which had resulted in vacancies in team. As a result temporary agency staff were being used on a regular basis. Some people who used the service expressed dissatisfaction with the use of agency staff. One person told us, "I don't like the way the agency staff speak sometimes it's not very nice". We discussed this with the service manager who told us that they had been made aware of some issues with agency staff and had taken action to deal with this.

During our August 2016 inspection we found that people could not be assured that safe recruitment practices were always followed. During this inspection we found that although some improvements had been made further improvements were still required.

Safe recruitment processes were still not always followed. A standard interview assessment form was completed and we saw that detailed notes were taken by the interviewer. However, no scoring of the candidate's answers had been carried out and there was no written confirmation of their suitability for the role. References from previous employers had not always been taken prior to new staff starting work. The manager had audited staff files and taken action retrospectively to obtain such references. In addition, we could not be sure that criminal records checks had been obtained prior to new staff starting work because the relevant records were not fully completed. This placed people at risk of being supported by unsuitable staff.

People were protected from risks associated with the environment. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire risk and legionella, and control measures were in place to reduce these risks. The service manager had identified some gaps in staff knowledge in relation to fire procedures and had taken action to arrange training.

Inadequate

Is the service effective?

Our findings

In our August 2016 inspection we found a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's rights under the Mental Capacity Act were not respected. We asked the provider to make improvements but during this inspection found that the required improvements had not been made.

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. We checked whether the service was working within the principles of the MCA.

People's rights under the Mental Capacity Act (2005) (MCA) were not protected as the principles of the act were not correctly applied. Mental capacity assessments and best interest decisions were not always in place as required and where mental capacity assessments were in place many were not sufficiently detailed or decision specific. For example, one person was not able to consent to the content of their care plan and other aspects of their care and treatment. Despite this there were no mental capacity assessments or best interests decisions in place related to any aspect of their care and support and there was limited information in their care plan about how to support them with decision making and choice. This approach did not respect people's rights under the MCA. The service manager when asked about capacity assessments acknowledged that many assessments were not in place as required and further work was needed.

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

Some people were being deprived of their liberty without the necessary application to the local authority having been made. For example, one person, who lacked the capacity to consent to their care, had significant restrictions on their freedom of movement including physical restraint imposed by staff for the purposes of personal care. They also had their freedom restricted as they were not free to leave the home unescorted were under the continuous supervision of staff. Despite this there were no mental capacity assessments in place and no application had been made to authorise these restrictions on the person. We reviewed this person's care plan and found that key sections such as DoLS and memory and understanding sections were blank as was a consent form. This failure to properly apply the principles of the MCA did not respect people's rights.

Where people had DoLS in place the management and staff team did not have a knowledge of conditions imposed to ensure their wellbeing. Consequently we found that these conditions were not being met. For example a DoLS had been granted for one person in November 2016. The condition stated that the person should be supported to practice their religious beliefs if they wished. There was no reference to this in the

person's care plan and two members of staff we spoke with were unaware of the person's religious needs. The service manager also confirmed that they were not aware of any conditions on people's DoLS authorisations. This did not respect people's rights and did not ensure that people were supported in the least restrictive way possible.

The approach to making and managing DoLS applications was incomplete. We saw a record of DoLS applications made, however this did not contain the most up to date information. A number of DoLS had recently been authorised however the service manager informed us that they had not yet had the opportunity to look at these applications. This posed a risk that unnecessary restrictions may have been imposed upon people without the required authorisations and did not respect their human rights.

Staff had a variable knowledge of the MCA and but on the whole were able to describe how the act applied in their role. Staff did not have an understanding of DoLS and were not aware if anyone had a DoLS in place, one member of staff told us, "Yes I think most people are on a DoLS." This was not the case as a significant number of people living at Bowbridge Court had capacity to make decisions.

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

Where people had capacity we observed staff supporting people to make choices and decisions and staff gained their consent before providing care and support.

People received care and support from staff who did not always have the skills and qualifications necessary to support them safely. This was reflected in the comments made by people living at Bowbridge Court and their relatives. One person told us, "Some (staff) know what they're doing, some don't." Another person told us, "(Some staff) don't always know what they're doing. They can be a bit idle. They need a bit more supervision." Whilst some staff had up to date training in areas such as the MCA, dementia awareness and equality and diversity this was not always the case. Records showed that 16 staff had no recent training in safeguarding and we observed that this lack of knowledge or failure to effectively apply their knowledge had an impact on people who used the service. For example during our inspection visit we observed records of incidents of a safeguarding nature. However, staff had not identified the need to share this information with the management team and consequently no referrals had been made to the local authority safeguarding adult's team.

Staff told us they had not been provided with training in relation to specific health conditions that people lived with and we found not all staff had an understanding of these conditions. The staff we spoke with could not always demonstrate how they would respond should a person present symptoms relating to their healthcare conditions. We spoke with two members of staff about health conditions that people had and both had very limited knowledge of signs and symptoms that would show a person's health may be deteriorating.

Training was not provided on an on-going basis to ensure that staff's skills and knowledge remained up to date. The service manager informed us that new staff received a two week taught induction period, however following this there was little ongoing training. This was supported by training records which showed that many staff did not have any, or up to date, training across a number of areas. For example, four staff did not have records of any training and a further four staff did not have up to date training as the training matrix showed that all, or most of their training had expired. Furthermore staff did not receive any training in the care planning and risk assessment processes in use at Bowbridge Court. We saw that this had resulted in poor quality care plans and inaccurate and incomplete risk assessments.

The service manager told us that staff did not currently complete the Care Certificate. The Care Certificate is a set of national standards for staff working in health and social care to follow and equip them with the knowledge and skills to provide safe, compassionate care and support.

The above insufficiencies in staff training, knowledge and skill placed people at risk of not having their needs met appropriately or safely. We spoke with the service manager about this who informed us that they had identified issues with ongoing training for staff and were planning to improve this.

Although staff told us that they felt supported and could go to the manager for support, they did not receive regular supervision or appraisal of their work. This meant that staff were not given regular formal opportunities to access support and opportunities for staff to reflect on their practice and share any concerns may be missed. This was of particular concern given the gaps in staff training and knowledge. The service manager was aware of this but told us that they had not yet had time to prioritise this.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of unplanned weight loss. Although we saw that most people who used the service were weighed regularly to identify any unplanned fluctuations in their weight this was not the case for all people. We observed the care records of three people where it had been recorded that staff were 'unable to weigh' them. One of these people's care plan's showed that they were at high risk of malnutrition, however they had not been weighed since October 2016 at which point a very low weight had been recorded. It was not clear what alternative methods had been considered to monitor the person's weight. This meant that staff may not identify weight loss and put the person at risk of unplanned weight loss and malnutrition.

Despite the above the majority of other care plans contained information about what support people needed with nutrition and people's weight and BMI were assessed regularly. We saw that where changes or concerns were noted action was taken. For example one person's appetite had decreased, this had been identified by the staff team and they were monitoring the person's weight and food intake and had contacted the GP to request specialist support.

People could not be assured that they would receive effective support in relation to their health. Where people had specific health conditions we found that care plans did not consistently contain adequate detail in relation to people's health needs. Whilst some people's care plans contained some information about health conditions other plans contained very limited or contradictory information. For example, an assessment conducted prior to a person moving into Bowbridge Court stated that they had a particular health condition, however their care plan did not contain any further information about this condition. We also found that staff knowledge of specific health conditions was limited. This placed people at risk of not receiving the support they required.

In spite of the above, records showed that people were supported to attend appointments and access healthcare. People we spoke with all told us that staff would notice if they were unwell and would call the doctor if needed. The relative of one person told us, "They (staff) notice if she is unwell) the other morning they couldn't get her out of bed so they called the doctor." The outcomes of appointments with professionals including GP's, dieticians and specialist nurses were recorded in people's care plans. Staff made contact with relevant healthcare professionals when people's needs changed. For example, staff were concerned that one person was struggling to chew and swallow their food and had contacted the Speech and Language Therapy (SALT) team for advice. Guidance provided was in the person's care plan and being

followed in practice. Another member of staff described a recent situation where they had taken action to summoned emergency support in relation to a change in a person's health needs.

Most people were positive about the food at Bowbridge Court and told us that they were given a choice of food and drink. One person told us, "The food is very good, there's always an alternative choice and your relative can eat with you as well. There's usually afternoon cake and you can help yourself." Another person told us, "The food is nourishing and there are choices, tea is available all the time. I like to eat in my room." During our visit we observed meal times on all three floors. Most people appeared to enjoy their food. One person did not want what they had chosen and staff respected this and offered the person an alternative. People were offered drinks and snacks throughout the day. When people required specialist diets these were provided and the kitchen staff had clear information about people's dietary needs.

Requires Improvement

Is the service caring?

Our findings

People could not be assured that they would be provided with consistently kind and caring support. Feedback from people who used the service about the caring approach of staff team was variable. Most people commented positively on the staff and told us that on the whole they were kind and caring. One person told us "I think the staff do a marvellous job," another person said, "The staff are kind. Yes I think they know me. This is a good place." The relative of a third person told us, "I'm pleased with the carers [relation] has." However, two people commented that that the approach of the staff team was not consistent. One person told us, "Some of them (staff) don't understand, don't give people enough time and can be a bit abrupt." Another person commented, "It all depends on the carers, some good, some bad, some treat you as a thing, not a person. The staff I am close to know me, we have a routine."

A number of people commented that the care they experienced was affected by how busy staff were. One person told us, "The staff are kind mostly, they can get a bit stressed when busy." This was echoed by the relative of another person who told us, "There is an issue of time, I wish they could do more one to one care." A further two people told us that this affected communication with staff. One person said, "Staff listen to me if they have time," and another person said, "Yes I can talk to staff but I don't if I can help it, I don't want to take their time up."

During our visit staff treated people with warmth and kindness, they were polite and friendly and we observed examples of positive interactions. We observed staff took the time to sit and chat with people and shared mealtimes with people who lived at Bowbridge Court. The staff we spoke with told us that they enjoyed working at the home and 'putting a smile on people's faces.' One member of staff told us, "I feel very proud of the care that we are able to give people, seeing people happy and relaxed." We observed staff encouraging and supporting people, taking their time and working at people's own pace. We saw one person being supported to move using a hoist, the staff members were gentle and reassuring and the person appeared calm and relaxed throughout.

The people we spoke with felt they had developed positive relationships with some of the staff at Bowbridge Court. One person said, "The staff are lovely, we all get on well" and another person told us, "I do feel good with them (staff)." During our inspection visit we observed that staff knew people well and understood the best ways to approach different people. One person enjoyed singing and staff acted spontaneously to sing along with the person, which they enjoyed. However, some people commented that high turnover in the staff team made it difficult to get to know staff and form relationships with them. For example one person told us, "I don't know who they (staff) are because they change all the time." Another person told us, "Most of them know me well by now after all this time, but we have had so many changes, at one point I knew all their names, now I don't." We spoke with the service manager about recent changes in the staff team who informed us that they were passionate about supporting and developing the staff team to prevent further changes.

People were not always offered the opportunity to be involved in the planning or reviewing of their care plans. The care plans we looked at did not contain evidence that people or families had been involved in

decision making. This was confirmed by people we spoke with, one person told us, "Did I see my care plan? No I just slotted in." The relative of another person told us they had not been involved developing their care plan, but told us that if they wanted to see their loved one's care plan they could do so. We discussed this with the service manager who told us that they were planning work to increase people's involvement in care planning.

Despite having limited involvement in care planning people told us that they felt involved in day to day decisions about their support and this was reflected in people's comments. One person told us, "Yes there are choices, they (staff) will say now what do you want to do? Do you want to get out of bed?" During our visit we saw that staff routinely checked with people about their preferences for care and support, people were offered choices about how and where they spent their time, what they ate and their involvement in activities. For example, a film was shown during the afternoon and everybody was offered the opportunity to watch. If somebody declined then staff respected their decision.

People could not always be assured that they would receive support that was based upon their individual needs and preferences. Although most care plans contained information about people's personal history, interests and hobbies we found that the quality and quantity of this information was variable. Whilst we observed that some staff used information about people's histories to inform their conversations with people who used the service, the varying levels of information in care plans put people at risk of inconsistent support in this area.

Where specific social needs had been identified action had not always been taken to ensure people had these needs met. For example, one person's social needs had been identified in a recent Deprivation of Liberty Safeguards (DoLS) authorisation. This specified that action must be taken to promote the person's individual interests and record the person's engagement with this. The person's care plan contained no reference to their hobbies and interests and we spoke with a member of staff who told us that although they were aware of the person's specific interests and spoke to them about this sometimes there were no other measures in place to enable the person to pursue their interests.

The quality of information of care plans about how people communicated and how staff should communicate with them was variable. Although our observations during our inspection visit demonstrated that staff had an understanding of people's communication needs. The lack of information in care plans meant there was a risk that people may not receive the support they required in this area. Some of the systems in the home did not promote effective communication. For example information about planned meals was displayed around the service in a pictorial format in an attempt to communicate this to people, however we saw that this information was sometimes incomplete.

Staff encouraged people to maintain as much independence as possible. One person told us, "When I came out of hospital, one member of staff really helped me walk again by putting a
chair behind me and encouraging me to walk to the dining room and back again." We observed several people who enjoyed walking around the home or helping to wash the dishes and were able to do so with the support of staff.

People we spoke with told us that staff respected their right to privacy. One person said, "They respect my privacy and dignity." The staff we spoke with were able to describe how they respected people's privacy and dignity. One staff member said, "This is their home. Their bedroom is their own private space." We observed that staff treated people in a respectful manner and assisted people to return to their bedrooms if they wished to do so. There were no restrictions on when people's friends and relatives could visit them and there were a number of small quiet lounges in the home which gave people the option of more privacy when

their friends and families visited.

Staff respected people's right to confidentiality. Conversations about people's support needs were held in areas that could not be overheard and care records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

During our August 2016 inspection we found that people were at risk of inconsistent support as care plans were not always accurate or up to date. During this inspection we found that improvements had not been made to care plans. Consequently there was an ongoing risk that people may not receive responsive care and support.

People could not be assured that they would receive the support they required as care plans did not contain sufficient guidance for staff. For example, one person's care plan noted that they could become anxious, but the only guidance provided to staff was to 'offer support' to the person. It did not detail what support was appropriate for this person. The person had also been prescribed a medicine which can alleviate anxiety to be administered as required, only if other techniques had not succeeded. In addition, there was no protocol available to staff to help them understand when it would be appropriate to administer the medicine. The lack of guidance for staff meant there was a risk of over-reliance on medicines to reduce their anxiety.

Care plans relating to people's health needs did not always contain an adequate level of detail to ensure support was responsive to their needs. For example one person had a history of repeated infections, however their care plan did not contain any information about the impact of this or guidance about how best to support the person. This lack of information posed a risk that staff may not identify deterioration in people's health needs.

Some people who used the service sometimes communicated through behaviour which others may find challenging. Care plans did not clearly detail how staff should respond to support these people and minimise the impact on others. Whilst staff responded appropriately to people throughout our visit the lack of guidance for staff put people at risk of receiving inconsistent support.

Although care plans had been marked as having been reviewed monthly we found that plans were not updated in response to people's changing needs. For example, one person's support needs had changed but their care plan had not been amended to reflect this, their care plan stated that the person was independent when accessing the toilet, however it did not reflect the need for close monitoring due to a high risk of falls.

Some care plans were very basic and lacked detail and guidance for staff. For example one person's care plan had no information contained in the 'sleep and rest' section; however they had been assessed as being at high risk of falls and we observed that they had a motion sensor in their room to alert staff to any movements to try and reduce this risk. This was not referred to in their care plan which meant there was a risk that they may not receive the support they required. We observed that another person spent the majority of their time in their bedroom due to their limited mobility and support needs. This meant that their social interaction was limited and restricted to when staff went into their room. Their care plan relating to social interaction and activities directed staff to talk about their hobbies and encourage the person to talk about them. However, there was no detail provided about what hobbies the person had. This meant that there was a risk the person's social needs may not be met.

The above inadequacies in care planning meant that staff did not always have access to information about how to support people safely and effectively and this put people at risk of receiving inconsistent, unsafe support. These risks were increased due to the high number of recently recruited care staff at Bowbridge Court. The service manager told us they and the provider were aware of the shortfalls in care planning and told us that improvements were planned, but this work had not yet started.

Comments from some people who used the service reflected the above concerns about inconsistencies in the care provided at Bowbridge Court. One person told us, "New staff make it up as they go along, they don't know me." The relative of another person told us, "[Relation] does not always have their teeth removed or their hearing aid removed at night. [Relation] is sometimes in other people's clothes." In contrast other people gave positive feedback about the support provided and told us that they had the freedom to do as they wished and felt well cared for. One person said, "I can do a lot for myself, but I know staff are there when I need them." The staff we spoke with told us that they found care plans to be helpful and detailed. They also felt that they would be informed during the shift handover of any pertinent pieces of information about people.

People were enabled to take part in social activities. People told us that there were a variety of activities on offer and they had enough to do. The provider employed a regional activities coordinator who visited the service regularly and arranged a programme of activities. There were posters throughout the service which advertised planned activities such as singers, cinema evenings, chair aerobics and other events. During our inspection visit we observed people enjoying both group and individual activities, such as watching a film and a sensory activity. Staff were clear about their role in facilitating activities on days when the activities coordinator was not in the service and there was a weekly timetable of group activities on offer. We saw that staff were proactive in initiating one to one activities with people, when they had time, such as doing jigsaws, reading with people and chatting. One member of staff told us, "A lot of people decline to take part in activities but will take part with encouragement. We try to think of different things for people."

People were supported to maintain relationships with family and friends. During our visit we saw people's relatives and friends visiting. People spent time together in communal areas and appeared to feel comfortable and relaxed.

People were supported to raise issues and concerns and there were systems in place to respond to complaints. People told us that they felt able to make a complaint, knew how to do so and were confident that any concerns would be taken seriously. One person said, "If I have got any concerns I know I can always go to the senior carer." We looked at the records of complaints received since the previous inspection. The majority of complaints had been investigated in a timely manner and a face to face meeting was offered to the complainant. A response letter was then sent which aimed to address each aspect of the complaint. However, we found a small number of complaints where the outcome was not recorded and it was not always clear if any further follow up actions were required to reduce the likelihood of similar complaints happening again. We discussed this with the service manager who informed us that action would be taken to ensure proper recording of future complaints.

Inadequate

Is the service well-led?

Our findings

During our August 2016 we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure the safe and effective running of the home. During this inspection we found that improvements had not been made in this area and people who used the service remained at risk of receiving unsafe support that did not meet their needs due to a lack of robust systems and processes.

There had been a failure to act on the concerns resulting from our last inspection. Actions planned to address concerns raised as a result of our August 2016 inspection had not been completed and very few improvements had been made. The provider submitted an action plan to us in September 2016 in response to the concerns we identified during our last inspection. This had been developed by a number of senior managers employed by the provider and stated that all actions planned to improve the quality and safety of the service would be completed by the end of October 2016. For example the plan stated that action would be taken to ensure that 'safeguarding referrals were made and notifications submitted to CQC.' During our inspection we found that this had not been completed and there was still a failure to make referrals to the safeguarding team and make notifications to us. Actions related to care planning, risk assessment, accidents and incidents, training, medication, the Mental Capacity Act 2005 and governance and leadership had also not been achieved. This ongoing lack of effective leadership and governance at Bowbridge Court had resulted in negative outcomes for people who used the service.

The systems and processes in place to identify, address and manage risks to the health, safety and welfare of the people who used the service were not effective. It is of significant concern that a number of serious risks to the health and safety of people living at Bowbridge Court had not been identified prior to our inspection. Despite audits having been conducted by the service manager and provider a number of the issues of concern that were found during our inspection had not previously been identified. Consequently no action had been taken to safeguard people from harm. This demonstrated the ineffectiveness of the governance and oversight processes in place at Bowbridge Court. The failure to identify risks associated with people's care and support and issues such as the use of physical interventions put people at unnecessary risk of harm.

Although there were systems in place to audit medicines management these had not been effective in bringing about change. Medicines management was audited as part of the providers monthly quality assessment visit. The most recent of these audits had been effective in identifying some of the above issues, but had not been effective in bringing about improvement.

There was no effective system in place for analysing, investigating and learning from accidents and incidents across the service. Trends of accidents and incidents, such as the location or timing, were recorded but no analysis had been completed. Furthermore, records showed that no incident investigations had been conducted since the end of January 2017. Records showed that two people had sustained fractures in this period but no investigation had been undertaken into either incident. This failure to prioritise the analysis of accidents and incidents meant that opportunities may have been missed to identify ways of preventing

future incidents. This exposed service users to the unnecessary risk of potential harm and injury. We spoke with the service manager about this who informed us that they were aware of the need for analysis of accidents and incidents. However they had not been able to undertake this work due to competing demands upon their time.

Where investigations had been undertaken the findings of these had not been used to make improvement to the quality of the service. For example, an incident investigation conducted in November 2016 had identified that staff required training in diabetes. However we found that no action had been taken to address this and staff still had no training in diabetes. In addition we spoke with the relative of one person who told us that they felt they had not been fully informed about the circumstances of a recent incident involving their relation.

There were insufficient processes in place to ensure that adequate assessments were undertaken when people moved into Bowbridge Court and this put people at risk of harm. One person had moved into the home at the end of December 2016, the assessment completed prior to this was very basic and contained contradictory information. We also reviewed their care plan and found it had not been put in place until April 2017. This meant that staff did not have enough information to inform the care and support provided to this person for a period of over three months. Other care plans we reviewed were also very basic and lacked meaningful detail to inform the support provided by staff. For example behaviour charts related to another person showed that they sometimes behaved in a way that put other people at risk. There was no detail of this in their care plan. This failure to ensure that staff had access to accurate and up to date information about the people they were supporting put people living at Bowbridge Court at risk of receiving inconsistent and unsafe support.

The provider had failed to ensure adequate management cover at the service during periods of high staff vacancies and this had led to some management tasks not being completed. During our inspection the service manager informed us that a number of the management team had recently left or changed roles. This included the two deputy managers, the kitchen manager and the front of house manager, these vacancies had an impact on the capacity of the service manager. For example, on the second day of our inspection there was no front of house manager, which meant that the service manager had to cover aspects this role as well as their own. We found that this had also resulted in action having not been taken in response to known issues. Although the service manager was aware of some issues identified during inspection, such as the lack of moving and handling risk assessments, they informed us that they had not had the capacity to take action on this. This failure to take action had exposed people to the risk of harm.

Furthermore during periods where there was reduced management cover at Bowbridge Court additional resources had not been made available to ensure continued quality of care. We reviewed complaints records relating to a period of reduced management cover and found that there was a very significant increase in complaints for this period. A total of 13 complaints were made by people who used the service or their relatives during this period, all of which related to the quality of care or communication and leadership.

There were limited opportunities for staff to meet to discuss the operation of the service. Records showed that there had only been one staff meeting in the six months prior to our inspection and staff did not have regular supervision. This was of particular concern as we found that staff did not always have a clear understanding of what was expected of them and this had a negative impact on the quality of the service. For example we found that staff did not report incidents between people who used the service and staff were not aware of their responsibility to ensure the correct setting of pressure relief mattresses and consequently no action had been taken to rectify these issues. Had effective methods for communicating

and sharing information with staff been in place these issues may have been avoidable.

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

During our last inspection we found that the provider had failed to notify us of some events within the service, which they are required to by law. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. During this inspection we again found that the provider had not always notified us of incidents in the service. There had been a failure to notify us of some safeguarding incidents and serious injuries sustained by people who used the service. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.
This was an ongoing breach of regulation 18 of the Care Quality Commission (Registration) Regulations) 2009.
Bowbridge Court is required to have a registered manager in post as a condition of their registration. There was no registered manager in post at the time of the inspection and our records showed that the service had been without a registered manager since October 2016. There was a service manager in place during our inspection who had taken over responsibility for the day to day running of the service in November 2016. They informed us that they would be submitting an application to register as manager for the service. We will monitor this.

There were limited opportunities for people who used the service and their families to get involved in the development and running of the service. We saw records of recent meetings held for people living at the home and saw that these were run by the provider's activity coordinator and consequently focused on activities and events. People were not given formal opportunities to discuss other areas such as concerns, complaints or the general running of the home. The service manager told us that they had identified this as an area for development and planned to attend future meetings. Despite the lack of formal opportunities to contribute to the running of the service most people and their families told us they would feel comfortable approaching staff or the management team with any concerns. The relative of one person told us that they felt that communication about changes within the home, such as being informed about changes in the staff team, could be improved. We shared this feedback with the service manager who was receptive and informed us that they would take action to address this.
A number of people we spoke with raised concerns about the recent high turnover of staff at the home and told us that they found this unsettling. One person told us, "Because staff change all the time this make you feel like the place is not properly run and you feel afraid it could deteriorate." We discussed this with the service manager who told us that they were working on ways to value and support the staff team to improve retention.
Despite the concerns identified during our inspection visit people we spoke with told us they were, on the whole, happy living at Bowbridge Court and said that they felt the home was welcoming and homely. Staff also told us that they were happy working at Bowbridge Court and felt supported by the management team. The staff we spoke with told us that the atmosphere and culture of the service had improved under the leadership of the manager. One member of staff told us, "Things have settled down a lot and it has become a better place to work. It has meant that we can focus more on residents." Staff were aware of their duty to report any concerns to the management team and told us that they were able to approach the manager at any time and felt able to 'hold their hand up' if they made a mistake.
Throughout our time at Bowbridge Court the management team were open, honest and receptive to feedback. Following our inspection the provider took swift action to develop an action plan based upon the most significant issues we found.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of incidents in the service. Regulation 18 (1) (2) (b) (e)

The enforcement action we took:

We imposed conditions on the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people were unable to consent to their care and treatment their rights under the Mental Capacity Act 2005 were not protected. Regulation 11 (1) (2) (3)

The enforcement action we took:

We imposed conditions on the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from risks associated with their care and support. Medicines were not stored or managed safely. Regulation 12 (1) (2) (a) (b) (e) (g)

The enforcement action we took:

We imposed conditions on the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

People were not protected from the use of restrictive physical interventions. Action was not taken to protect people from the risk of harm and abuse.

Regulation 13 (1) (2) (3) (4) (b)

The enforcement action we took:

We imposed conditions on the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Equipment used by the service provider was not always clean. Regulation 15 (1) (a)

The enforcement action we took:

We imposed conditions on the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were not effective and timely action was not taken in response to known issues. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

We imposed conditions on the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs. Regulation 18 (1) (2) (a)

The enforcement action we took:

We imposed conditions on the registration of this location.