Care UK Community Partnerships Limited

Bowes House

Inspection report

25 Battle Road, Hailsham, East Sussex,
BN27 1DU
Tel: 0333 321 0925
Website: www.careuk.com

Date of inspection visit: 16 & 17 March 2015
Date of publication: 06/05/2015

Ratings

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

Overall summary

We inspected Bowes House on the 16 and 17 March 2015. Bowes House provides accommodation and nursing care for up to 90 people, who have nursing needs, including poor mobility, diabetes, as well as those living in various stages of dementia. The home also had a contract with the CCG (Clinical Commissioning Group) to provide rehabilitation for people, for up to 12 weeks. Either to prevent a hospital admission or for people to receive rehabilitation before going home from hospital. There were 67 people living at the home on the days of our inspections.

The home was adapted to provide a safe environment for people living there. Bathrooms were specially designed and doors were wide enough so people who were in wheelchairs could move freely around the building. Accommodation was provided over two floors and split into four units. The units included Aylesham (Elderly Residential), Weald (Nursing care), Barley (Dementia care) and Meadow (Rehabilitation and End of Life care). Local school children were involved in the naming of each unit.

Bowes House belongs to the large corporate organisation called Care UK. Care UK provides nursing care all over England and has several nursing homes within the local area.

A manager was in post but they were not the registered manager. A registered manager is a person who has

Summary of findings

registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The manager had been in post nearly six months but had not yet submitted an application to the CQC.

People's needs had been assessed and individual care plans devised and developed. However care plans were often contradictory and did not provide clear guidance for staff. Care plans were not regularly reviewed when changes to people's health and wellbeing had occurred. Documentation also failed to tell us what action had been taken when someone had suffered weight loss. Despite concerns with documentation, we saw that people received the care they required. However, we have identified recording as an area of practice that requires improvement.

Most people spoke highly of the activities and opportunity for social engagement. The provider employed dedicated activities coordinators and throughout the inspection, we observed regular group activities. However, some people commented they were not supported to pursue their individual hobbies and interests. One person told us, "The group activities are not for me." We have identified this as an area of practice that requires improvement.

Medicines were stored safely and in line with legal requirements. People received their medicines on time; however, consideration had not been given as to whether people could be supported to regain their independence with their medicine regime. Pain assessments were not consistently completed. Therefore, there were no formal systems or mechanisms in place to recognise and acknowledge when people were in pain and required pain relief. We have identified this as an area of practice that requires improvement.

Incident and accidents were consistently recorded; however, they were not reviewed on a regular basis to monitor for any emerging trends or patterns. We have identified this as an area of practice that requires improvement.

People were treated with respect and dignity by staff. They were spoken with and supported in a sensitive, respectful and caring manner. People were seen laughing and smiling with staff. Staff understood the importance of monitoring people's health and well-being on a daily basis.

Everyone we spoke with was happy with the food provided and people were supported to eat and drink enough to meet their nutrition and hydration needs.

Staff commented they felt well supported by the unit leaders, registered nurses and deputy manager. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. Training schedules were kept up to date. Plans were in place to promote good practice and develop the knowledge and skills of staff.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Bowes House was not consistently safe. Medicines were stored safely and people confirmed they received their medicines on time, however, staff had not considered whether people could re-gain their independence with their medicine regime or enable people to self-administer medicine. The management of pain also required improvement.

People told us they felt safe living at Bowes House and staff were aware of the measures to keep people safe. Risks to people's safety were identified and methods were put in place to reduce these risks as far as possible.

Recruitment systems were in place to ensure staff were suitable to work with people.

Is the service effective?

Good

Bowes House was effective. Staff received essential training to meet people's needs and had detailed knowledge about people's individual preferences. Staff recognised that people's healthcare needs could change rapidly and mechanisms were in place to maintain people's health and wellbeing.

People, who were able, gave consent to their care. For people who were unable to give consent, the provider complied with the requirements of the Mental Capacity Act 2005 (MCA). The provider knew about the Deprivation of Liberty Safeguards (DoLS) and had made appropriate applications in this respect.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

Is the service caring?

Good

Bowes House was caring. People were supported in a stable and caring environment. The staff promoted an atmosphere which was kind and friendly.

People were treated with kindness and compassion and their dignity respected. Staff members developed good relationships with people using the service, which ensured people received the care they wanted in the way they wanted it.

People's friends and family were welcomed at the home and staff supported and encouraged these relationships.

Summary of findings

Is the service responsive? Bowes House was not consistently responsive. Care plans lacked detailed information on people's past history, hobbies, interests and important memories. Activities were not always meaningful for people. People's psychological needs were not always addressed or reflected in their care plans. People's concerns and complaints were investigated, responded to promptly and used to improve the quality of the service.	**Requires Improvement**
Is the service well-led? Bowes House was not consistently well-led. Care plans did not always contain clear guidance on how best to support the person. Incidents and accidents were not monitored for any emerging trends or themes. The provider had a quality assurance framework in place which included visits from the governance manager. The deputy manager was open and responsive to our concerns and demonstrated a strong commitment to delivering the best possible care and support for people.	**Requires Improvement**

Bowes 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.

We visited the home on the 16 and 17 March 2015. This was an unannounced inspection. The inspection team consisted of four inspectors, a specialist nursing advisor and an expert by experience who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared from the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the Local Authority and Clinical Commissioning Group (CCG) to obtain their views about the care provided in the home. We last inspected Bowes House in January 2014 where we had no concerns.

During the inspection we spoke with 21 people who lived at the home, three visiting relatives, 12 staff members, two registered nurses, the training lead, activities coordinator, housekeeper and the deputy manager. The manager of Bowes House was not present during our inspection. They were attending a training event.

We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounges. Some people with specific physical or psychological needs were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at 21 care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Bowes House. This is when we looked at their care documentation in depth and obtained their views on how they found living at Bowes House. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Bowes House. One person commented, “Absolutely, I feel safer here than I did at home.” Relatives confirmed they felt confident leaving their loved ones in the care of Bowes House. Although people told us they felt safe, we found areas of practice which were not consistently safe.

Medicines were stored safely. People commented they felt confident in staff’s administration of medicines. Throughout the home, dedicated medicine rooms were available which safely stored medicines in lockable trollies. Medicine fridges were maintained and kept at a recommended temperature. Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines and some are more susceptible than others. Documentation confirmed the temperatures of fridges and clinical rooms were checked on a daily basis and were consistently within the recommended limits. We spent time observing the medicine round on each unit. Medicines were given safely and correctly. Whilst administering medicines, staff preserved the dignity and privacy of the individual. For example, staff discreetly asked people sitting in communal areas if they were happy taking their medicines there. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines

Helping people to look after their own medicines is important in enabling people to retain their independence. On the day of the inspection, we were informed that no one was self-administering their medicine. We discussed with people and staff on the rehabilitation unit (Meadow), why people, with the plan to return home were not being supported to manage their own medicine regime. The deputy manager commented that often people were admitted to the rehabilitation unit due to not managing their medicines independently which subsequently caused them to become unwell. However, staff had not given consideration or assessed whether the person may wish to regain their independence with their own medicine regime or whether they could be supported to independently self-administer their medicine. Therefore people were not consistently empowered to be independent with their medicine regime. We have identified this as an area of practice that requires improvement.

Ensuring that people living with pain have the right help and medication to reduce suffering and improve their quality of life. For people living with dementia or communication difficulties, they may not be able to verbalise they are in pain or discomfort. Pain management risk assessments were not consistently completed. Therefore, there was no consistent mechanism in place for the measuring, understanding and assessment of people’s pain levels. For people receiving rehabilitation, we queried how the registered nurses, occupational therapist and physiotherapist were aware of people’s individual pain levels and how that could hinder their rehabilitation programme. The registered nurse commented that pain levels were assessed informally prior to people undertaking rehabilitation exercise. However, this was not formally assessed or documented. The lack of a formal mechanism to assess and measure pain could hinder people’s rehabilitation progress and there was a risk of people experiencing pain not being administered pain relief. We have identified this as an area of practice that requires improvement.

Many people living at Bowes House required the support of an air mattress (inflatable mattress which could protect people from the risk of pressure damage) as they had been assessed as high risk of skin breakdown (pressure ulcers). When receiving care on an air mattress, it is important that the setting of the air mattress matches the person’s weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. We were informed the settings of air mattresses were checked daily, however, there was no recording to confirm it was checked and on the right setting. We checked a sample of air mattresses and found they were on the correct setting for the individual person. However, the failure to record could potentially place people at risk. We have identified this as an area of practice that requires improvement.

People were supported to take everyday risks. We observed people move freely around the home and its secure gardens and patio. People made their own choices about how and where they spent their time. A group of ladies after lunch enjoyed convening in one of the communal lounges for an afternoon of card games. One person told us, “Sometimes I go to the café and cinema, saw a film last week, also had a walk out in the courtyard, and I look forward to doing that more.”

Requires Improvement

Is the service safe?

Staff understood and respected that people should be supported to live independent and autonomous lives whilst living in a care setting. For people living with dementia, Barley unit (dementia unit) had a 1950s kitchen whereby cooking classes were held and people could continue with kitchen tasks (if they so wished) as they would have done at home. Staff recognised that people could place themselves at risk cooking independently (risk of leaving the oven or burning themselves); however, staff also recognised that cooking is integral to some people's identity and well-being. Staff assisted people with kitchen tasks whilst respecting their autonomy.

Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "When people first move to Barley unit (dementia unit), they can be upset, agitated and confused, therefore they can be challenging at times. However, we give them space, explain everything and help them to feel settled." Another member of staff told us, "If a person is challenging, we will try and diffuse the situation, take them away from the situation or if they are challenging towards us, give them space and return later." Information was available in people's care plans on behaviour that challenges along with the actions required to manage the behaviour. For example, one person could become agitated and raise their voice. Guidance within their care plan guided staff to provide one to one activities as lack of stimulation was a trigger for agitation.

Risks to people were assessed and risk assessments devised and implemented. Where people were at risk of choking, risk assessments had been undertaken and plans of action were in place, for example Malnutrition Universal Screening Tools (MUST). Diabetic and pressure sore risk assessments were in place where people were at risk. People had been provided with appropriate equipment which enabled them to move independently and retain their independence. Where people required assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer.

Training schedules confirmed all staff had received manual handling training and staff demonstrated a sound awareness of the measures to safely move someone from a chair to a bed with the aid of a hoist. One member of staff told us how they would check the equipment before using it, check the sling and carefully explain to the person what was happening.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment such as hoists and wheelchairs were stored securely but accessible when needed. Regular checks on lifting equipment and the fire detection system were undertaken to make sure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, staff safety and welfare. However, the provider could not demonstrate they had a business continuity plan in place. A business continuity plan considered what the home would do in the event of a gas failure, severe weather such as snow or a heat wave or the loss of heating. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal evacuation plan. The deputy manager confirmed there was an agreement in place with the local school if people needed to be evacuated to safety. Consideration had been given as to what to do in an emergency, however, a formal continuity plan was not in place. We have identified this as an area of practice that requires improvement.

Staff talked to us about their responsibility to recognise and report any abuse. They were able to give examples of what they considered to be abuse and neglect and told us they would always report any incidents to the manager or deputy manager who would ensure that safeguarding matters were reported to the Care Quality Commission (CQC) and to the safeguarding team at the local authority. Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance.

Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. Staff files contained evidence to show where necessary; staff belonged to the relevant

Requires Improvement

Is the service safe?

professional body. Documentation confirmed that all nurses employed by Bowes House, bank nurses as well all had registration with the nursing midwifery council (NMC) which were up to date.

Good

Is the service effective?

Our findings

People and visiting relatives spoke positively of the home and of staff members. One person told us, "I'm well looked after." Visiting relatives expressed confidence in the skills of staff.

Staff told us they felt supported and received an effective induction which enabled them to provide safe care to people. All new members of staff were provided with a 12 week induction (probation period). This included two weeks shadowing more experienced members of staff and time to read policies and procedures. Staff spoke positively of the induction programme and that it provided them with the skills, expertise and confidence to work unsupervised.

There was a comprehensive training programme available for staff. This included essential training such as mental capacity. Specific training was also available such as dementia awareness, Parkinson's awareness, falls and diabetes management. Training was provided through face to face training sessions and e-learning. The deputy manager told us that staff who had completed e-learning could not be signed off until they had passed the assessment stage and their level of understanding had been assessed.

A dedicated training coordinator was in post whose role included ensuring staff's training was up to date and identifying any further training which would help develop the skills of staff. A training room was available for all staff which included information folders on various topic areas and access to on-line resources. Registered nurses received on-going clinical training which also maintained their continuing professional development. Clinical training included management of pressure ulcers, syringe drivers and catheter care. The deputy manager told us, "We also encourage care staff to attend clinical training such as the prevention of pressure ulcers, as they are also providing vital pressure care."

Staff spoke positively of the training opportunities and felt valued as employees. The provider encouraged staff to progress with their career and staff were offered the opportunities to obtaining a National Vocational Qualification (NVQ). The deputy manager demonstrated a strong understanding of the importance of having a skilled, confident and experienced workforce.

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Unit managers were responsible for the supervisions of staff on their unit. Staff commented that they received supervision on an ad hoc basis. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Although staff did not receive regular supervisions, they found the forums of staff meetings and handovers helpful and provided them with the opportunity to raise any concerns, discuss practice issues and encouraged them to reflect on their own practice. Daily handovers on each unit allowed staff to discuss the change in people's needs or if anyone was unwell. Staff commented they also felt able to approach the deputy manager or unit leaders with any concerns or queries.

People were complimentary about the food and drink. One person told us, "It's all excellent." We spent time observing lunchtime on each unit. Tables were laid out with refreshments available. Napkins and condiments were also available and the cutlery was of a good standard. The atmosphere was calming and relaxing for people. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. For people living with dementia, they were empowered to make decisions on what they preferred to eat. Staff members showed them the options which enabled them to make a choice. Staff members commented on how they also monitored facial expressions to ascertain if the person was enjoying the meal or not. If not, alternative options were offered.

People's care plans included a nutritional assessment to identify those who were at risk of poor nutrition and dehydration. Where a risk had been identified they were referred to the dietician and the Speech and Language Therapist (SALT) for a further assessment. Documentation included recommendations from SALT teams and dieticians. Where a need for a specialist diet had been identified we saw that this was provided. For example some people were on a soft diet due to problems with swallowing. People had individual food and fluid charts which was evaluated at the end of each day to ensure the person ate and drank sufficient amounts. Staff recognised

Good

Is the service effective?

the importance of ensuring people had regular drinks to hand and throughout the inspection we observed staff supporting people to drink and ensuring jugs of fluid were readily available for people to help themselves.

Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. People's ever changing health needs were reviewed and staff encouraged people to be as independent as possible. People with mobility problems were encouraged to stay mobile and to go for regular walks. One person told us in depth how they had progressed from staff supporting them when they went for a walk with their walking aid, to walking independently with a call bell attached so they could summon assistance when required. People felt that staff had a firm understanding of their healthcare needs. One person told us, "I have Parkinson's and staff know what it means and how my symptoms present."

People felt their healthcare needs were managed and maintained. One person told us in depth how despite a recent diagnosis, they had been working with staff to improve their mobility and consequently their quality of life. Staff worked in partnership with external healthcare professionals to promote and maintain people's healthcare needs. Healthcare professionals such as tissue viability nurses, Parkinson's nurses, dementia in-reach team and falls prevention team regularly visited the home providing vital input and advice for staff. People confirmed if they ever felt unwell, the nurse was informed and visited them along with their GP. Visiting relatives confirmed they were kept updated with any changes to their loved ones healthcare needs.

Staff understood the importance of regularly monitoring people's health and wellbeing. Staff recognised that for people living with dementia, they may not be able to communicate if they felt unwell. One staff member told us "We monitor facial expressions, changes in behaviour or if someone is more agitated, it may be a sign they are experiencing a urinary tract infection." Staff were aware that people's healthcare needs could change rapidly. Mechanisms were in place to keep an overview of people's health; this included regular blood pressure checking, temperatures and pulse rating checks.

People who could speak with us commented they felt able to make their own decisions and those decisions were respected by staff. Training schedules confirmed staff had received training on the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) contains five key principles that must be followed when assessing people's capacity to make decisions. Staff were knowledgeable about the requirements of the MCA and told us they gained consent from people before they provided personal care. Staff were able to describe the principles of the MCA. One staff member told us, "It's the best training I've had. I am very aware of the five principles of the MCA. I know about verbal and recorded consent and the same with refusals of care. We record all refusals".

For specific decisions, mental capacity assessments were in place and completed in line with legal requirements. They considered the specific decision and whether the person could understand, weigh up, retain or communicate their decisions. Meetings of best interests were available and documentation confirmed family members were involved in the decision making process.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. On the day of the inspection, four people were subject to a Deprivation of Liberty Safeguard. Information was readily available within their care plan regarding the DoLS and what it meant for the individual. In March 2014, changes were made by a court ruling to the Deprivation Liberty Safeguards (DoLS) and what may now constitute a deprivation of liberty. Bowes House operated a locked door policy. A key code was required to exit the building and to enter and exit Barley unit (dementia unit). Due to this, people could not leave when they so wished, and could be subject to continuous supervision and control. The manager and deputy manager had identified that a further 20 DoLS applications were required as a result of the recent court ruling. Those applications were in the process of being made.

Good

Is the service caring?

Our findings

People commented they felt happy living at Bowes House. One person told us, "I get on well with the care staff, we have a giggle." Another person told us, "I'm happy and well looked after."

The home was calm and relaxed across all units during our inspection. At the entrance to the home, was Lynn's café. Staff informed us this was the hub of the home. Coffee, tea and other refreshments were available along with the daily newspaper as well as fresh cakes and cookies. Throughout the inspection, we saw people gathering at the coffee shop, sitting with relatives, or sitting together, chatting drinking coffee or eating a cake.

Bowes House recognised the companionship pets bring to older people. The house had two guinea pigs and tortoises for people to pet, hold and take care off. Throughout the inspection, the guinea pigs were out in the Lynn's café for people to pet and hold. Alongside this, relatives regularly brought in dogs for people to stroke and the home worked in partnership with a local petting service. Dogs, cats, lambs and other animals were brought to the home for people to hold and pet. People confirmed they enjoyed the companionship the animals brought them and enjoyed having regular animals to the home.

For people living with dementia, a safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. It can also help to make up for impaired memory, learning and reasoning skills. On each person's bedroom door was a memory box which contained photographs of themselves and items of importance. This helped to orient people to their bedrooms. People living with dementia often make use of past experiences from to make sense of the present. Throughout Barley unit (dementia unit), items from the past were around along with 1940s, 1950s and 1960s objects for people to touch and feel. This helped to trigger memories and enhance past skills, hobbies or occupations.

Staff were supportive and caring. Staff showed they were able to communicate with people and understood their needs. They interacted in a meaningful way which people enjoyed and responded to. Staff spoke enthusiastically about people's likes and dislikes. They demonstrated they knew people really well and were important to them. One member of staff told us with compassion how they had built up one person's confidence and together they now went to the local shops which the person really enjoyed.

People were supported to build relationships with each other as well as with staff. Staff had a good understanding of people's social preferences, and encouraged people to spend time with friends they had made at the home. Throughout the inspection we observed groups of people sitting spending time together, talking or playing cards. The deputy manager told us, "It's lovely seeing people make friends and spend time together here."

Staff understood the principles of privacy and dignity. One staff member told us, "Dignity is about respecting people's choices as well as ensuring doors are closed." Privacy and dignity was covered during staff's induction and the provider had policies and resources readily available for staff which provided guidance and advice. Throughout the inspection, people were called by their preferred name. We observed staff knocking on people's doors and waiting before entering. Staff were also observed speaking with people discretely about their personal care needs.

People confirmed staff upheld their privacy and dignity. One person told us, "Carers never enter the room without knocking; they also make sure that the door is closed and, where necessary, close the curtain before any personal care is done." People commented that they were made to feel comfortable at Bowes House and to treat Bowes House as their own home. People's rooms were personalised with their belongings and memorabilia. With pride, people showed us their photographs and items of importance. People commented that staff recognised that their bedroom was their own space and this was respected by staff.

People were supported to maintain their personal and physical appearance. People were dressed in the clothes they preferred and in the way they wanted. Ladies were supported with their make-up (if wished) and jewellery. A hairdresser and chiropodist visited the home on a regular basis along with a manicurist. People commented they enjoyed getting their hair and nails done.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. They were able to say how they wanted to spend their day and what care and support they needed. One person told us,

Good

Is the service caring?

"I'm in charge of my day and what I do." Visiting relatives told us they felt involved in their loved one's care and were kept informed of any changes. Throughout the inspection, we observed staff enquiring about people's comfort and responding promptly if they required any assistance.

Staff recognised that people's religious and cultural needs should not be overlooked. The provider understood that people may not be able to attend services in the community and therefore organised for local church alliance groups to visit the home and provide services for people. Where required and if needed, staff would support people to attend local churches in the area.

Visiting times were flexible and staff confirmed people's relatives and friends were able to visit without restrictions. Throughout the inspection we observed friends and family continually visiting, taking people out and being welcomed by staff. Lynn's café at times was full of people and their relatives enjoying coffee, cakes and interacting with staff.

Requires Improvement

Is the service responsive?

Our findings

Some people spoke highly of the activities and activities coordinators, however, some people felt more support with individual activities was needed. One person told us, "Activities are not specific to me." Care plans lacked personalised information on the person's life history and psychological care needs.

Personalised care planning is at the heart of the health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. Each person had their own care plan. Each section of the care plan was relevant to the person and their needs. Areas covered included mobility, nutrition, daily life, emotional support, continence and personal care. Care plans contained detailed information on the person's current health and social needs and their preferences with how they would like their care to be delivered. For example one person had made it clear they preferred finger foods as they were easier to manage. However, care plans lacked detailed personal information, such as the person's life history. For people living with dementia, life story work can be used to help develop an understanding of a person's past experiences and how they have coped with changes in their life. The lack of personal information on the people's past hobbies, interests and personality traits meant staff lacked vital information on the person and would be unable to engage with the person about their history. From talking to staff it was clear they had spent time getting to know the person, however, this was not reflected in the person's care plan. We have therefore identified this as an area of practice that requires improvement.

Some people spoke highly of the activities provided and the opportunity for social engagement. One person told us, "I think this home is amazing. There are so many activities which are good." However, some people felt the opportunity for one to one activities required improvement.

The home had two full time activities coordinator and one part time activities coordinator. A weekly timetable was displayed throughout the home and activities included coffee mornings, talking books, cinema club, book club and dominoes. Throughout the inspection we observed the activities coordinators regularly interacting with people and undertaking group activities. Group activities were well attended. One afternoon, people were seen interacting and enjoying an ABC challenge (memory game). The activities coordinator spent time encouraging everyone to participate and enjoy the game.

For people living with dementia, a dedicated activities coordinator was employed to provide stimulation and activities specifically for Barley unit (dementia unit). We spent time observing the activities on Barley unit. On both days of the inspection, preparations for St Patrick's Day were being made. People were gathered in the dining room listening to Irish music whilst enjoying making decorations. Staff recognised the importance for social engagement and stimulation for people living with dementia. Staff and the activities coordinator were regularly seen engaging with people and enquiring what they would like to do.

On other units, people's experience of activities and social engagement was not consistently positive. People confirmed there were considerable group activities to join and participate in. However, their individual hobbies and interests were not always encouraged. One person told us in depth how they wanted to continue doing a hobby of theirs, however, this was not encouraged by staff. Another person told us that staff did not make time for one to one activities. A third person commented that activities were not specific to the individual. Meaningful activities and pursuit of individual hobbies and interests can promote people's physical, mental and social wellbeing. There was a consistent focus on group activities within the home rather than individual one to one activities. We have therefore identified this as an area of practice that requires improvement.

We recommend that the service considers the National Institute for Health and Care Excellence quality standard for mental wellbeing of older people in care homes.

Enabling people to maintain and develop their personal identity during and after their move to a care home promotes dignity and has a positive impact on their sense of identity and mental wellbeing. We looked at how Bowes House was responsive to people needs when they moved into the home. People confirmed they felt welcomed and treated as an individual. Staff and deputy manager informed us that the home provided care and support for couples who had moved into the home together.

Requires Improvement

Is the service responsive?

Staff and the deputy manager commented on the psychological impact the move into the care home had been on the couples. For example, the impact of being on different units and the loss of the carer role. However, this information was not reflected in the individuals care plan. Their individual needs had been assessed and consideration had not been given to their care needs as a couple living in a care home. We have therefore identified this as an area of practice that requires improvement.

People and their relatives felt confident in raising any concerns or complaints. One person told us, “I'd happily speak up.” The complaints policy was displayed in the entrance of the home and across the various units. Staff told us they would support people to make a complaint. We looked at the management of complaints and how complaints were dealt with and any learning that had taken place.

The provider had received 12 complaints in the past year. The complaint had been acknowledged and responded to appropriately in a timely manner. Each complaint considered the action taken and the learning to be taken forward. One complaint had resulted in changes to the end of life admission process for new residents.

Requires Improvement

Is the service well-led?

Our findings

People had mixed views regarding the leadership of the home. Some people commented it was well-led whereas commented they didn't know who the manager was. One person told us, "I think the home lacks leadership, the manager is not here enough, they are not visible."

A manager was in post but they were not the registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The manager in post has not yet submitted an application to the CQC.

The manager had been in post for six months and some staff spoke highly of the manager. One member of staff told us, "Very approachable, interested in all staff, puts needs of residents and their families first." However not all staff were aware who the manager was and had not yet met the manager. People and their relatives also had mixed comments about the manager. Some people spoke highly whereas others reflected they needed to know the manager more before being able to comment on whether the home was well-led or not. We have therefore identified this as an area of practice that requires improvement.

Staff spoke highly of the level of teamwork within the individual units. One staff member told us, "We've got a really nice team; we're listened to and supported." However, we found the home operated in four separate units rather than one home. Throughout the inspection, staff members commented on the divisions between each unit. One staff member told us, "The division between units is too rigid. "The deputy manager acknowledged that they had identified the tensions between the various units and measures were being implemented to ease this tension. This included the rotation of all staff across the various units; however, this action had not yet been commenced.

We found concerns with the recording of people's care plans throughout the four units. Within each person's care plan various assessment tools were completed. These include FRASE (falls risk assessment), Barthel (activities of daily living) and CAPE (Clifton Assessment Procedures for the Elderly). However, the information recorded in each assessment was often contradictory. For example, one person's Barthel assessment identified they were fully independent with their continence needs, where as their CAPE assessment stated they required full assistance from staff to meet their continence needs. Another person's care plan stated throughout various levels of need with mobility. One section of their care plan stated they were fully mobile with no support. Another section reflected they required the support of a zimmerframe (mobility aid). Information in care plans was contradictory and did not contain clear guidance on the support needs of the person. Despite information being contradictory in the care plan, we found people received the level of care and support they needed and staff were clear on how to provide safe care.

Where people's level of need had changed, this was not consistently updated in their care plan. One person's care plan stated they were requiring the support of a full body hoist (mobility aid) due to a fracture which meant they were unable to weight bear. Staff confirmed the fracture had now healed and the person was able to weight bear and no longer required the support of a hoist. However, this has not been updated in their care plans. The daily notes for one person reflected they could exhibit behaviour that challenges. Staff could clearly tell us how they managed the behaviour, but this had not been reflected in the person's care plan. Care plans therefore failed to provide sufficient guidance and support.

Documentation also did not consistently reflect the action taken by staff when people had lost weight. We raised concerns regarding one person's weight as they had been continuing to lose weight over a three month period. The deputy manager could clearly tell us the action which was being taken, however, this was not reflected in the person's care plan. We found this was a trend throughout the home. Documentation failed to tell us what happened following the identification of weight loss. From talking to staff it was clear where any risks had been identified, referrals to appropriate healthcare professionals had been made, but this was not always recorded in the person's care plan.

Due to the above concerns we have therefore identified a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. This relates to poor recording keeping.

Requires Improvement

Is the service well-led?

Most people and staff felt staffing levels were sufficient. One member of staff told us, "I think we have enough staff, we're tripping over each other sometimes". Some people commented that at times they didn't feel there was enough staff, but on the whole people commented that they felt safe. One person told us, "Staffing is better now, but was a bit bad at Christmas".

We spent time with the deputy manager and looked at how staffing levels were calculated. The provider used an electronic system called Caresys (Care Home Management Software). We were informed that the intention was, that each person's CAPE assessment which determined their level of need would be entered onto Caresys, which would then determine the number of hours of care that individual required. However, the deputy manager informed us that they were not currently using Caresys for this purpose. Staffing levels were calculated on an informal basis. There was no formal process in place to determine the level of staff required to safely meet people's individual care needs. We have therefore identified this as an area of practice that requires improvement.

Despite a formal system not being used to assess staffing levels, we found staffing numbers were sufficient and did not place people at risk. Call bells were answered in a timely manner. Staff were continually presence throughout the four units and communal areas were never left unattended.

Accidents and incidents were recorded appropriately. Documentation included the unit where the accident/ incident occurred, the date and time, person involved and nature of the injury. However, there was no evidence that incident and accidents were being reviewed on a regular basis to monitor for any emerging trends or themes. The deputy manager commented that they looked at each individual incident and accident but not collectively as a whole to ascertain if there are any patterns or trends. Follow up actions to each incident and accident were also not clear and the deputy manager recognised that clearer recording was required. From speaking to the deputy manager it was clear follow up action had been taken and measures implemented to reduce the risk of any future harm, however, documentation failed to reflect this. We have therefore identified this as an area of practice that requires improvement.

The provider had clear visions and direction for the home. The vision statement included, "We believe that every one of us can make a difference. We see the world from the point of view of our service users and customers. We continually strive for innovation and for new ways to improve the service we offer." This was made available to people when they moved into the home and was displayed throughout the home. Staff were not consistently aware of the values and visions of the home but demonstrated a strong commitment to providing high quality care. One staff member told us, "I'm really happy here and well supported, the training really helps as well." Another staff member told us, "They come in here not walking and go out walking and with a smile on their face."

There were systems and processes in place to consult with people, relatives and staff. The provider sent out a yearly satisfaction survey to people and relatives. This enabled the manager and deputy manager to monitor people's satisfaction with the service provided. Regular staff meetings were held on each unit which provided staff with the forum to air any concerns or raise any discussions. 'Resident meetings and relatives' were held on a regular basis. These provided people and their relatives to discuss any concerns, queries or make any suggestions. Minutes from the last meeting in January 2015 demonstrated that food, staffing levels and activities had been discussed. Mixed had mixed views about the role and purpose of residents meetings. People confirmed they found the forum of 'residents meetings' very helpful.

Systems were in place to identify, assess and manage risks to the health, safety and welfare of the people. These included quality assurance audits and regulatory governance audits by the provider's governance manager. In February 2015, the governance manager had visited Bowes House, looking at the five key lines of enquiry, is the service safe, effective, caring, responsive and well-led. The areas of concern identified throughout the inspection had been identified by the governance manager. An action plan had been implemented with plans to make improvements. The manager and deputy manager were continuing to work towards the action plan and had not yet implemented all actions identified.

Staff and the deputy manager demonstrated a strong commitment to the on-going improvement to providing high quality care. Throughout the inspection, the deputy

Requires Improvement

Is the service well-led?

manager was open and responsive to our concerns. The deputy manager told us, “We have some work to do with our care plans and recording, but we always strive to improve.”

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The deputy manager of the Bowes House had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(c) Regulations 2014 The provider did not maintain accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.