Care Quality Commission

Givecare

Bosworth Court Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 21 and 22 September 2015 and was unannounced. At our last inspection on 18 August 2014 the provider was meeting the regulations.

Bosworth Court Care Home is a registered care service, providing accommodation, nursing and personal care for up to 47 older people. There were 36 people using the service at the time of our inspection. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor.

The service should have a registered manager in post. 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. However at the time of our inspection there was not a registered manager in post. The last registered manager had left the service 12 months ago. The provider was in the process of recruiting to the registered manager's post and interviews were scheduled to be held within a few weeks of our inspection. The acting manager who was in post at the time of our inspection had been covering the role since August 2015.

Summary of findings

Staff had a good understanding of the types of abuse and how they were able to report them. There was a safeguarding policy in place that provided definitions of abuse and the process both internally and externally for reporting for staff to follow.

There were systems in place to ensure that people received their medicines as prescribed, but medicines were not always stored safely to protect people from risks.

Staff had received relevant training to enable them to fulfil their roles. Some staff did not have sufficiently detailed knowledge of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards to help them to care for people in accordance with the legislation. We saw that appropriate referrals had been made to the local authority where people lacked the capacity to consent to restrictions relating to their care.

Staff understood how they were able to ensure that people's privacy and dignity was respected but we observed that this was not always carried out. We observed some positive interactions from staff members towards people and concern for people's well-being. We also heard some remarks and comments from staff that concerned us.

Staff had a good understanding of people's preferences and life histories. We saw that life story booklets were completed but the information was not used to inform people's care plans.

People told us that they felt able to raise any concerns but relatives did not always feel assured that they would be acted upon. We found that complaints that had been received had been investigated and responded to by the service.

We found that records relating to people's personal care and requirements were stored in a communal area and were accessible to anybody within the service.

We found that audits that were in place had failed to identify the inappropriate storage of creams. We saw that records were not being accurately maintained for people.

There were not sufficient staff on duty to meet people's needs. People's requests for assistance were not met as staff were too busy to be able to respond. Inadequate staffing levels had an impact on the care and treatment that people received.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?
The service was not consistently safe.

People's needs were not always met as there were not always enough staff. People received their medicines as prescribed. Medicines were not always stored safely to protect people from risks.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff felt well supported in their roles. People did not always receive appropriate information and aids to enable them to choose their food. Some staff did not have a detailed understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff knew people well and understood their needs but people's needs were not always responded too promptly. We heard staff talking indiscreetly and without regard to people's privacy and dignity. People's privacy and dignity was not always respected.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People and their relatives were involved in plans of care. People told us that they felt able to raise any concerns but relatives did not always feel assured that they would be acted upon. Group activities regularly took place but few individual activities.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Staff felt that the manager was approachable. There was no registered manager in post.

Records did not always provide the information about people's care and they were not all stored securely. Audits had failed to effectively identify some shortfalls.

Requires improvement

Bosworth Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 22 September and was unannounced.

The inspection was carried out by two inspectors, a specialist advisor in nursing care 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, their area of expertise was for older people with dementia.

We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority and health authority, who had funding responsibility for people who were using the service.

We used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed a SOFI observation for four people who used the service.

We spoke with seven people that used the service. We spoke with nine relatives of people using the service either in person during our inspection or by telephone following our visit.

We spoke with a director of the service, the acting manager and the hotel manager about how the service was run. We spoke with two registered nurses, two senior carers, two care workers, two chefs, the activities co-ordinator and the housekeeper about their roles and people's care. We looked at the care records of four people using the service and other documentation about how the home was managed. This included policies and procedures, staff records and records associated with quality assurance processes.

Requires improvement

Is the service safe?

Our findings

People told us that they had to wait for staff to meet their needs. One person told us, "If you press the call button at different times you have to wait, but I can understand staff may be busy elsewhere." Another person told us, "I always have to wait for staff." Relatives told us that there were not enough staff. One relative told us, "There are not enough carers for the number of residents." They went on to tell us how they had observed times when there are no staff in the lounge, or times when somebody had asked to go to the toilet but were told that they'd have to wait. Another relative told us, "There is not enough staff." They felt this was impacting on their relatives care. A relative of a person that used the service told us how they ensured that they always visited at mealtimes so that they were able to support them with their meals. They told us that they did not feel that the carers would have the time to this. Some staff told us the staffing levels were sufficient to meet people's needs but others told us that they needed more staff. A visiting professional told us, "They could do with more staff on most days."

During our inspection we saw a person tell a member of staff that they did not feel well and that wanted to go to bed. The staff member responded by telling them that they would ensure they were in bed in 30 minutes but that they could not help before then as there were no other staff available. The staff member was polite in their response but the person just wanted to go to bed. During lunchtime we observed that meals were left covered on an unheated trolley in a communal area for 20 minutes before they were given to people to eat because there were no staff available to assist people with their meals. We also saw that another person was not assisted with their lunchtime meal until 2:15pm as staff were too busy. We saw another staff member who was supporting a person to eat constantly interrupted as they needed to attend to other people. We found that staff were particularly busy during and after the lunchtime period. We saw that people's needs were not being met as there were not enough staff .

We discussed staffing levels with the director and acting manager who believed that they were working in line with published guidance. However people's dependency levels were not being taken into consideration. The acting manager told us that they had recently made some changes to the staffing levels and brought in additional staff to support at meal times. However we still found that sufficient staff were not deployed to meet people's needs.

These matters concerning staffing were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 Staffing.

People told us that they felt safe at the service. One person told us, "Oh yes that is what I like about here the security is very good there is a fire check every Monday." Relatives told us that felt that the service was 'generally' safe.

Staff had a good understanding of the types of abuse and how they were able to report them. There was a safeguarding policy in place that provided definitions of abuse and the process both internally and externally for reporting for staff to follow. This did not include contact numbers for external agencies but staff felt they would be able to find them. We saw that relevant safeguarding referrals had been made.

We found that incidents and accidents were being recorded but there was not always sufficient detail to obtain an understanding of an event such as a person's behaviours over a period of time. For example, staff told us that a person had displayed behaviour that challenged others over the weekend period and tried to abscond from the service. However the person's records did not reflect this. This meant that it was difficult for other professionals involved on people's care to establish a true picture of the person's overall needs.

We saw that where risks associated with people's care had been assessed control measures to reduce the risks had been identified and put in place. However these were not always carried out. For example a person who was at risk of developing pressure ulcers required regular positional changes to prevent them developing. However, records showed that the positional changes were not carried out in line with the risk assessment guidance. This person had remained in the same position for two days. We discussed this with the acting manager who advised that they would look into it.

There were checks carried out on equipment at the service to ensure that it was safe. There was a policy in place for staff to follow in the case of an emergency or untoward event. We saw that some people had personal emergency evacuation plans within their care plans. We discussed this

Requires improvement

Is the service safe?

with the acting manager. They advised us that there was a master copy of people's requirements in the event of an emergency kept at the fire panel. However, this had not been updated following changes at the service. It was not an accurate reflection of the people at the service during our inspection. The acting manager advised that this would be updated as and when people joined or left the service and when their individual needs changed.

There were systems in place to ensure that people received their medicines as prescribed. However, during our inspection we found that one person had not received their medicine as required. This was due to a labelling error by staff at the service. We discussed with the nurse how this could be recorded as a 'near miss' incident and to use it as a learning point to try and prevent it from happening again.

We found that medicines were being stored above the recommended temperatures. This had been ongoing for over a month. We spoke with the nurse about this who advised that there was an air conditioning unit in the treatment room where medicines were stored but it had broken. They also advised that supplementary drinks had been removed from the treatment room because of the high temperature.

We found that prescribed creams were left accessible in communal bathrooms. We found one cream in the bathroom that staff advised was still being used that had been prescribed two years prior to the date of our inspection. We discussed this with the acting manager who advised that this would be addressed.

Requires improvement

Is the service effective?

Our findings

Staff told us that they'd had relevant training to enable them to fulfil their roles. One staff member told us, "I'm happy with the training, I've been put forward for a course that I wanted to do." Another staff member told us, "I don't think I'm missing any training." We looked at the training records available and found that not all staff had received training in dementia. This mattered because the service provided care for a number of people living with dementia. The acting manager told us that training was in the process of being updated and was going to be delivered by the training coordinator for the provider. We were advised that there were some training dates planned but this did still not cover all of the care staff members. We saw that staff were supported to attend external courses. The acting manager was in the process of completing a level five qualification in health and social care.

Staff told us that received supervisions and appraisals but the length of time between them varied. [Supervision is a process where staff members meet with their manager to discuss how they are performing and if there are any training needs or concerns]. This was due to the recent changes in management at the service. Staff members felt able to approach the acting manager with any concerns and felt well supported by them. There was a clinical lead at the service who over saw the clinical side of the service. Nursing staff had not received clinical supervision at the time of our inspection as the clinical lead had been away.

A relative of a person told us, "[My relative] is not able to make decisions for themselves, [their wife] does it for them." We saw that the service did have consent forms in place but these had frequently been signed by people's relatives without any further explanation. These did not necessarily demonstrate consent to people's care as it was unclear why a relative was signing instead of the person themselves. We discussed this with staff who explained that it was because people were not always able to sign things themselves or not able to understand the decision being asked.

The Mental Capacity Act 2005 (MCA) is legislation used to protect people who might not be able to make informed decisions on their own about the care and support they received. There was no evidence that the decisions relating to consent had been made in line with the requirements of the MCA. However, we did see for some people that MCA assessments had been undertaken in relation to specific areas of their care in line with the legislation.

The Deprivation of Liberty Safeguards (DoLS) is legislation that protects people who are or may be deprived of their liberty through the use of restraint, restriction of movement and control. Any restrictions must be authorised by a local authority. We saw that where people were being deprived of their liberty that relevant referrals to the local authority had been made.

We spoke with staff about MCA and DoLS about their understanding of the legislation and it varied. Staff were not able to tell us which people had DoLS authorisations in place. We looked at people's care plans and we found that although some people had authorised DoLS in place this was not documented their care plan. We also found that some possible restrictions to people's care and support had not been included in the DoLS applications. We spoke with the acting manager about this who advised that this was one area that she had not yet started to address. She advised that this would be something that she would look into.

People were generally positive about the food. One person told us, "Staff come and ask me what I want to eat then they bring me my meal, the foods not too bad." Another person told us, "I think we do very well indeed, sometimes it can be cold, not hot enough." Relatives told us, "Generally [the food] is pretty good."

We saw that food was served on the ground floor and a lift used to transport the meals upstairs. We saw meals left on an unheated trolley upstairs for 20 minutes before they were served. This meant that some people's food would not have been served as hot as it should have been.

We saw that people were provided with a choice of main courses but it was evident that some people could not recollect what the choices were there were no visual choices available. We discussed this with the acting manager who advised that it was something that had previously been in place and that the service would look to reintroduce. People were offered pudding but there was no explanation to people of what it was and there were no choices offered to people.

We saw that staff were particularly busy over the lunchtime period. One staff member was assisting two people to eat

Requires improvement

Is the service effective?

at the same time. Another was assisting a person to eat while talking with another person to keep them calm. We saw how staff tried to verbally encourage another person to eat their meal, but they did so from a distance. Their efforts had no impact. The person's food was then removed without any discussion. This meant that people were not effectively supported to eat and drink.

We spoke with the chefs at the service who had a good understanding of people's dietary needs. They told us how they were in the process of updating the menus and tried to keep things varied and seasonal. The food menus available showed that a varied and nutritious diet was available. Where there had been an identified need for people's food and fluids to be monitored we saw that this was taking place. We also saw that bright coloured [dementia friendly] high sided plates were provided for people to try and encourage and enable people to eat independently.

People told us that if they need to see health professionals then they were able to. Records showed that other health professionals were involved in people's care. A visiting professional told us how the service was working with themselves, the tissue viability nurses and the GP to support a person. We saw that a range of health professionals were involved in people's care such as speech and language therapists, the mental health team, the DoLS team and the continuing health care team.

Requires improvement

Is the service caring?

Our findings

We received mixed feedback from people about the staff. One person told us, "Mostly [the staff] are caring but some are bullies, there are one or two staff I like and one or two I don't, when they provide my care I want them out quick." Another person told us, "They [the staff] are very caring on the whole, I feel they are very concerned about privacy and dignity." A third person told us, "One or two staff are not always pleasant." Relatives echoed these mixed comments. One relative told us, "One or two [staff] are really good with [my relative], staff do know what they are doing but they are short staffed." Another relative told us, "Some carers are really lovely and very kind, some are not."

We observed some positive interactions from staff members towards people and concern for people's well-being. However, we also heard staff talking indiscreetly and without regard to people's privacy and dignity. We heard a staff member talk openly to another about a person in a communal area whilst in front of that person. We also saw a staff member announce loudly in a communal area populated with people that an ambulance had arrived to take a person to a hospital appointment.

We saw that staff were too busy to ensure that people's needs were responded too without delay. We saw that one member of care staff got up in the middle of supporting a person with their dinner, to attend to something else without explaining before returning a few minutes later. We saw people waiting to have their needs met. A relative told us they had been at the service when people who requested to use the toilet were told, "In a minute." Another relative told us, "The only problem I have is there are not enough staff especially when [my relative] wants to use the toilet, but the staff are lovely they know how to handle [my relative]."

Staff were knowledgeable about people's life histories, interests and specific care needs and we saw that the service operated a key worker system. This enabled people to have a named staff member to contact and oversee their care. Staff understood their responsibilities of being a key worker and told us that the system worked well.

Staff had a good understanding of how they were able to respect people's privacy and dignity and prompt their independence while providing care. Staff were able to give us examples of how they did this while supporting people with their care. However, our earlier observations showed this did not always happen. A relative told us, "Staff do show privacy, dignity and kindness especially when [my relative] displays behaviours." However we saw a number of people who spent time in their rooms had their doors wide opened. Staff could not confirm if this was the person's preference and this was not recorded as a preference in people's care plans.

Relatives told us that they were able to visit any time and they were able to stay as long as they liked. One relative told us that they always liked to visit at the same time. Another told us how their visits varied dependent on their other commitments. Staff confirmed that there were no restrictions on visiting times.

Requires improvement

Is the service responsive?

Our findings

One person told us, "You can choose what time you go to bed and get up." A relative told us, "I am happy now because [my relative's] care plan has been discussed with me by the nurse." Another relative told us, "I have been told about [my relative's] care plan but not seen it."

We saw that people and their relatives had been involved in putting together information about people's life history's and their likes and dislikes. This information however was not reflected into people's care plans. We found that care plans were responsive to people's needs but they were not always updated following evaluations and reviews. For example we found that one person's care plan clearly described the need for a DoLS application to be considered, however this had not been updated since an application had been made and authorised by the supervisory body several months prior to our visit.

We also found that records did not always evidence that care was being carried out in line with people's care plans. Repositioning charts did not always show a change of position and people's daily fluid charts had not always fully completed to provide an accurate record of the fluids that they'd had.

The activities coordinator told us how they were carrying out a communal activity in the morning and focusing on more one to one activities for people that didn't participate in the morning activities during the afternoon. She gave us an example of how she spent time with a person reading a paper with them. She also told us how one person liked their nails painting and how she tried to do this for them when she had time. We looked at the persons nails and we saw that the paint was peeling off. When asked specifically about activities, one person told us, "We just sit here, I get fed up at times." Another person told us, "I am usually back in my room for about 10am and I watch T.V. or do my word search."

During our inspection we saw two group activities taking place. Group activities that were carried out included bingo, art and craft sessions including flower arranging, pamper sessions, music, crosswords, quizzes, and the throwing and catching of balls. A relative told us, "Staff don't have time to sit with residents and have a chat." The activities coordinator advised us that approximately half of the people at the service engaged in the activities that were on offer.

There were group activities taking place but it was not evident that activities reflected people's individual hobbies and interests. The activities coordinator was relatively new to the role and still building up the types of activities that she engaged people. She also explained that she was in the process of finding out about what people wanted to do. The information in people's life stories that the manger provided was not being used to develop the activities at the service. There was a sensory room at the service which could be used as stimulation for people but this was not being regularly used.

People told us that if they were not happy with their care that they felt able to raise their concerns. One person told us, "I would tell staff [if I had a complaint] or if it is serious I would go to the manager in the office." Another person told us, "I would tell them if I wasn't happy." They went on to say, "I have no complaints." Relatives told us that they felt able to raise any concerns but they did not always feel that they were listened to or acted upon. Relatives were not aware of the complaints procedure but understood their rights to make a complaint.

We saw that the service had a complaints policy and procedure in place that provided details about how the complaint would be investigated and responded to. The policy also included contact details of where people could refer their complaint to should they be dissatisfied with services response. We looked at some complaints that had been received by the service. We saw that they had been logged, investigated and responded to by the manager at service.

Requires improvement

Is the service well-led?

Our findings

We found folders that confidential information about people's care being stored in communal areas. We spoke with the acting manager about this and they confirmed that they would address the matter. We also found that the nurse's station door was left propped open where people's confidential records were kept. This meant that systems or processes were not in place to ensure that people's records were maintained securely. Relatives and visitors to the service had access to people's care information.

We saw that records were not being accurately maintained for people. For example the acting manager told us and a health professional how one person had tried to abscond over the weekend. We looked at this persons records and this had not been recorded anywhere and had not been notified to the Care Quality Commission. This meant that it was hard to establish a thorough understanding of the persons needs and ensure that they received the right care.

We found that audits that had taken place had failed to identify the concerns we had found. For example the medication audit and environmental checks had failed to identify the out of date prescribed creams that had been stored in communal bathrooms. Prescribed creams were accessible to anyone that used the service. There was a risk that people may not realise what the creams were for and either eat them or use them. The introduction of a `VIP of the day' audit had identified some actions that needed to be taken but they had not been carried out. The medication room temperature had been recorded as above the recommended guidelines but action had not been taken to rectify this. This meant that the systems that were in place to assess, monitor and improve the quality and safety of the services provided were not effective.

We saw that staff meetings took place six monthly. We looked at the minutes of the last meeting and we saw that these were used by management at the service to provide updates to staff and also focus on areas of improvement that were required. We also saw that staff were able to provide feedback and discuss concerns. We saw that staff had raised concerns about the staffing levels. Staff were advised that the service was staffed to capacity. There was no evidence of how this had been determined and no explanation provided to staff. During our inspection we identified concerns with the staffing levels. The provider had failed to act on feedback that staff had provided.

Relatives told us that they had raised the issue of staffing levels with the manager at the service as they were concerned about these. They had been told that the staffing levels were in line with published guidance and were appropriate. The service had failed to act on these concerns that had been raised.

These matters constituted a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 Good Governance.

When asked if people thought the service was well led one person responded, "I don't know. They are waiting for a new manager, I hope it's one that can see what is happening." Another person told us, "No, the last manager they had wouldn't work weekends." Although staff knew who the acting manager of the service was people that used the service and their relatives did not seem quite so sure. A relative told us, "Well I'm never quite sure what is happening, [my relative] attends residents meetings but I don't think there has been one for a while." We saw that the last meeting for residents and their relatives had taken place over a year ago.

There was not a registered manager at the service although the service were in the process of recruiting to the post. There was an acting manager overseeing the service. A staff member told us, "[The manager] is supportive, very much so, shame she is not a nurse, but she does come on to the floor to help us." Another staff member told us, "The acting manager is very approachable." They went on to tell us, "They [the management] are fair to us all." The acting manager told us how they worked shifts at the service alongside staff to support them and enable them to look at new ways of working to improve the service. The acting manager told us about a number of new ideas that they were introducing to improve the service. These included changes to care documentation used by staff and the way that care tasks were delegated.

The service was not registered with the Care Quality Commission for the regulated activities that they were providing. They were employing nurses to provide the treatments of disease, disorder and injury and they were not registered to provide this care. We discussed with the acting manager and director during feedback. Since the inspection the provider has been in the process of ensuring that the correct registration is in place.

Requires improvement

Is the service well-led?

We found that quality assurance questionnaires had been sent out to relatives and staff. Relatives had made comments such as, 'I would like the residents to be taken to the toilet a little quicker when they ask' and 'sometimes a quicker response to the bell.' The acting manager told us that they would collate the results and produce an action plan to follow up areas of improvement that were required once after they had received more questionnaires back as they had only recently been sent out. We saw that the staff feedback about the service was positive.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's needs. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to ensure that people's care records were fully and accurately completed and kept securely. Systems that were in place to assess, monitor and improve the quality and safety of the services provided were not effective. Systems that were in place to assess monitor and mitigate risks were not effective. Regulation 17 (1) (2) (a), (b) and (c).