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Bowland Lodge

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

Summary of findings

Overall summary

About the service
Bowland Lodge is a residential care home proving accommodation for persons who require nursing or personal care to up to a maximum of 36 people. The service provides support to people living with mental health conditions and dementia. At the time of our inspection there were 19 people using the service.

People's experience of using this service and what we found
Bowland Lodge has had a continuous breach in relation to good governance since February 2018. Concerns in relation to ensuring risks are assessed, managed and mitigated have been ongoing since that time. At this inspection some risks had not been assessed. The quality assurance system had not been effective in identifying the shortfalls we identified in relation to risk management, ensuring care records were complete, accurate and contemporaneous, failure to implement the Mental Capacity Act appropriately and concerns in relation to record keeping.

Staff and the management team were not following the current guidance in relation to PPE. Some risks had not been assessed. There were concerns in relation to fire drills and Portable Appliance Testing had not been completed since October 2019. Medicines were administered safely, however, there were some recording concerns related to 'as required' medicines. There were mixed views on staffing levels. Safe recruitment practices were followed and people told us they felt safe.

Staff were observed to offer people choice. Records did not promote staff to support people to have maximum choice and control of their lives and support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The principles of the Mental Capacity Act had not been implemented or followed. We have made a recommendation about this.

Pre-admission assessments were completed. However, people's identified needs were not always care planned or risk assessed. Staff said they were well supported and had attended required training, although some commented that the majority of training was by eLearning. People were supported to access healthcare services and support. There was an ongoing refurbishment plan which had been delayed due to the COVID-19 pandemic.

People had no complaints about Bowland Lodge. A system was in place to record and investigate any concerns. Policies were in place in relation to the Accessible Information Standard and end of life care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 2 July 2019) and there was a breach of regulation relating to good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in

breach of regulations.

This service has been rated requires improvement or inadequate for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about Infection, Prevention and Control (IPC) and visiting concerns. We looked at IPC measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the provider can respond to COVID-19 and other infection outbreaks effectively.

We previously carried out an unannounced comprehensive inspection of this service on 5, 6 and 22 March 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective, Responsive and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bowland Lodge on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We identified a breach in relation to safe care and treatment and a continuing breach of good governance at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Bowland Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Bowland Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included notifications which the provider had sent us about certain incidents that had occurred at the service. We sought feedback from the local authority's safeguarding adults' team and commissioning teams and the local infection prevention and control team. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information

about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and spent time in the communal areas with people during the inspection. We spoke with the registered manager, the deputy manager, three care workers, two senior care workers and three members of ancillary staff including the cook, a member of housekeeping and maintenance staff.

We reviewed three peoples care records and five peoples medicine records. We looked at one staff file in relation to recruitment. A variety of records relating to the management of the service, including audits were reviewed.

After the inspection □
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data, policies and procedures and quality assurance information that the registered manager had shared with us electronically. We made several attempts to contact relatives by telephone for feedback on the service but were not successful.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not assured that PPE was being worn correctly by staff and the management team to prevent and control infection.
- On day one of the inspection, staff, including the management team, failed to follow government guidance in relation to the wearing of PPE. Staff were seen wearing masks under their chin, putting their mask on in the dining room whilst wearing an apron and gloves and touching and pulling their masks from their faces.
- We also observed staff wearing gloves and aprons when they did not need to, and some staff did not have long hair tied up.
- Competency checks in relation to the wearing of PPE were not completed and there was limited action taken to ensure people, staff and visitors were protected from the risk of COVID-19 infection.

Systems and staff practices had not been properly established to prevent and control the spread of infections. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said they spoke with staff following our feedback and would ask the IPC team for support. We raised it with the IPC team who said they would contact the registered manager.

- We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider's infection prevention and control policy was up to date.
- Government guidance in relation to visiting was being followed at the time of our inspection.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Some risks had not been assessed or mitigated, including choking risk, suicidal ideation, some health conditions and some risks relating to people's mobility needs.
- Lessons had not been learned from previous inspections and there were continued failings to assess,

monitor and manage risks. .
● There was a track record of failing to provide good standards of safety over the previous three inspections dating back to February 2018 and no evidence that lessons had been learned following each inspection to ensure a robust and effective system was in place to improve the management of risks.
● Concerns were identified in relation to the premises. Portable Appliance Testing had not taken place since October 2019. The registered manager had raised this with the provider several times.
● A detailed record of fire drills was not always maintained. The time and names of people and staff involved in fire drills were not always recorded.

Systems and processes had not been established to assess and mitigate risks. This placed people at risk of harm. This was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● We identified gaps in the recording of some medicines.
● One person had a protocol for the administration of 'as required' paracetamol which was not documented on the medicine administration record.
● Protocols for the administration of some 'as required' medicines didn't indicate how staff would know if the person needed their medicine. For example would the person ask for the medicine or would staff have to observe for non-verbal gestures.

While we identified no direct impact to people, the providers failure to maintain appropriate and complete records is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Routinely prescribed medicines were administered safely by staff who had been assessed as competent.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to safeguard people.
● Staff understood how to identify signs of abuse and how to report concerns. People told us they felt safe and one person said, "The staff are the best."
● Records included the actions taken in response to safeguarding concerns.

Staffing and recruitment
● There were enough staff to meet people's needs.
● There were mixed views on staffing levels. Some staff felt they did not have enough time to spend with people. We shared this with the registered manager who commented that people didn't engage in 'activities,' instead people chose to go out and about or spend time in their rooms.
● Safe recruitment practices were followed. The registered manager said, "There's a really low turnover of staff here so we don't often need to recruit."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The principles of the MCA were not fully implemented or followed. It had been identified at the last inspection that action was required to ensure records demonstrated how the principles of the MCA were followed.
- Some people had capacity assessments which were several years old and did not relate to a specific decision or restriction. People's capacity had not been reassessed over a period of up to seven years.
- One person had restrictions detailed in their care plans. There had been no capacity assessment and best interest decision completed. It was also documented in the monthly review that the restrictions had not been required since October 2020, however, this had not led to the care plan and risk assessment being archived.

We recommend the provider and registered manager refer to current guidance in relation to MCA.

- Care staff sought people's consent before providing care and support.
- The registered manager submitted DoLS applications to the local authority. Although they said they still needed to complete this for one person who had been resident for three weeks.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Pre-admission assessments were completed by the management team and included detail on people's needs and preferences.
- For one person their identified needs at admission had not always been reflected in their care plans and

risk assessments.

Staff support: induction, training, skills and experience
● Staff were supported by the registered manager and deputy manager.
● Staff had attended training, including in mental health conditions and alcohol use. Some staff commented that the majority of training was by eLearning and they would benefit from some face to face learning.
● A training matrix was used to monitor completion of training.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people with their dietary needs.
● Care records included people's dietary requirements if they had been assessed as needing a specialist diet. However, as identified at our last inspection, there continued to be further action needed to ensure peoples' specific requirements in relation to fluid intake were recorded.
● It had been recorded if people had diet-controlled diabetes, but there was no information in care records to detail what foods, if any, they should limit or avoid.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access health and social care services such as GPs, district nursing and speech and language therapy. If people consented to the referral, staff supported them to access support with alcohol dependency, if needed.
● Referrals were timely and staff followed the guidance of external health care professionals.

Adapting service, design, decoration to meet people's needs
● The ongoing refurbishment plan discussed at our last inspection was still ongoing due to delays caused by the COVID-19 pandemic.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Action was needed to ensure care plans and risk assessments were accurate, complete and reflected people's needs. This had also been identified at our last inspection.
- During a Direct Monitoring Call in August 2021 the registered manager said care plans and risk assessments reflected people's needs. During the inspection we found not all needs had been fully planned for or assessed including mobility needs, needs relating to swallowing difficulties and mental health needs.

Failure to maintain appropriate and complete records is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some care plans promoted people's independence, so they were not overly supported by care staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had care plans in place for social activities. Staff and the registered manager said people didn't really engage in planned activities but preferred to go out and about or spend time in their rooms.
- We didn't observe any planned activities being offered to people. Staff commented that they would like more time to spend with people individually.
- People said they enjoyed going to the pub, spending time in their rooms or spending time with staff.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The registered manager said no one currently residing at Bowland Lodge required had any specific communication needs.
- An accessible information policy was in place however it was not dated.

Improving care quality in response to complaints or concerns

- A system was in place to record and respond to complaints and concerns. Complainants had been kept up to date on the progress of any investigations and the outcome was shared with them.

● People said they had no complaints at the current time.

End of life care and support

● No one was currently receiving end of life care and support. Some people had details on their end of life care wishes in care plans. One person's spiritual care plan had not been reviewed since 2017.

● An end of life care policy was in place and staff had attended training.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the provider had failed to maintain records relating to risk management and care planning. The quality assurance system needed to be fully embedded to ensure shortfalls were identified. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient action had been taken. The provider has continued to be in breach of this regulation since February 2018.

● Systems and processes for identifying, capturing and managing organisational risks and risks to people remained ineffective. There was a longstanding track record of the provider and registered manager failing to implement robust governance procedures to improve the quality and safety of the service.
● The quality assurance system had not been effective in identifying the serious shortfalls we identified in relation to the assessment and mitigation of risks, including IPC risks; ensuring accurate, complete and contemporaneous care records were maintained; implementing the principles of MCA and the management of 'as required' medicines.
● The principles of good quality assurance were not understood, and the service lacked a serious drive for improvements that are essential for a safe, high-quality service.
● Following the last inspection an action plan was submitted to the commission. This included that an external consultancy company had been employed to support the registered manager to identify and assess risks. This process had failed to achieve the required improvements and failed identify the shortfalls noted during this inspection.
● There was no evidence that the provider and registered manager had learned lessons, reflected on and improved the service following the previous three inspections which had also identified concerns with risk management and record keeping.

Systems had not been established or operated properly to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers are required to ensure each service has a statement of purpose which is kept up to date and submitted to the CQC. We discussed this with the registered manager as people who have needs relating to

alcohol use are supported at the service. Consideration had not been given to adding this to the statement of purpose.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There had been no incidents that required the registered manager to act on the duty of candour. They described duty of candour as being a responsibility to be open, honest and transparent.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People chose not to engage in residents' meetings but were involved in care planning and making day to day decisions.

● Staff said they had not attended any staff meetings. We spoke with the registered manager who said, "I see the staff every day and keep them updated. I record things using interaction forms rather than staff meetings."

● Staff said there was limited opportunity for them to discuss issues with the registered manager, such as wanting to spend more time with people and developing activities.

Working in partnership with others

● Staff worked in partnership with healthcare agencies and specialist alcohol support services.

● The registered manager said they had been supported by the local authority commissioning team during the pandemic. However, they said they didn't have the time to engage in provider meetings. This meant there was a lack of opportunity to engage with peers, make network connections, share best practice, and learn from other registered managers and providers.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. There were failings to assess and mitigate risks to the health and safety of service users, including the prevention and control the spread of infection. Reg 12(1)(2)(a)(b)(h)

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 17 HSCA RA Regulations 2014 Good governance There was a failure to establish and operate systems and processes to ensure compliance. There were failures to assess, monitor and improve the quality and safety of the service and failures to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. There were failures to maintain accurate, complete and contemporaneous records in respect of each service user. 17(1)(2)(a)(b)(c)

The enforcement action we took:

We issued a warning notice.