Bamfield Lodge Limited

# Bamfield Lodge

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Bamfield Lodge is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bamfield Lodge provides accommodation with nursing and personal care for up to 60 people. At the time of our inspection 47 people were living in the home. The home comprises four units over three floors. Crocus, on the ground floor, provides personal care, Bluebell and Daffodil on the first floor provide nursing care and Snowdrop on the second floor provides care for people living with dementia.

At the last inspection on 26 September 2017 the service was rated Requires Improvement. We found repeated breaches of the regulations relating to management of medicines, risk management and quality assurance systems. We imposed a condition on the provider's registration. We also found a breach of the regulation relating to staff supervision and training and we issued a requirement action. Following the inspection, the provider was required to send us an action plan each month telling us how they were making the required improvements.

We carried out a comprehensive inspection on 29 & 30 August 2018. At this inspection, we found improvements had been made and the legal requirements had been met. However, further improvements were needed to make sure all shortfalls were promptly identified and where changes had been made, these were consistent and sustained.

At the time of our inspection, an incident relating to medicines management for medicines that required additional security had been reported to the police and to the Local Authority safeguarding team. A safeguarding investigation was being undertaken.

Overall, the service has remained Requires Improvement.

There was a registered manager in post. They completed the registration process soon after our inspection visit. 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.

Sufficient numbers of staff were not deployed on the first day of our inspection. Sufficient staff were deployed on the second day of our inspection.

Staff were safely recruited. Staff received sufficient supervision and training to ensure they could meet people's needs.

There were improvements in the management of medicines and shortfalls were acted upon with actions agreed. Further improvements were needed to make sure the improvements were consistently implemented.

Staff demonstrated a good understanding of safeguarding and whistle-blowing and knew how to report concerns.

People were helped to exercise support and control over their lives. People were supported to consent to care and make decisions. The principles of the Mental Capacity Act (MCA) 2005 had been followed.

Risk assessments and risk management plans were in place. Improvements were needed to make sure care was consistently delivered in line with assessed and current needs.

Incidents and accidents were recorded and showed that actions were taken to minimise the risk of reoccurrence.

People's dietary requirements and preferences were recorded. People did not always receive the support they needed at mealtimes.

Staff were kind and caring. People were being treated with dignity and respect and people's privacy was maintained.

An activities programme provided a range of activities and entertainment.

Systems were in place for monitoring quality and safety. Improvements were needed to make sure shortfalls were identified and actions taken consistently to make improvements.

In line with our procedures for services that have been repeatedly rated as Requires Improvement, we will meet with the registered manager. We will discuss the actions they are taking to make sure the service improves to Good when we undertake our next inspection. We will also require an action plan to be sent to us each month to tell us about the improvements they are making.

## 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 remains requires improvement.

Improvements had been made to the management of medicines. Further improvements were needed to make sure changes and improvements were consistent.

People were protected from abuse because staff had received training and knew how to identify and act on concerns.

On the first day of our inspection, the deployment of staff was not sufficient to meet the needs of people living in the home. On the second day, sufficient staff were deployed.

Accidents and incidents were reported and actions taken to reduce recurrences.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

### Is the service effective?

**Requires Improvement**

The service remains requires improvement.

The service complied with the requirements of the Mental Capacity Act 2005 (MCA). People were asked for consent before care was provided. Where best interest decisions were made, these were recorded.

Nutritional needs and preferences were recorded and actions taken when people's weight changed. Improvements were needed to make sure the dining experience met the needs of people in all areas of the home.

Staff received training and support to enable them to meet people's needs.

People had access to a GP and other health care professionals.

### Is the service caring?

**Good**

The service remains good.

## Is the service responsive?

**Requires Improvement**

The service remains requires improvement.

Improvements had been made and care records were personalised. Further improvements were needed to make sure care was delivered as planned.

People had the opportunity to express their views and the complaints procedure was easily accessible.

## Is the service well-led?

**Requires Improvement**

The service remains requires improvement.

Systems were in place to assess, monitor and mitigate risks to people. Systems needed to be strengthened to make sure shortfalls were promptly identified and consistently acted upon.

A registered manager was in post. People spoke positively about the new leadership in the home and could provide feedback and express their views.

The registered manager recognised their responsibilities regarding notifications required by the Commission.

# Bamfield Lodge

**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.

We undertook a comprehensive inspection of Bamfield Lodge on 29 & 30 August 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events that the provider is required to tell us about by law.

During our visit we spoke with 17 people who lived at the home and 5 visitors. We spent time with people in their bedrooms and in communal areas. We observed how people were being cared for and supported.

We spoke with the provider's regional manager, regional support manager, registered manager and 14 staff that included registered nurses, care staff, maintenance, housekeeping, laundry and catering staff.

We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at six people's care records in detail and checked other care records for specific information. We attended a head of department daily meeting, looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, survey results, complaints records and other records relating to the monitoring and management of the care home.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection on 26 September 2017 we rated this key question as Requires Improvement. This was because medicines were not always safely managed. Accurate records of amounts of medicines were not maintained and fluid thickening agents were not safely stored. Where variable dosages were prescribed, the actual amounts people were given were not always recorded, application of prescribed creams to people's skin was not accurately recorded, and where medicine was crushed this was not being safely undertaken. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

At this inspection sufficient improvements had been made and the legal requirements had been met. Further improvements were needed, as detailed below, to make sure the improvements were consistent and embedded within the service.

People told us they received their medicines when they needed them. One person commented, "The staff always give me my tablets at the right time…I would die if I didn't have them. I don't want to look after my tablets. I like the staff to do that." We observed medicines being given to people by registered nurses and care staff who had received medicines management training. Staff explained to people what they were being given, drinks were offered, and staff stayed with people to make sure their medicines had been taken. We heard staff asking people who were prescribed pain relieving medicines to be taken when required, if they had pain and if they needed these medicines.

Staff signed the medication administration record sheets (MARs) to confirm people had taken their medicines. A 'missing signature' checklist was in use to record when staff identified and recorded if they noticed missing signatures. However, the checks were not always fully completed and did not always confirm that actions had been taken when shortfalls were identified.

Systems were in place to record amounts of medicines received into the home and medicines no longer required. Systems were also in place for medicines that required cool storage and medicines that required additional security. A safeguarding investigation was being undertaken that related to management of medicines that required additional security. However, the medicines we checked that required additional security were fully accounted for and a registered nurse told us, "We check at the start and end of our shift to make sure they are correct."

There were no unsecured fluid thickening agents, and the staff we spoke with were aware of the need to store this safely. Improvements had been made in the recording of actual amounts of medicines given to people. We did find, for one person prescribed variable doses of medicines, the actual amount given had not been recorded on one occasion. This meant the effectiveness of that medicine may not be accurately assessed, and the stock amount remaining may not be accurately recorded.

The recording of topical medicines had improved. These are creams and ointments applied to people's skin. Topical MARs were kept in people's bedrooms, with instructions and guidance for staff. Most topical MARs were completed when the treatments had been given, although we still found occasional gaps in recording.

We spoke with staff who told us the creams and ointments had been applied and the lack of recording was an oversight.

At the inspection on 26 September 2017 we found shortfalls in the risk management plans for falls, pressure ulcers and safety checks. This was another breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

At this inspection, risk management plans were in place. Improvements had been made since our last inspection and the legal requirement was being met. Falls were monitored, recorded and actions taken to minimise risks of recurrence. A relative who told us about a person who had a few falls said the staff were, 'amazing'. We checked the records for this person and found actions had been taken and they had been referred to a specialist nurse and the dementia well-being service. The relative also told us, "If staff are busy in the dining room, it can be a worry as my husband wanders around and that is when he falls. As he has had so many, this worries me."

Where people were unable to use their calls bells individual risk assessments stated the frequency of checks people needed to keep them safe. We found occasional gaps in recording where the risk assessments had not been fully completed. However, the staff we spoke with could tell us how often people needed to be checked and records of safety checks were completed.

People using the service and relatives told us they felt the care home was not sufficiently staffed at times. Comments included, "I don't think there's enough staff", "I think there should be more staff but they have an awful job to get staff here," "The staff are always rushing. They have little opportunity to talk to the residents but we do have a laugh," and, "It is alright. I feel safe but sometimes staff are rushed off their feet."

One person told us, "When I first lived here, I didn't feel safe as people kept coming into my room. They do not do that now. If I use my buzzer, they do not come straight away. I generally look at my watch and they usually take about 15 minutes." Other people and relatives told us they did not always receive prompt responses when they called for help and support. A relative told us, "Call bells ringing, people waiting."

There was no system in place to monitor the call bell system. Call bells sounded throughout the whole home, rather than on individual floors each time a person called for assistance, or when a sensor mat triggered the call bell. The registered manager had arranged for a contractor to visit to review the system with a view to it being upgraded and to add a monitoring system so they could check the timeliness of responses to people's calls.

At our last inspection we recommended that the provider reviewed the numbers and deployment of staff to make sure sufficient staff were available to consistently provide care, support and treatment for people using the service.

At this inspection, the registered manager, who had been in post since May 2018, told us they had successfully recruited. Staffing levels had improved since they had started, and they were aiming to staff the home at higher levels than those indicated by the provider's dependency tool. People recognised additional staff had recently been appointed and told us there were, "Lots of new faces to get used to" and, "New and agency staff take longer as we often have to tell them what we need."

For the morning shifts, the dependency tool determined 10 staff were required. In our discussions with regional manager, regional support manager and the registered manager, they told us they aimed to provide 13 staff on duty as a minimum, and where possible, up to 15 staff, as an 'ideal' number. This showed

the provider's dependency tool did not accurately reflect the actual staff numbers required on each of the four units.

We checked the staff rotas and found on most occasions, a minimum of 13 staff were on duty. In the month leading up to our inspection, there were four days when there were less than 13 staff on duty. On most days, the home was reliant on one or two agency registered nurses who were allocated to Bluebell and Daffodil units. These were the units where we observed staff 'rushing' and telling us they struggled to deliver the care that was needed. On the first day of our inspection, there were 12 nursing and care staff allocated on duty, and one staff allocated to 'writing care plans only.' This was due to staff sickness. We received a specific concern from one person on the first day of our inspection. They told us they had called for help and had not received the care they needed. We brought this to the attention of the registered manager at the time.

On the second day of our inspection, there were 15 nursing and care staff on duty. Additional staff had been allocated to Bluebell and Daffodil units. Care was not rushed and people were provided with the care and support they needed.

People and relatives also told us, "I think the care is safe and they understand Mum's needs" "I feel really safe here, the staff care for you," "Yes I feel safe. I like being able to have a drink when I want," and, "I feel Mum is safe. I think it's the best place for her. Staff are fantastic. Cannot fault them. We all feel reassured. The staff are helpful and friendly and they always appear to be very attentive. Staff can be slightly thin on the ground sometimes but usually there appears to be enough."

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They could give examples of signs and types of abuse and what they would do to protect people, including how to report any concerns.

Staff were safely recruited. Staff files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

Overall, the environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. Personal emergency evacuation plans were recorded for each person. They provided guidance about how people could be moved in an emergency if evacuation of the building was required.

The provider routinely secured wardrobes to the wall to reduce the risk of them falling or being pulled over. We found two wardrobes that had not been secured and bought this to the attention of the maintenance team at the time. They told us in addition to securing the wardrobes we had identified, they would check all the wardrobes in the home just to make sure they were safe.

A business continuity plan was in place and this set out the procedures to be followed in the event of an emergency, such as power failure or significant equipment failure that caused disruption to the normal running of the home. This meant people could be confident their care needs would continue to be met in the event of such a situation occurring.

The bedrooms and communal areas were clean. We spoke with members of the housekeeping and laundry

teams who described their role and responsibilities. We observed staff using gloves and aprons when needed which showed good infection control practices. However, we noted that recliner chairs in use were dirty and ingrained with stale food. The covering on one recliner chair was also ripped and worn. We brought this to the attention of the registered manager at the time.

A redecoration programme was in place. On the first floor we found small areas of carpet that were frayed and had lifted in areas, and a metal door strip leading into a dining room was raised. These were hazards that had not been risk assessed. We brought these shortfalls to the attention of the registered manager at the time.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection on 26 September 2017 we rated this key question as Requires Improvement. There was a lack of appropriate training and supervision for staff. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the legal requirement had been met. We found that improvements were needed to make sure people consistently received the level of support they needed at mealtimes. We brought this to the attention of the registered manager at the time. This key question continues to be rated as Requires Improvement.

We received mixed feedback from people who used the service and relatives about the food and drink provided that included, "I can ask for extra food and drink and they are very good at bringing it in between meals," "The food is good-very nutritious. I like the fact that there is always plenty of vegetables and it appears well-balanced with a good choice," "The food has got better recently. I had a nice tomato soup yesterday. It was gorgeous and we had pasta and cakes." We also received feedback that was not so positive that included, "Normally the food is not cooked properly" and, "When there are only two staff you can't always get a drink."

On the first day of our inspection, the lunch time service in the Bluebell unit dining room was chaotic, rushed, noisy and disorganised. We also saw a member of staff trying to support two people with their meals at the same time. A member of staff told us they shared a hot trolley with the Daffodil unit, so one unit had to wait each day until the other had finished meal service, before the hot trolley was available for them.

One person in the Daffodil unit was provided with lunch in their bedroom. They had not eaten and a member of staff asked if they were hungry or not. The member of staff took away the meal without offering encouragement, support or assistance. They commented to another member of staff the person was 'too tired to eat.' Ten minutes later, we saw an agency registered nurse had taken a meal into the person, and providing support and encouragement and the person was eating the meal. We brought our observation to the attention of the registered manager.

In contrast, the meal service in Crocus unit was calm and organised. On Snowdrop unit, people were supported at their own pace. People had chosen meals in advance and alternatives were offered if people changed their mind. For people who needed additional support to make choices, a member of staff told us they had photographs of meals to show people. They also told us, "We don't use these." The photographs had been introduced by the provider to help people who were unable to easily communicate choices and preferences, to make choices at the time of service.

On the second day, the staffing allocation had increased. The meal service on Bluebell unit had improved and staff were available to support people. The service was calm and unrushed and people were provided with the support they needed.

We spoke with catering staff who could tell us about people's individual needs and preferences, likes and dislikes. They told us they received copies of 'food passports' when people moved into the home and when

needs changed.

Care plans contained nutritional assessments. When people's food and fluid needed monitoring, this was completed and records were completed. When people's weight changed, actions were taken. When people had lost weight, support and advice was sought and people were referred to the GP.

Staff told us they were now receiving effective support since the registered manager had been in post and they had received supervisions. A member of staff told us, "Maybe not having as many supervisions yet as we're supposed to, but they're getting better." Other comments included, "I had a supervision a few weeks ago," and, "I get one to one supervision and have some time with the clinical lead." In July 2018, the registered manager had noted in an internal training update that, 'appraisal plan in place for the next three months, we have concentrated on ensuring the team leaders have received a supervision as I am new in post. Heads of Department have received recent appraisal training to enable them to complete with the people they line manage.'

People using the service and relatives told us they felt most staff were knowledgeable and understood their needs. Two people also commented they did not always feel so confident when they were being supported by agency staff.

When new staff started in post they completed an induction programme and shadowed colleagues to gain practical experience. One member of staff told us how they were supported with induction training. They told us they received what they described as the theoretical training. They told us they then completed shadow shifts, where they observed care delivery and then buddy shifts where they were supported to participate in care delivery. They said they weren't expected to work unsupervised until they felt confident to do so and when they could, "Put into practice what I'd learned. It was all so supportive."

Staff told us they were provided with regular update and refresher training. These included topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and nutrition and food hygiene. There were high levels of staff attendance and overall compliance was noted at 95 percent. Medication and medication competency showed the lowest level of compliance at 58 percent and 64 percent respectively. A plan was in place to address this low level of compliance.

Where registered nurses and care home assistant practitioners needed training to meet the specific needs of people living in the home, they told us this was provided. We checked the training records and saw that staff had received training in topics including catheterisation, venepuncture, pressure area care and diabetes, including management of insulin.

The registered manager was a 'dementia friend champion' trained by the Alzheimer's Society, to support staff to become 'dementia friends.' The purpose of dementia friends is to enhance understanding of the needs and experiences of people who are living with dementia. To date, the registered manager had supported 15 staff to become dementia friends. This meant people could be confident that staff were committed to enhancing their knowledge and understanding to enable them to provide more effective support.

We checked the records for people who had been assessed and needed assistance to move or change position on a regular basis. Pressure relieving equipment, such as pressure relieving mattresses were provided. The records also stated the frequency people needed to be supported to change position.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people

who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People had been assessed for their capacity to consent to specific aspects of their care. When they lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's. People told us that staff asked before they provided support. One person told us, "They always ask me if they can help me before doing anything." We heard staff asking people for consent before they provided support to people during our inspection. Staff told us how they obtained consent from people, and understood people had the right to refuse care. They told us if they were concerned about a person's refusal to agree to care they would consult with senior staff.

People who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. The service had submitted a DoLS applications for people that were waiting to be processed by the local authority. Twelve people in the home had DoLS authorisations in place. We checked the conditions attached to one person's authorisation. Staff were required to record episodes of the person asking to leave the home, and how they were distracted and reassured. The DoLS conditions had been written into the care plan and were being met. A designated staff member was responsible for applying, following up and monitoring how the DoLS process was working in the home. The registered manager had recognised that staff needed further training to enhance their knowledge and understanding of DoLS and training had been arranged.

People were supported to access the healthcare services they needed. For example, people received support from the GP, district nurses, dementia well-being service and physiotherapists. One person told us, "The doctor comes every week and recently, when I was under the weather, the staff called the doctor in to see me." Another person said, "I can tell the staff if I am not feeling well and they get the doctor. I recently had two falls and they fetched the doctor…the doctor has been out to see me regularly. The staff are marvellous. I am very lucky to be here."

Good

# Is the service caring?

## Our findings

People told us they had good relationships with staff and were well looked after. Feedback included, "The staff look after me. They are very friendly and they care for me and are gentle with me," "The staff are alright. Always speak to me. They are very nice, kind people. I have a laugh with them. They are wonderful people," and, "I like living here. It's really good. The staff are brilliant. They are lovely. They get you what you want. They will do anything. They're good as gold. They are all nice to me. They help me get dressed. They look after me beautifully and they take the time to sit with me."

We observed people being treated in kind and respectful ways. Staff were helpful and friendly and people looked relaxed and comfortable in their presence. They provided reassurance and emotional support to people when needed. For example, we saw staff speaking with people in a kind and friendly manner and providing appropriate and reassuring touches when needed.

We also observed, on the first day of our inspection, staff talking with each other and within earshot of people using the service, about the staffing levels and about the work they still had to do. This conversation showed a lack of thought from staff, as such conversations may be worrying for people using the service. One member of staff told us they were not always able to respond to people's needs quickly enough because they didn't always have enough staff on duty. They told us they were 'running late.' On the second day, there was a significant improvement. Additional staff were available and people were provided with the care they needed and when they needed it.

People told us that staff supported and encouraged them to make choices with one person commenting, "I get my own clothes ready" and a relative said, "Mum always looks well presented."
People's independence was promoted and encouraged. One person told us, "I like to do what I can for myself. If I want to go to my room I do it on my own." We heard staff asking people what they wanted to do and when people needed assistance with mobility, where they wanted to sit.

Staff clearly knew people well and could describe people's personal histories, interests and preferences. These were also recorded in the care plans. A member of staff told us about the care and support they provided for one person on a regular basis. They told us they always checked to make sure the person was ready to be supported with personal care. They told us how the person liked to be addressed. They also told us how they were always mindful when they delivered care, that it was in accordance with one of the provider's values, 'to make every moment count.'

Care staff told us how they made sure people's dignity and privacy was promoted and maintained. They made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care. A member of staff told us, "It's so important and I always think, what if it was my Nan."

People's rights to a family life were respected. Visitors were made welcome at any time. One relative told us, "I would recommend the home, no reservations. There are no restrictions on visiting. I come at different times and always feel welcomed."

We read recent compliment cards and letters received in the home. They included the following comments. 'I visited [name of person] last Saturday which was obviously really sad to see him in his last days. But it also was so reassuring and such a relief to see that he is in your care. Everyone, without exception, was really friendly, kind, thoughtful and very responsive and professional. What more could anyone hope for' and, 'To all your wonderful carers in all your various roles, as the card says, I can't thank you enough for all you did for Mum. Your love and kindness to all the residents makes such a difference in their lives.'

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection on 26 September 2017 we rated this key question as Requires Improvement. This was because care plans were not always responsive and personalised to people's individual and current needs, and did not always provide sufficient guidance for staff on how to meet people's needs. At this inspection, in the six care plans we looked at, significant improvements had been made. Care plans were updated on a regular basis. Further improvements were needed, as detailed below, to make sure all people consistently received the personalised care they needed. This key question continues to be rated Requires Improvement.

Staff told us, as we have reported in the safe section of the report, they did not always have sufficient staff to provide personalised care. One member of staff commented that, 'It's not just about numbers. When we have new staff and agency staff too, it can be tough. We might have the numbers but it takes longer because they have to be shown what to do." Another member of staff told us, "Sometimes people have to stay in bed until late in the morning when we've had shortages of staff, and sometimes people have to wait for meals." They told us they occasionally did not provide baths or showers for people because there was not enough time. In addition, on the first day of our inspection, we observed that people were not provided with timely support at mealtimes. We also raised a complaint on behalf of one person who told us they had not received a response to their call bell.

For one person, a member of staff told us they often needed three staff to provide support for a person who used a hoist. They told us this was because the person often found movement painful, so an additional member of staff provided physical assistance and reassurance to the person whilst they were being moved. This was not reflected in the care records that stated the person required two staff to support them to move with the hoist. For another person, their care records did not fully reflect how to approach and respond to the person when they were distressed or displayed behaviours that may be challenging to others. Observations noted by the dementia well-being team, that the person may 'respond better when staff do not talk too much' had not been incorporated into their care plan.

For other people records provided details of how their needs were to be met. In addition to the detail of how people were supported with physical care, prompts such as actions to take 'If I get upset/anxious' enabled staff to consider and record support interventions for people unable to fully communicate their needs and wishes.

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known. On the day of moving into the home, the registered manager had introduced a 'meet and greet' service where a member of staff was specifically allocated for a morning or afternoon to help the person settle in and familiarise with the care home.

Other care plans were designed to reflect individual needs, choices and preferences. Care was planned and records were checked and reviewed each month. Relatives told us they were kept up to date and involved when there were changes and commented, "Staff are very responsive. They keep us informed about Mum's well-being. My sister who visits regularly has a good relationship with the staff and would have something to

say if things were not right," and, "I am confident in the staff's abilities to care for my [name of person] and I have free rein to visit as often as I please. I have a meeting planned with dementia well-being and the manager to talk about the care and I am happy with how they are handling it."

A range of activities were usually provided. One person told us, "Whatever activities there are, I join in. I do gardening and planting seeds. There is a lovely garden. It is really good here. I would never complain. There is always something going on and the food is home cooked. We all went to an art gallery recently in town and we had a light lunch. It was really nice." Another person commented, "I enjoy going down to the garden. The staff take me in my wheelchair. When there are only two staff (in the area of the home where the person lived) I miss out on opportunities to go down. I wouldn't ask if there weren't enough staff."

At the time of our inspection, due to unforeseen circumstances, none of the three activity staff were working. We were therefore unable to experience and observe the 'usual programme of activities, engagement and one to one support.' The provider's regional activity support manager visited on the first day of our inspection, to provide support and to coordinate the group activities. A musical entertainer also visited and people in the lounge looked to be enjoying the singing and dancing. In addition, staff played 'games in the lounges' with people. This included board games and chair exercises with balloons and balls.

The registered manager told us about the introduction of the 'Magic Moments Club' to provide new experiences for people. They told us about the 'picnic in the park' event held in June, the festivities organised for the recent 'royal wedding' and their aim to enable more people to enjoy events and activities outside of the home.

Bamfield Lodge was one of a group of care homes in Bristol participating in a project with 'Alive,' an organisation dedicated to improving the quality of life of older people through meaningful activity and increased social interaction. Their 'communities of interest' is a project that works to connect care homes to groups in their local community. As part of the project, people had been involved in activities with a local nursery, entertained by folk singers, were compiling a cookery book and planning a 'wheelchair bicycle' activity.

People and relatives told us they were aware of the complaints procedure and would feel comfortable raising concerns if they needed to. The complaint we raised on behalf of a person using the service was investigated and the registered manager provided a response within the timeframe as required within the provider's complaints policy.

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection on 26 September 2017 we rated this key question as Requires Improvement. This was because accurate records were not always maintained and there was a lack of an effective quality assurance programme to mitigate risks to people and drive improvements. This was a repeated breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

At this inspection, significant improvements had been made. Further improvements were needed, and the service needed to be able to demonstrate they could consistently identify shortfalls and sustain the changes and improvements they had already made. For example, the provider has been sending an action plan to CQC each month. The updates since January 2018 stated that actions taken regarding the 'nutrition and the dining experience' had been 'reviewed and sustained.' This was not what we observed on the first day of our inspection, where the meal service in part of the home was chaotic and disorganised, and people were not always provided with the support they needed. The registered manager told us this was not a regular occurrence. They were responsive to our feedback and acted to address this shortfall we had observed.

The provider had a range of monitoring and auditing systems. They also had a cleaning programme and a redecoration programme. However, we found shortfalls in the environment including unsecured wardrobes, areas of carpet that were worn and frayed and recliner chairs that were not clean. These shortfalls had not been identified in the providers auditing programme. The registered manager and their team acted in response to our findings. The maintenance team told us they checked wardrobes were secure on a regular basis. They told us furniture had recently been moved when areas of the home were being decorated, and this was an oversight. The recliner chairs were cleaned and the task specifically added to the night staff cleaning programme, before the end of our inspection.

People and their relatives spoke positively about the recently appointed registered manager who had started in post in May 2018. Feedback included, "I have seen the manager. Her name is [name]. She speaks very softly when she talks to me," "There is a new manager. I would recommend this home. I have a friend whose Mum is also here and he says the same thing. I cannot think of any improvements. Generally, I am very satisfied," and, "The new manager is good. I would go to her if I had any concerns."

The provider's action plan showed that improvements had been made. Risk assessments were completed and risk management plans were in place. Care records had improved and were written in a more personalised way. A plan was in place and staff supervisions were being completed. Overall compliance with mandatory training had improved. The registered manager told us their initial priority since starting in post was a focus on staff recruitment. They had successfully recruited care staff and told us their next main challenges were the recruitment of registered nurses and a focus on the dining experience.

People using the service and relatives were provided with opportunities to feedback at meetings which were held on a regular basis. We looked at the minutes from the last two meetings. In June 2018, the registered manager arranged the meeting to introduce themselves. They shared that they were 'carefully reviewing dependency levels so we have the right number and type of staff we need.' At the most recent meeting there

was a discussion about the food provision and the activities programme. In addition, an annual satisfaction survey was completed. The results from the most recent survey had just been collated, and actions had not yet been agreed. However, the 'headline' feedback showed the highest scores were achieved for activities and entertainment and the lowest scores for food quality and staff turnover.

The registered manager completed a 'daily walkabout' in the home and recorded their findings. In addition, they held daily 'flash meetings with heads of department where key issues and changes in the home were discussed. The heads of department then communicated messages from the meetings to their respective teams. The registered manager had undertaken night visits, to monitor how care was provided during the night, in addition to working the night shift on two occasions. They told us they had no concerns, that staff worked well and care was provided as needed.

Staff were positive about the registered manager and their comments included, "She was really supportive to me when I was worried about working on the nursing floor," and, "I think she's really good, just hope she stays."

Staff had the opportunity to express their views at general staff meetings. Minutes were recorded and circulated. Staff had the opportunity to contribute and the registered manager shared information and discussed changes and improvements they were planning to make. In addition, a team engagement survey had been completed. Results were collated and actions had been agreed in response to the lowest scoring responses to, 'I know what is expected of me at work' and 'I have the opportunity to do what I do best every day at work.'

Staff were aware of the provider's values. A member of staff told us, "We all know what the values are, such as making moments count."

The registered manager could tell us how they kept up to date with current practice. They told us they received support, direction and guidance from the provider. This included bi-monthly meetings with other registered managers and with invited speakers. They also participated in home review meetings with the regional support manager and regional manager, where key issues and progress with the home action plan were discussed. They took the opportunity to attend local authority forums and care roadshows.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.