

Bedford Citizens Housing Association Limited

Bedford Charter House

Inspection report

Bedford Charter House
1B Kimbolton Road
Bedford
Bedfordshire
MK40 2PU

Tel: 01234321400
Website: www.bchal.org

Date of inspection visit:
16 February 2016

Date of publication:
14 April 2016

Ratings

Overall rating for this service

Requires Improvement 

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?

Good 

Summary of findings

Overall summary

This inspection took place on 16 February 2016. It was unannounced.

Bedford Charter House is a substantial, purpose built care home, which opened in February 2015. Prior to this, the service had operated from a smaller building on the same site. The new building provides a service for up to 72 people who have a range of care needs including dementia and physical disabilities. Short term (respite) care is also provided. During this inspection, 68 people were using the service.

A registered manager was 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.

Systems were in place to ensure people's daily medicines were managed in a safe way and they got their medication when they needed it. However, concerns were identified in terms of how people's PRN (as required) and topical medication was managed.

Processes were in place to manage identifiable risks within the service, and ensure people did not have their freedom unnecessarily restricted. We did find some anomalies in terms of how often risk assessments had been reviewed or completed however.

We saw that although people were given opportunities to be involved in making decisions about their care and support, their care plans were not always adequately robust, or reflective of their current needs.

We also found that the service worked to the Mental Capacity Act 2005 key principles, which meant that people's consent was sought in line with legislation and guidance. However, this information was not always transferred into people's care plans.

Despite this, we did see evidence of work that had begun to review everyone's risk assessments and care plans, as a part of an improved care plan system that was due to be implemented.

The registered manager also had a plan to address gaps in staff training and supervision; to ensure all staff working in the home received the right support and training to carry out their roles and meet people's assessed needs.

People felt safe living at the service. Staff had been trained to recognise signs of potential abuse and keep people safe.

There were sufficient numbers of suitable staff to ensure people's safety and meet their individual needs.

The provider carried out proper recruitment checks on new staff to make sure they were suitable to work at the service.

People had enough to eat and drink. Assistance was provided to those who needed help with eating and drinking, in a discreet and helpful manner.

People's healthcare needs were met. The service had developed positive working relationships with external healthcare professionals to ensure effective arrangements were in place to meet people's healthcare needs.

Staff were motivated and provided care and support in a caring and meaningful way. They treated people with kindness and compassion and respected their privacy and dignity at all times.

People's social needs were provided for and they were given opportunities to participate in meaningful activities. It was clear that the provider recognised this as an important part of people's lives.

A complaints procedure had been developed to let people know how to raise concerns about the service if they needed to.

There were effective management and leadership arrangements in place.

Systems were also in place to monitor the quality of the service provided.

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.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, concerns were identified regarding the management of PRN (as required) and topical medication.

Risks were managed so that people's freedom, choice and control were not restricted more than necessary. We did find some anomalies in terms of how often risk assessments had been reviewed or completed however.

Staff understood how to protect people from avoidable harm and abuse.

There were sufficient numbers of suitable staff.

The provider carried out robust checks on new staff to make sure they were suitable to work at the service.

Is the service effective?

Requires Improvement 

The service was not always effective.

Gaps were identified in terms of staff training and supervisions.

The service acted in line with legislation and guidance in terms of seeking people's consent and assessing their capacity to make decisions about their care and support. However, this information was not always transferred into people's care plans.

People were supported to have sufficient to eat and drink.

People were also supported to maintain good health and have access to relevant healthcare services.

Is the service caring?

Good 

The service was caring.

Staff were motivated and treated people with kindness and

compassion.

Staff listened to people and supported them to make their own decisions as far as possible.

People's privacy and dignity was respected and promoted.□

Is the service responsive?

The service was not always responsive.

People received personalised care that was responsive to their needs. However, care plans were not always adequately robust, or reflective of people's current needs.

Systems were in place to enable people to raise concerns or make a complaint, if they needed to.

Requires Improvement ●

Is the service well-led?

The service was well-led.

We found that the service promoted a positive culture that was person centred, inclusive and empowering.

There was a registered manager in post who provided effective leadership for the service.

There were systems in place to support the service to deliver good quality care.

Good ●

Bedford Charter House

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 16 February 2016. It was carried out by two inspectors.

We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

In addition, we asked for feedback from the local authority, who have a quality monitoring and commissioning role with the service. We found that the local authority were carrying out their own monitoring checks at the same time as our inspection, accompanied by a consultant clinical pharmacist from the local complex care team, who took the lead role for checking medication systems within the home.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences.

We spoke with 12 people living in the home and observed the care being provided to a number of other people during key points of the day including lunch time and when medication was being administered. We also spoke with the registered manager, five care members of staff, the chef, the activity coordinator and two administration staff. After the inspection, a relative took the time to contact us to provide feedback about their experience of the service.

We then looked at care records for six people, as well as other records relating to the running of the service - such as staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Is the service safe?

Our findings

Systems were in place to ensure people's daily medicines were managed so that they received them safely, but these were not consistently followed. Although people told us they received their medication when they needed it - one person told us: "I get my tablets when I need them and they make sure I have them on time", concerns were identified regarding the management of PRN (as required) and topical medication.

A PRN protocol was in place for each person providing guidance for staff on what PRN medication had been prescribed for each person, and its purpose. Protocols we looked at were not sufficiently detailed. For example, one person's protocol recorded that they had been prescribed a particular medication for 'pain'. However, there was no further information about the type or location of the pain. Another person required their medication to be given covertly; to maintain their health and wellbeing. There were clear records setting out the reason for this and the fact that the decision had been made in the person's best interests. However, there was no information to instruct staff on how best to give the medication.

We saw evidence that staff did not always ensure people took their PRN medication as prescribed. For example, an entry on one person's medication administration records (MAR) recorded that their pain relief had not been given one lunch time because: 'resident still drinking tea with codeine from morning round'. This meant that the person had not received their full dose in the morning. We noted that the person's PRN protocol listed two different types of medication for 'pain relief', but there was no further guidance on which one was the most appropriate to give and when. This placed the person at risk of not receiving the right pain relief when they needed it.

MAR charts did not always record the reasons for PRN medication being given, making it difficult to assess whether a person's healthcare condition had increased or decreased. In addition, one person who required medication for breathlessness did not have information about this in their care plan; although it had been identified as a need at assessment stage. This meant there was a risk that staff might not have full knowledge of the person's medication requirements.

Staff were also not clear about when to give PRN medication. For example, one person was given a heart burn / indigestion remedy whilst they were still eating lunch. When asked, staff were not sure whether the person should have been given this before or after food. Aside from the fact that this may have spoiled the taste of the person's meal, it is likely that the benefit of the medication would have been reduced. The registered manager confirmed afterwards that it should have been given after food.

Topical creams had been prescribed for some people and corresponding administration records were being maintained. We noted these did not always detail what the creams were for. In one person's records we saw clear information about the purpose of the cream and directions for its use. However, there was nothing on the administration record to show that this particular cream had been used, because two different creams had been recorded instead. In addition, we noted a number of gaps on the administration charts, indicating that the topical creams may not have been given as prescribed.

These were breaches of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoke to us about how risks to people were assessed to ensure their safety and protect them. They described the processes used to manage identifiable risks to individuals such as malnutrition, moving and handling, falls and skin integrity.

We saw that people had individual risk assessments in place to assess the level of risk to them. In general the assessments were clear and had been reviewed on a regular basis; to ensure the care being provided was still appropriate for each person. However, we did identify some anomalies in terms of how often assessments had been reviewed or completed. For example, in one person's file we saw that their malnutrition assessment score required the person to be weighed weekly. This had not been done and when we spoke with the registered manager we found that the score had been totalled incorrectly, meaning that the person did not actually require monitoring on a weekly basis. The registered manager told us that everyone's risk assessments would be reviewed as a part of his plan to implement an improved care plan system.

People told us that they felt safe living in the home. One person said: "I feel secure here." Another person told us: "I do feel safe and that's down to the staff here." Staff told us they had been trained to recognise signs of potential abuse and were clear about their responsibilities in regard to keeping people safe. One staff member told us: "We would always report things to our senior who would check it out." Another member of staff added: "We keep body maps, bruise charts for safeguardings; we would always go to the senior." Information was on display which contained clear information about safeguarding, and who to contact in the event of suspected abuse. Records we looked at confirmed that the majority of staff had received training in safeguarding and that the home followed locally agreed safeguarding protocols.

One of the home's administrators showed us that records were being maintained of incidents and accidents that had occurred in the home, in order to minimise the likelihood of a reoccurrence. We saw that one person had experienced a high number of falls in recent months, but there was a clear record in their care records of contact with relevant external professionals; to support the person and minimise the risk of further falls in future. We observed staff on a number of occasions supporting people as they moved about the home. They demonstrated safe techniques and supported people in a reassuring manner.

Other records showed that systems were in place to ensure the premises were managed in a way that ensured the safety of people, staff and visitors. We observed a new staff member being shown where the fire access points were and where the extinguishers were within the service. Records also showed that security arrangements at the home were being reviewed in response to a break in a couple of weeks before hand. Staff confirmed that no one had been harmed, but action was being taken to ensure staff and people felt safe in the future.

People told us there were sufficient numbers of staff to keep them safe. Staff we spoke with were also content with staffing levels in the home. One staff member said, "I think there are enough staff, when we have agency they try to get the same ones for consistency, when they don't that's when it impacts. It's not management's fault, they try and recruit, they really do." Another staff member told us: "We get put all over the home and I prefer that...we get moved around but that helps us to know people." The registered manager confirmed that there were a small number of staff vacancies, so agency staff had been used to ensure staffing levels did not fall below planned levels. However, he told us he tried to book the same members of agency staff, for consistency of care and told us he allocated staff on each shift; to ensure an even mix of skills and experience on each level of the home. Another member of staff confirmed that new

staff were being appointed and told us: "We have great new staff, we all get on well."

Records showed that the service was actively seeking to recruit new staff and rotas demonstrated that a number of new staff had recently been appointed, reducing the number of staff vacancies. We also saw evidence that the service had taken the positive decision not to admit anyone new to the home, and also reduced the number of respite places, until staffing levels had increased. The registered manager was very clear about not increasing these numbers until good care was consistently achievable for everyone using the service. We saw on the day of our inspection that the planned numbers of care staff were on duty, supplemented with additional support from the registered manager, catering, activity, housekeeping, administrative and maintenance staff.

The registered manager described the processes in place to ensure that safe recruitment practices were being followed; to ensure new staff were suitable to work with people living in the home. We were told that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. We looked at a sample of staff records and found that all legally required checks had been carried out. Proformas were also in place for agency staff working in the home, which contained information about their checks and training.

Is the service effective?

Our findings

Staff told us they felt well supported although some told us the frequency of formal supervision sessions had slipped during the past months. One member of staff said: "It's been a long time since I had supervision, we need supervisions for feedback. It's been a long time since I had an appraisal." The registered manager acknowledged this, and showed us that he had begun to address the supervision gaps. He also told us he was looking to introduce group supervisions to supplement individual sessions; to provide staff with additional support in carrying out their roles and responsibilities. Despite the gaps in supervision, staff we spoke with were positive about the new registered manager's open door approach. During the inspection a member of staff needed to speak with the registered manager about a training query, and we saw that this was quickly facilitated.

People confirmed they received effective care from staff with the right skills and knowledge. Staff told us that they received the right training to carry out their roles, including support to achieve national health and social care qualifications. One member of staff said: "The training is really good; helps give us the knowledge to do manual handling and give medication." We were also told, "I definitely think we have enough training." Another staff member said: "The training is good and I have been funded to do my NVQ Level 2 and 3." A new staff member talked to us about their induction training and said they had shadowed a more experienced member of staff, to support them in gaining the right skills and knowledge to meet the needs of the people using the service. The registered manager confirmed that new staff completed the Care Certificate, which was introduced in April 2015 for new health and social care workers as part of their induction. He also confirmed that new staff shadowed a more experienced member of staff for up to five days before being counted as part of the rota. We observed this to be the case on the day of this inspection.

Training matrixes had been developed which provided information to enable the registered manager to review staff training and see when updates / refresher training was due. This confirmed that staff had received training that was relevant to their roles such as induction, safeguarding, dementia, moving and handling and dignity. Due to staff changes, there were some gaps on the matrix in key areas such as nutrition and the Mental Capacity Act 2005 however, the new registered manager was able to demonstrate that he was in the process of arranging training, and told us the gaps would be filled by May 2016. Due to the numbers and skill mix of staff on duty, there was evidence that staff had sufficient knowledge and skills to meet people's needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 were being met, and found that systems were in place to assess people's capacity. Throughout the inspection we observed that staff sought consent from people before undertaking any activity. They demonstrated a good understanding of people's needs and encouraged them to make their own choices and decisions, as far as possible. For example, giving them a choice of what activity to do, what drinks to have and even down to what colour hoop they wanted to use within an exercise session. People were seen to respond positively to this approach.

Records also showed that decisions had been made in people's best interests where they lacked capacity; to ensure they received the right care and support to maintain their health and wellbeing. We saw that these decisions had been made involving the person's GP and / or relatives. However, this information was not always transferred into people's care plans, meaning that when people were considered to have variable capacity, there was limited guidance for staff as to what areas each person had the ability to consent to and what areas they did not.

Some people had a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form in their care plan. The DNACPR forms we saw demonstrated involvement from the person concerned and clearly recorded the reason for it being in place. Information about people's advanced decisions about their care had also been included within their care plans.

People told us they had enough to eat and drink and that they enjoyed the food provided. One person said: "The food is always really nice here, very tasty and we always have a choice." Other people commented that they enjoyed the food and explained that they got to discuss menu options at the resident meetings that were held. "[Name of catering manager] always comes down to ask me about the food, he tells me if I don't like something just to ask and I can have something different." The chef told us that menus were completed on a four weekly programme and took into account people's preferences and choices. When cultural diets or condition specific diets were required we found that systems were in place to ensure the kitchen staff were aware of these, for example, soft options or diabetic diets. Records showed that people's nutritional needs had been assessed, with any specific requirements such as soft options or assistance with eating outlined. Menu options were also displayed on each dining table and on notice boards throughout the service.

Throughout the day a choice of food and drinks were readily available. When someone in their room requested a cold drink because they had run out, this was arranged quickly by staff. During lunch time we saw that people were given time to eat and drink and the pace was not rushed. Assistance was provided in a discreet and helpful manner to people who required help with eating and drinking. We noted that dining tables were laid appropriately; providing a visual clue for people living with dementia that it was time to eat. However one person who ate lunch in their room told us they would also like to be provided with salt. We also observed that some people's dining experience was affected by the length of time they were sat at dining tables, before their meal was served however. For example, a small number of people were seen sitting at tables for over 20 minutes, at times with their eyes closed.

People confirmed they were supported to maintain good health and have access to relevant healthcare services. One person told us: "They look after my diabetes and they look after me." Staff told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support. Records demonstrated that referrals were made to relevant health services when people's needs changed, and a log of visits to and from external health care professionals was being maintained in people's care records.

Is the service caring?

Our findings

People confirmed that they were treated with kindness and compassion. They spoke positively about the care and support they received. One person told us: "Yes, it's okay really okay here, I'm happy and they look after me well." Another person said: "They always come when I want them to; they always have a smile on their faces. It's very nice here thank you." A third person added: "I've been here ages, seen this new place being built. I can't fault them; they are all so lovely, kind and caring to me." After the inspection a relative contacted us in writing and described the service as: 'Amazing'. They went on to say that the staff and management had provided good support to them and their relatives.

We observed many positive interactions between staff and the people using the service throughout the inspection. Staff demonstrated a good understanding of the needs of the people they were supporting and their approach was personalised. For example we observed one staff member interacting with someone who had a special possession. We heard the staff member asking respectful and meaningful questions about the object in question. We also observed and overheard lots of laughter and chatter between staff and people. It was clear from the conversations we heard that staff were knowledgeable about the people they were speaking with and knew how best to engage them.

We noted staff to be supportive. During an activity session, the activity coordinator offered gentle encouragement to people to participate and offered support when this was required. We observed other staff providing people with positive feedback too, in a kind and sincere manner. For example a member of staff entered the activity room and smiled at someone, saying: "You are doing well." The person responded by giving the staff member a 'thumbs up' in recognition and smiled back.

People confirmed they felt involved in making decisions about their care and day to day routines. We noted that staff listened to people and provided information in a way that was appropriate for each person. We also heard them taking the time to check people were okay with the support and care provided. For example we heard comments such as: "Is that better?" and "How's that - happy?" We observed one person who was unsure about participating in an activity. A staff member took time to explain the activity to the person; reassuring them about their worries. After this, the person was seen happily joining in. This approach provided the person with the information and confidence to make their own decision about whether or not to join in with the activity. Staff also enquired with people to ensure they had everything they were likely to need to hand such as tissues, newspapers and fluids.

People told us that their privacy and dignity was respected. A member of staff told us: "It's their home, not ours; we draw the curtains and make sure we shut the door for personal care." We saw staff knocking on people's doors before entering their rooms, demonstrating respect for people's private space. Staff communicated with people with respect too, using a gentle tone of voice and offering reassurance when this was needed.

In addition, we noted the building had been designed to a high standard, which provided people with comfortable and dignified surroundings. The building provided lots of space on each floor, meaning that

people could choose where they spent their time - whether in company or alone. We saw one person who liked to sit in the reception area so they could see what was going on, and another person who liked to sit with staff at the nursing station. Facilities had also been provided throughout the building to enable people to spend time with friends and relatives in comfortable and peaceful surroundings. Information that had been developed for people using the service and prospective users, confirmed that visitors were able to visit without restriction. We observed a number of people receiving visitors during the inspection.

Is the service responsive?

Our findings

People confirmed that they, or those acting on their behalf, were able to contribute to the assessment and planning of their care. Staff told us that before people used the service, they were asked for information about their needs. This information was then used to develop a care plan that reflected how each person wanted to receive their care and support. One staff member said: "We know how to write care plans."

We reviewed care records and found that people had been asked for information prior to moving in. We looked at care records for someone who received occasional respite care from the service. The person's relatives had provided information about their needs in 2014, but there was no evidence to show that this had been reviewed with the relatives when the person had been readmitted in 2016. This meant there was a risk that the person's care plan was not up to date or reflective of their current needs. The new registered manager advised that he had already recognised that improvements were required in terms of respite care provision. Records supported this, and showed that he had reduced the number of respite beds currently offered, until he was satisfied that this service could be properly met. He also told us he intended to introduce six monthly reviews for everyone using the service, and 'resident of the day'. He explained this was an initiative to support staff to really understand what is important to each resident, and to review in depth what would make a difference to them.

Care plans we looked at had been reviewed regularly; to ensure the care and support being provided to people was still appropriate for them. We also noted that handwritten updates had been added in as people's needs changed, indicating that these were used as working documents. However, we found that some care plans were not sufficiently robust or personalised. For example, one person's care plan stated they needed to wear repose boots, to minimise the risk of them developing a pressure ulcer, but the plan did not include information for staff on how often this should happen. We also found that plans did not always demonstrate the involvement of the person.

Daily records were being maintained to demonstrate the care provided to people. A tick box chart had been developed to demonstrate the interventions and interactions provided to people each day. We saw that there were gaps in the charts, meaning they did not adequately demonstrate the care provided to people as detailed in their care plans. The registered manager showed us some separate computerised records which did contain additional information about each person and addressed most of the gaps. However, he acknowledged that the current system did not provide a clear oversight of each person's care. The registered manager showed us a new daily report and an example care plan that he planned to introduce to address both these issues. He told us he aimed to work on this with the new deputy manager to ensure everyone had a care plan containing sufficient detail to meet their needs, by June 2016. Records showed that he had already shared these plans with staff working in the home, and this work was ready to begin.

People talked to us about their hobbies and social interests. It was clear from the facilities provided and the activities team in place, that the provider recognised this as an important part of people's lives. We saw that a number of different areas had been created in the home for people to enjoy and spend time in including: a clubhouse, gym, library with computer facilities, activity room, a sensory room, a snooker table and a full

size hairdressing salon. One person told us: "We have a hairdresser here, she's good." During the inspection we saw people using this facility. We spoke with one of the activity coordinators who told us about activities that were provided. They also explained that they visited people in their own bedrooms if they did not wish to join in with the group activities provided, so they did not miss out.

We observed activities taking place throughout the day - some planned and some not. We noted that the use of the television was kept to a minimum, and people were encouraged to participate in activities that were meaningful for them. Activities we observed were undertaken at an appropriate pace for the people involved and when support was required, this was done so discreetly. We observed lots of smiling faces and heard happy comments made. During an exercise session a variety of individual exercises were completed, to keep people engaged and stimulated. People were clearly having fun - clapping, smiling and laughing with each other. We also observed a 'music for memory' session taking place. This was a lively activity that incorporated musical instruments and movement. Later in the day, we heard a member of staff reminiscing and singing with a person who responded with an infectious chuckle; indicating their enjoyment of the interactions taking place. We observed the staff providing activities to be confident and enthusiastic in carrying out their roles. Their focus was very much on the people using the service.

A weekly activity schedule was available for people which included a variety of activities for them to choose from for example, word games, arm chair exercises, quizzes, arts and crafts and board games. We also saw evidence to suggest that the service had organised themed events to celebrate key dates and holidays such as Christmas, Burns Night and St Patricks Day. Photographs were seen on display of people smiling, as they participated in some of the activities that had been provided.

Everyone we spoke with told us they knew how to make a complaint or raise a concern. People told us they felt the staff team were approachable and that they would feel comfortable speaking with a member of staff if the need arose. One person told us: "I have no complaints at all." Another person added: "No complaints about anything." Staff we spoke with were clear that they would report any complaints they received to a senior member of staff.

We saw clear information had been developed for people outlining the process they should follow if they had any concerns. We spoke with the registered manager who showed us that a record of complaints and compliments was being maintained. We noted from this that concerns were taken seriously, and people were kept updated on the actions taken in response. This showed that people were listened to and lessons learnt from their experiences, concerns and complaints.

We saw that relatives had taken the time to provide positive comments and praise too. Recent written compliments included: 'You have all been unfailingly kind' and 'Thank you for your amazing kindness and professionalism in caring for [Name of Person]'. A third person had written: 'Given the workload, strain and difficulties all the staff have faced, this pays enormous tribute to the ethos and professionalism of your organisation'.

Is the service well-led?

Our findings

People told us there were opportunities for them to be involved in developing the service, which included attending resident and relative meetings, and completing satisfaction surveys. We read some of the most recent meeting minutes and noted that people clearly felt comfortable expressing themselves and putting ideas forward.

We saw that key members of staff attended meetings, enabling people to ask direct questions about particular areas of the home. For example, the catering manager regularly attended meetings, to seek people's feedback about the food provided. Minutes we read provided clear information about actions taken in response to people's feedback, demonstrating that they were listened to and had their views acted on. Similarly, surveys had been used to gain feedback from people, relatives and staff. The results had been collated with clear action points in response to any suggested areas for improvement. We noted from the tone and content of records that feedback was received positively from the provider and senior staff, and the corresponding action points reflected this.

Bedford Charter House is run by a voluntary, non executive board who are supported by a senior management team who each have different responsibilities for running the service. Staff told us about an internal consultative committee made up of the key members of staff from each team, such as care, catering, housekeeping and maintenance. They told us this provided staff with the opportunity to be involved in the day to day running of the service, and to provide feedback. Records showed that staff were actively encouraged to get involved with these meetings. Recent minutes also highlighted that the provider / CEO had taken time out from her normal duties, to observe day to day practice within the home and identify areas for improvement, which she had. Minutes also recorded that staff had been given the opportunity to spend time with the CEO, enabling them to see what her job entailed. This demonstrated an inclusive and empowering approach from senior staff.

We saw lots of information around the home for people, staff and visitors regarding the staff employed, the complaints process, safeguarding arrangements, activities, fire safety arrangements and the home's philosophy of care. Clear information had also been developed for prospective users of the service, setting out what they could expect from the service, their rights and also information about fees and the cost of any extra services. Useful contact numbers had been provided for people, so that they could contact the different teams within the service such as reception, catering, finance, the registered manager and provider, directly. This demonstrated an open and transparent approach in terms of how information was provided to and communicated with people.

The service demonstrated good management and leadership. Everyone we talked with spoke positively about the management of the home. Since the new building opened in February 2015 there had been a change in manager, with the new registered manager taking up his post in October 2015. People told us they found the new registered manager approachable and supportive. It was clear that he was having a positive impact on the service. People we spoke with knew who the registered manager was, and felt that he did a good job. One person said: "[The registered manager] is always very cheerful, very helpful and very caring."

We observed the registered manager going round the building. It was clear that he knew people and they knew him, which for a service of this size was notable.

Staff also felt that the manager was doing a good job and was working hard to improve the service. One staff member told us, "I love it, I'm very happy; I don't mind working anywhere [in the home]. They are all lovely; we can always have a laugh." Another staff member said, "The manager is lovely, always nice, very approachable." A third staff member said, "[The registered manager] is good, we can always knock on the door for help, he sorts things out for us." We observed this to be the case during the inspection. The registered manager told us that a new deputy manager had been appointed, who would be able to support them in taking the service forward and providing a good quality service. The registered manager confirmed he felt well supported by the provider and confirmed appropriate resources were available to drive improvement in the home.

Staff we spoke with were clear about their roles and responsibilities across the service. There was a lead person for different aspects of the service such as catering, housekeeping, administration and maintenance, and each lead had clearly defined responsibilities. All the staff we spoke with spoke enthusiastically about their roles and knew what was expected of them; to ensure people received support in the way they needed it. We observed staff working cohesively together throughout the inspection and noted the way they communicated with one another to be respectful and friendly. We also found the manager to be open, organised and knowledgeable about the service - he responded positively to our findings and feedback, as did staff, who we found to be helpful and accommodating.

Systems were in place to ensure legally notifiable incidents were reported to us, the Care Quality Commission (CQC). However our records showed that not all notifiable incidents had not been reported as required. We noted that some of these had occurred during a period of management change. After the inspection, the provider contacted us to confirm that action had been taken to ensure all notifiable events would be reported as required in future.

The registered manager talked to us about the monitoring systems in place to check the quality of service provided. Records showed that internal audits and checks took place on a regular basis; to ensure the service was providing safe, good quality care. We noted that more recent audits had been developed to correspond with the Care Quality Commission's five key questions which we focus on when inspecting services - is a service safe, effective, caring, responsive to people's needs and well-led? We saw that information was analysed on a regular basis, for example in terms of the number of falls occurring; as a way of identifying patterns and understanding when to request external support, to meet people's needs. We reviewed the quality audit information from the kitchen and found that regular cleaning took place along with monitoring of food temperatures, and fridge and freezer temperatures. We noted too that the kitchen had been awarded a 5 star (the highest level) food hygiene rating. Other areas where checks took place regularly included medication, training, staffing and care plans. This showed that arrangements were in place to monitor the quality of service provided to people, in order to drive continuous improvement.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were in place to ensure people's medicines were managed in a safe way and that they got their medication when they needed it. However, these were not consistently followed.