Bupa Care Homes (CFHCare) Limited

Bedford Nursing and Residential Home

Inspection report

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Leigh
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The unannounced inspection took place on 17 May 2016. The last inspection, which was a focused inspection, was undertaken on 30 December 2015. At this inspection we found there had been breaches of four regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing, safe management of medicines, assessing and mitigating risks to people using the service, need for consent, safeguarding and depriving people of their liberty without lawful authority. We found during this inspection that improvements had been made to meet the relevant regulations.

Bedford Nursing and Residential Home is a large care home with 180 beds that is operated by BUPA. The home is divided into six different units, each with 30 beds. Astley and Lilford care for people who require personal care and support, Croft and Kenyon look after people with mainly physical nursing needs and Pennington and Beech care for people with dementia care nursing needs. The home is situated in a residential part of Leigh that is not far from the town centre.

There was a manager at the home who was in the process of registering with the Care Quality Commission. 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.

At the inspection we found a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to safe administration of medicines.

Despite significant improvements in the area of medicines there were still some inconsistencies across the units and some issues with administration and disposal of medicines.

Appropriate safeguarding policies and procedures were in place at the home and staff were aware of the reporting procedures and signs to look for. Staff were aware of the whistle blowing policy and felt confident to report any poor practice they may witness.

Staffing levels at the home had improved, due to a significant reduction in reliance on agency staff as a result of recruitment of permanent staff.

Staff were recruited safely via a robust recruitment procedure. Staff induction was thorough and training was on-going for all staff. Supervisions had not taken place for some time, but plans were in place to implement a programme of supervisions and appraisals.

Appropriate risk assessments were in place and falls management had improved considerably. Health and safety measures were in place at the home.

People were given a choice of food and staff were aware of people's preferences and particular dietary requirements.

Care plans were person-centred and included relevant health and personal information. Reviews of care were undertaken regularly and records were complete and up to date.

The service had made some efforts to make the environment suitable for people living with dementia or some level of confusion. However, the environment would benefit from being more dementia friendly.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People we spoke with told us staff were caring and kind. We observed that staff responded quickly to people's needs, gave explanations of what they were doing and were reassuring.

Efforts were made to include people who used the service and their relatives in reviews of care.

Staff were beginning to undertake training in end of life care to allow people to spend their last days in the place of their choosing.

There were some activities on offer and plans in place to increase the number and relevance of activities in the near future.

Care plans included a lot of individual, personal information to assist staff to care for people appropriately.

There was an appropriate complaints policy in place and complaints were responded to in a timely way.

Staff support had improved with the new acting manager now in post. Plans were in place to ensure all staff were supported with regular supervisions and team meetings.

Quality audits were now taking place although there was still some room for improvement in collecting meaningful data.

Areas such as falls and accident monitoring were now being looked at in more depth and incidents of falls with injury had reduced.

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 consistently safe.

Appropriate safeguarding policies and procedures were in place at the home and staff were aware of the reporting procedures and signs to look for.

Despite significant improvements in the area of medicines there were still some inconsistencies across the units and some issues with administration and disposal of medicines.

Staffing levels at the home had improved, due to a significant reduction in reliance on agency staff as a result of recruitment of permanent staff.

Staff were recruited safely via a robust recruitment procedure.

Appropriate risk assessments were in place, falls management had improved and health and safety measures were in place.

Is the service effective?

Good

The service was effective.

People were given a choice of food and staff were aware of people's preferences and particular dietary requirements.

Staff induction was thorough and training was on-going for all staff.

Supervisions had not taken place for some time, but plans were in place to implement a programme of supervisions and appraisals.

Care plans included relevant health and personal information and reviews were complete and up to date.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People we spoke with told us staff were caring and kind. We observed that staff responded quickly to people's needs, gave explanations of what they were doing and were reassuring.

Efforts were made to include people who used the service and their relatives in reviews of care.

Staff were beginning to undertake training in end of life care to allow people to spend their last days in the place of their choosing.

Is the service responsive?

Good

The service was responsive.

There were some activities on offer and plans in place to increase the number and relevance of activities in the near future.

Care plans were person-centred and included a lot of individual information to assist staff to care for people appropriately.

There was an appropriate complaints policy in place and complaints were responded to in a timely way.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff support had improved with the new acting manager now in post.

Quality audits were now taking place although there was still some room for improvement in collecting meaningful data.

Areas such as falls and accident monitoring were now being looked at in more depth and incidents of falls with injury had reduced.

Bedford Nursing and Residential Home

Detailed findings

Background to this inspection

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

The unannounced inspection took place on 17 May 2016. The inspection team consisted of three adult social care inspectors from the Care Quality Commission (CQC), and four specialist advisors (SPA), two of whom were pharmacists, one specialised in falls management and one in auditing and clinical governance.

Before this inspection we reviewed the previous inspection report and notifications that we had received from the service. We also made contact with the local authority commissioners of service to ascertain their views of the home. Prior to our inspection we were provided with a provider information return (PIR); this is a document that asked the provider to give us key information about the service, what the service does well and what they improvements they are planning to make.

During the inspection we observed care delivery within the home. We spoke with six people who used the service, two relatives 17 members of staff and two professional visitors. We looked at 14 care files, six staff files, medication records, audits, meeting minutes, the training matrix and other records kept by the service.

Requires Improvement

Is the service safe?

Our findings

Appropriate safeguarding policies and procedures were in place at the home. The home also had a 'Speak Up' whistle blowing policy for staff to report any instances of poor practice they may witness. 'Speak Up' posters were in evidence in the staff training room. Staff spoken with were aware of safeguarding procedures and signs to look for. They were aware of the whistle blowing policy and felt they would be confident to use it if necessary.

We spoke with the Clinical Service Manager (CSM) about on-going safeguarding matters. He demonstrated a good understanding of on-going issues and was able to explain where each matter was up to in terms of investigation and outcomes. We saw within the safeguarding file there was a table of alerts and guidance for staff on what and when to refer to the local authority safeguarding team and/or police as well as guidance on local procedures and policy.

To enter any of the units we had to ring a bell and a staff member who answered door asked to see identification and clarified the purpose of the visit before allowing us in. This was in line with company policy and demonstrated good working practice.

We looked at how medicines were managed in the home. At the previous inspection the service was issued with a Warning Notice around medicines management.

We witnessed significant improvements in this area and efforts had clearly been made around the area of photos, recording allergies and the addition of PRN (as and when required) protocols. There were however still some inconsistencies across the units inspected and a few instances of medicines which should have been disposed of being in evidence.

We saw a number of examples of good practice, such as medicine got ready for a person on Lilford (residential) who left the room were stored temporarily in a 'Tag Bag' with the person's name on. This demonstrated safe practice. Within the MARS on Lilford there was clear identification of 'early morning' and 'weekly' medicines and signatures showed their administration was happening. Some hand-written MARS were seen on this unit but for specific reasons and these were double checked by another team member. PRN protocols were in place on all units looked at and there was a clear understanding of their use. The majority of MARS had a photo front sheet (few missing due to problems with printer) and included allergy information. Fridge temperature records were thorough and within the manufacturer's recommended range. There was limited stock inside and the fridges were clean. The Controlled Drugs cabinets were locked and in good order, with limited stock holding.

On Astley (residential) we looked at how staff managed the changes with warfarin doses and found clear written records and communication of blood monitoring checks in place. One person was applying their own medication patch and there was a clear self-administration risk assessment to support this in the person's care plan.

On Lilford and Kenyon (general nursing) the breakfast medicines rounds took a long time to complete, meaning some medicines were given too late. We saw that occasionally pain relief had not been administered due to there being an insufficient gap between medicine rounds. As the morning round was running so late on Kenyon, one nurse requested a newly appointed unit manager to act as a runner. This meant the first nurse would dispense and give the medicines to the second nurse to administer. This is unsafe practice as the nurses should administer separate people's medicines to ensure secondary dispensing does not occur.

On one of the Kenyon we observed a nurse administering medicines. They spent time helping each person take their medicines with a lovely supporting manner but did not follow best practice when administering medicines. They made a record of the administration before giving the medicine to the person and also left the trolley unlocked and open at times. They did not observe one person taking their medicines and told us this person wanted to take them on their own and that this was recorded in the person's care plan. They made a record of the administration. We spoke with the unit manager as the person's care plan did state this but a risk assessment had not been carried out to support the person. We discussed the most appropriate way to record this and the acting manager said they would update their records immediately.

On one of the Croft (nursing) creams and PRN medicines were included in the Medication Administration Records (MARS) with signatures but there were no separate application charts. On Lilford, topical cream charts were in place with body maps. One person on the Beech (nursing/dementia) had a pain relieving patch re-applied from Tuesday to Wednesday, but no record was seen in the MARS. However, referral to the care records showed what had happened and was well documented. This demonstrated some recording inconsistencies between units.

Better communication with other professionals was required by the home. For example, on Croft, a person who received their food via percutaneous endoscopic gastrostomy (PEG) feeding, which is when a person is unable to eat their food orally and receive it through a tube into their stomach, had some medicines administered this way. Medicines administered via PEG needed clearer instructions, clarity from the prescriber and assistance from the pharmacy. Also a person who had been recently discharged from hospital had been refusing everything from food, fluids and medicines in last few days and there was no evidence of communication with the GP.

On Kenyon we checked MARS for 10 people and carried out audit checks on 29 medicines. MARS were clearly presented, however we found one medicine still on the trolley dated February 2016 that was not accounted for on the MAR chart and we also found one cream that had been discontinued during the previous week still stored in the fridge. This increased the risk that discontinued medicines could still be given and these should be disposed of promptly.

On Beech there were some bottle stores in the fridge which were out of date. The red 'opened' or 'use by' date stickers were not seen to be in use at all in this unit, though they were used appropriately on other units. Also on the same unit notes seen in one person's records made by a night nurse were almost illegible indicating that communication between team members may be unsafe at times. There were a few instances of inconsistent signatures and recording of morning medicines on this unit.

In the Beech store cupboard we found two bottles of powder/non-reconstituted Keflex (an anti-biotic), one dated 01/04/2016 on the label and the other 27/04/2015. The former had been delivered with last month's medicines and the latter with this month's. This indicated that the normal delivery of 2 x 100ml of this antibiotic had not been used last month, and therefore that the bottles, when made up with water, had not been used within the 10 days they should be. Action was taken straight away, and the GP contacted to

discuss a change to liquid form. We spoke with the acting manager about the other issues outlined and she agreed to address these immediately.

We asked staff who administered medicines about what training and assessments they had received. A nurse who did occasional shifts at the home had not had any assessment of their competency with the company since 2010. However, the unit manager on Astley had been assessed recently and a new senior carer on the same unit said they had received thorough medicines training upon induction, had been assessed on three occasions by the acting manager and felt very well supported with ongoing training as a new member of staff.

Some of the above instances of poor practice meant that medicines may not always be being administered safely and appropriately.

This was a breach of Regulation 12 (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we requested further evidence from the service to address the above concerns. The service supplied evidence of a thorough response to the mistakes made on the inspection day with regard to medicines administration. These included a thorough and complete supervision session with the nurse, with reflection on the errors made, followed by a theoretical and practical competence assessment.

The service provided a response to the concern regarding the length of medicines rounds which included a full medication review by the CCG pharmacy to ensure medicines were given at the correct time. They also changed some times of dosages, in consultation with the individual and GP, they introduced 'Do not Disturb' tabards for staff administering medicines, an extra staff member was placed on duty so that two medicines trolleys could be taken out at once and no calls were to be put through to the units until 10.30 am.

Clinical Service Managers (CSMs) were monitoring these measures daily and weekly reviews were being undertaken to ensure continued efficacy of the changes made. A new policy on disposal was implemented to help ensure effective and timely disposal of surplus medicines. A group supervision was held for nurses and health care assistants around application of topical creams to help ensure consistency of administration and recording and daily monitoring of this was implemented. The protocol for contacting professional support was discussed with lead nurses and re-distributed to help ensure timely and appropriate seeking of support and advice.

We looked at staffing levels as these were an issue at the last inspection and a Warning Notice was issued. We saw that the reliance on agency staff had been significantly reduced due to a massive recruitment programme. A registered mental health nurse (RMN) had recently been appointed in one of the dementia units to help improve care for people living with dementia. The acting manager told us that there were still a few vacancies to be filled, but she hoped to fill these imminently.

A dependency tool indicating the level of help each person required was in place. The acting manager planned to use this to inform rotas in the future. We noted that there were certain times of day when staff were under considerable pressure, such as during morning medicines rounds, when staff administering medicines were often disturbed with other demands on their time.

One staff member spoken with said, "Not staffed enough for resident's needs, we have a lot of incontinence needs. I have not had a day off for over a week, working seven 12 hour shifts in a row and am back in tomorrow doing another one. All staff on the unit are doing way over their overtime, this is because we are

short and don't want to let each other down". Another told us, "Anyone would say we could do with more staff, however teamwork on the unit is very good and we are able to manage the unit with the staff we have". A third said, "Today we have two nurses on, four carers with an extra one working 10 am – 10 pm, to cover a resident who needs 1:1. We have much less need for agency staff now, which is much better".

A relative commented, "Staff are very good, however they are run ragged as not enough of them. I have asked the manager about this and what the ratio is, as I don't think that four staff for 30 residents is sufficient."

We discussed this with the acting manager who agreed to look at how this could be resolved to ensure enough staff were around to meet everyone's needs appropriately. This was especially relevant at the busiest times, such as morning medicines rounds, to help ensure the person administering medicines could fully concentrate on this task without interruption.

We looked at six staff personnel files and saw that they included an application form, interview check list, offer letter, a minimum of two references, registration status for professional staff, proof of identity, eligibility to work in the UK and Disclosure and Barring Service (DBS) checks. This helped to ensure people were suitable to work with vulnerable people.

The eight care plans we looked at included relevant risk assessments in areas such as moving and handling, falls management, skin integrity and nutrition. These were reviewed at least monthly or before if changes were necessary. All the records we looked at were complete and up to date. However, more information would be helpful to staff around when a PEG was to be given (day or night) and care of the PEG site, as we saw some contradictory information within one care file. Also the service were not recording the amount of prescribed water given daily via this method.

Wound assessments were in place and information was inclusive of all relevant details. The service was using appropriate equipment, such as pressure relieving mattresses and bed rails, for those who required them. Assessments were in place for the use of equipment. One care plan we looked at did not state that positional changes were to be undertaken or that food intake was to be monitored. The service was carrying out these tasks but not necessarily recording them.

Thickened fluids were given appropriately where people were experiencing swallowing difficulties. However the service needed to accurately record the amount of thickened fluids given. There was no suction machine amongst emergency equipment on the units. This needed to be in place as there were a number of people on PEG feeds or on thickened fluids, which indicated that these people were at risk of choking. This was discussed with the manager who agreed to look into it.

There were appropriate policies and procedures around falls assessment and management and there had been recent positive development of management of falls by the Clinical Services Manager. The focus was on improving training for falls prevention and management. More thorough initial assessments when taking referrals from hospital had been implemented. We saw an improvement in reporting of falls and particularly near misses. Incidences of falls with injury had halved between February and April this year. One senior member of staff spoken with felt the more stable staff team, with better knowledge of individuals' needs, had contributed to the reduction in incidences of falls. They told us, "There has been a 'buy-in' by staff. They are becoming far more proactive rather than reactive. For example, we used to only refer to the falls team (external NHS provider) once an individual had fallen three times. Now we respond to every near miss reported and take a more thorough assessment and make changes such as the use of laser bed leaving alarms to alert us to potential falls, referring for medicine reviews and undertaking routine urine dip tests for

detecting early stages of Urinary Tract Infections (UTI) rather than keep finding people on the floor".

We case tracked four individuals via their care files and saw that each individual had a thorough risk assessment under the main heading 'Safety' which had a main section on safety and sub-sections on Falls Risk Assessment, Moving Around, Moving and Handling Risk Assessment. This was a comprehensive assessment process and of the four individuals we case tracked each had one of these completed and there was evidence of regular review and update. There was also a care pathway entitled 'Pathway for managing a resident who has fallen or who has been found on the floor'. This was an excellent tool for taking timely and appropriate action.

Health and Safety information, fire risk assessments, gas safety certificates and equipment and premises checks were all in place and up to date. Personal Emergency Evacuation Plans (PEEPs) were in place for each person. These were kept in the entrance to each unit in a red file for ease of access in the event of an emergency.

Good

Is the service effective?

Our findings

We asked people who used the service about the food at the home. One person said "The meals are not very good, they are overcooked, the chicken we had yesterday was dry, we also didn't have any gravy with it. We do get a choice of two things for meals and if we don't like these can ask for other choices such as omelettes. If I want a drink or anything else the staff will get it for me". Another person told us, "Food is good and you get a choice of what you want to eat, if you don't like the choices you can ask for something else. I get a drink whenever I want one and get asked a lot during the day if I want a drink".

A family member told us "Main issue I have is the food, seems to be quite a few complaints about this. I think that it must be prepared in advance and then kept warm under a heater which dries it out. There used to be someone who came round with a tea trolley at set times during the day, but don't see this happen anymore. I'm not sure how they can ensure everyone is drinking enough, as some people won't ask." Despite this comment we observed a tea trolley being wheeled around on two occasions. All individuals were asked politely and by name whether they wanted a drink and if they needed any help holding the cup or having their drink.

A staff member we spoke with said, "Everyone has a choice of what they want to eat. They choose their meals the day before from a list of two options; however there are alternatives if they don't like the two options available. No one here [on this unit] currently has any special dietary requirements, but four do need support with eating. We asked how this was managed considering there were only four staff on duty at meal times. The staff member said, "Meal times are staggered to ensure that those who need support with eating receive it".

The kitchen had a 5 star food hygiene rating, the highest rating, and was very clean. We spoke with the chef who told us the home worked on a four week menu cycle, with Summer and Winter menus. These were provided by BUPA and were in place at all of their homes. He said, "In regards to special diets, the staff on each unit inform me of these each day when they hand in the residents' meal choices". We saw an example of this, including choices, requirements and special diets. The home offered food 24 hours a day and each unit advertised a night bite menu, consisting mostly of tinned and non-perishable goods. Fresh food items were also put on the units daily.

The chef had completed lots of 'kitchen and catering related training', however had not had any training in safeguarding or MCA. It would be appropriate to have this training as he did spend time talking to people on the units. We saw there were new systems in place following recommendations from environmental health for monitoring temperatures and cleanliness. All of these were checked and were consistently up to date and completed.

Staff induction was thorough and comprehensive. We saw evidence of a week's induction where four days were spent undertaking mandatory training and one day was used to shadow a more experienced member of staff. Observations were carried out with new staff to ensure competence in all areas. One staff member told us they had shadowed for two days as they had little previous experience of care work. This

demonstrated that the induction was tailored to the needs of the particular new staff member and was flexible. Another told us, "Never known a place like it, every staff member has one week's classroom induction which includes one day's shadowing on the unit. We covered all areas during the training such as manual handling, safeguarding and so on. After I had finished the training I had almost two weeks shadowing on the unit where I was supernumerary, this was really useful to help me learn the role and get to know the residents and their needs".

Training was on-going for all staff and we were shown evidence that the home was now up to 98% completion of mandatory staff training. One staff member said, "I've no experience of working with dementia and not really been given any specific training in this area either. I cried after my first day as was such a shock. New staff aren't prepared enough for what to expect and many new staff don't stay. I have had to pick up skills and knowledge along the way and am now reasonably confident". We spoke with other staff on the dementia units and they were unaware of dementia models of care. However, one staff member did tell us they work on the basis of 'Person first, dementia second' which she linked back to the admiral nurse who supported them. The manager told us they were in the process of accessing 'Person first, dementia second' training and were intending to involve the local admiral nurse for advice and support.

Staff supervisions had consisted of information being given out to staff on various subjects up to the time of the inspection. We spoke with the acting manager who told us one to one meetings had not been a priority as she had been working on other priorities stemming from the shortfalls identified at the previous inspection. The acting manager told us she intended to begin a programme of supervision sessions and annual appraisals in the near future.

There were handover meetings in the mornings and afternoons. The '10 at 10' meeting was observed. This meeting was well-led and co-ordinated by one of the CSMs. The lead from each unit was in attendance, plus kitchen, finance and housekeeping leads. 'Round Table' discussions were held to discuss a variety of general day to day issues and events including; DBS letters, the up and coming 'Fun Day', housekeeping, staffing, training, hospice support and new admissions. These meetings were good practice and support staff communication and engagement.

We observed a person being supported to move from a wheelchair into a lounge chair using a stand aid. Good practice was displayed as two staff completed the manoeuvre, explained in advance what they were going to do, reassured the person before and during and repeated their explanations before each part of the process. They also sought permission before commencing the procedure.

We looked at eight care files which were clear and comprehensive and included a significant amount of personal and health information. Each plan contained a 'My day, my life my portrait' page. There were pre-admission assessments and care plans for each area of need. Risk assessments were included where required. There were monitoring charts for food and fluid intake, food diaries, topical cream charts with body maps and, with the exception of one file, positional change charts. We saw that issues such as sudden weight loss were acted on promptly. There were records of professional visits and correspondence between agencies. Daily notes were also included in the files. Each area of the files was detailed, complete and up to date. We noted that for one person with diabetes there was no specific diabetic care plan to include foot and eye care.

One health care professional we spoke with on the day told us, "The staff are very helpful – they work alongside you. They are very good". Another told us, "We had concerns but since the new manager took over there has been a dramatic change. Staff always try their best to follow advice and the service is getting back to where it was. They manage the step-down [from hospital] beds quite well. They value our service and the

unit managers ring quite a lot for advice".

There was a good system in place for transfers to hospital, a transfer form and a copy of the MAR chart. This helped to ensure the correct health and personal information was supplied on transfer.

In Astley there was a strong smell of urine, which remained throughout the day and was also commented on by a relative. They told us, "Air quality is poor, smells of urine. Pity they don't have air conditioning. It can also get very stuffy; trouble is if you open some windows to try and air it out, some people complain that it is too draughty. I have been to look around [other unit] to see if it was the same but it was much better there, the ambiance, the air quality, there was no smell of urine at all." We checked all bathrooms and toilet areas; they were clean and smelled fresher than the corridors. None of the other units had this odour. We spoke with the acting manager about this and she agreed to look into the source of the smell to try to eliminate it.

We felt that some units were better than others with regard to their suitability for people living with dementia or confusion. For example, some had themed areas within the units for people to enjoy, such as a replica pub with pumps and seating in Beech unit. An orientation board was in place on Beech and contained up to date and relevant information including day, date, month, year, weather and activities. Bathroom and toilet doors were painted a different colour than bedroom doors and all contained large signs with both a picture and text to indicate what the room was. All toilets had bright red toilet seats to help them stand out. The acting manager told us she was looking at developing dementia friendly environments in the near future to help enhance people's experience of living at the home.

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.

We looked at eight care files and saw a lot of information and documentation around MCA and best interests. There was evidence that best interests meetings were held and best interests decisions made for a range of different issues. For example, we saw decision making around place of residence, completing of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms, whether a DoLS should be applied for, use of covert medicines (medicines concealed within food or drink). In each case there was evidence that attempts had been made to involve the person at the centre of the decision to ascertain their views. Family members and professionals were included where appropriate and independent advocates involved when required.

DoLS were in place or had been applied for appropriately and evaluated regularly. There was a system to ensure the management were aware of who was subject to an authorisation and when this was due for review and/or renewal. DoLS application paperwork was in place in the files. One staff member said, "This [DoLS] is included in the training, we have a visual board in the office which has residents' initials on which includes who is on DoLS, I would check this to see who is on DoLS. Their care plans also contain information which will explain the reason why they are on DoLS and any conditions".

Consent was sought from people who used the service, where possible, or their representatives, for issues such as medicines administration and access to personal documents.

Good

Is the service caring?

Our findings

We spoke with six people who used the service. One person told us, "'Staff always knock and ask to come into my room and I am asked if it's okay before they do anything". Another person said, "It's great here, I'm looked after really well. The staff are tops. Any problems I have they listen and help me. If I want a drink at any time they will get one for me". A third person commented, "Staff here are great, you can have a laugh and a joke with the staff which makes being here good. I was able to personalise my room and like having family pictures on the wall".

One relative we spoke with said, "No problems, [relative] looks clean and well cared for. Staff are good".

We observed care on different units throughout the day. The general atmosphere within the home was calm and happy. Staff were on hand to assist people when they required it and we saw them explaining what they were doing when providing assistance and offering reassurance when people were a little anxious.

We saw a person who used the service holding a drink, which was slowly beginning to tip over. Staff were alert to this and supported her to have a drink and then placed the cup on a table. We observed a staff member on Astley asking a small group what they would like to watch on TV, getting a consensus from them before all agreeing on a channel. This was good practice ensuring all were included in the decision.

We saw letters within the care files inviting relatives to reviews of care. Each unit had a 'resident of the day' each day. This entailed a review of all aspects of this person's requirements and well-being, including care plans, environmental issues such as repairs to their room, food preferences and personal wishes. Relatives were welcome to attend on this day and encouraged to be involved in this process. We saw one family attending for this on the day of the inspection and they told us, "Today was the first time in three and a half years that I have been asked to discuss the care plan. Previously I was not asked my views or opinions which I don't think was very good practice. I found today really useful as I could voice my opinion on various things I have issues with." Equally important, we saw from documentation that the Clinical Service Manager reviewed the resident of the day discussion and agreed action the following day to ensure actions were taken and any trends monitored.

In some of the staff offices on the units there was a board on the wall with details about people's conditions and needs. This meant that visitors to the office could read this and know personal details about people on the unit and was potentially a breach of confidentiality. We spoke with the acting manager about this and she agreed to implement a different system with immediate effect to ensure people's details were kept confidential in the future.

There was a poster in the entrance outlining relatives' meetings. However, from speaking with relatives on the day it was clear that these were not currently happening. This was something the acting manager was planning to address in the near future.

People's future decisions around the time when they would be nearing the end of life were recorded in their

care plans. Where people did not wish to discuss these matters this was noted and the discussions were revisited and reviewed regularly.

The North West End of Life Care Programme for Care Homes was being accessed by a small number of staff at the time of the inspection and there were plans in place for more staff to link in with this training in the future. This would allow people to be cared for in their own home, if this was their choice, as they neared the end of their lives.

Good

Is the service responsive?

Our findings

We asked people who used the service about activities. One person said, "Could be more things to do, nice to have more choice. We are generally not asked what activities we want to do". Another told us, "In regards to activities, there is stuff going on most days, but I don't muck in as I'm not really a mixer, I prefer my own company so tend to watch the gogglebox in my room". A third person commented, "It's okay here, you make the best of it. There's not a lot to do but I don't want to do much anyway, I have my books and my knitting". A fourth person said, "Staff are very friendly, very nice if I want anything they come to help me. There is plenty to do here, we played skittles and did a quiz the other day".

The activities coordinator had recently left and a member of staff was being transferred from another position to take up the activities post. The newly transferred member of staff responsible for coordinating activities was extremely enthusiastic and innovative when discussing a person-centred activity programme. They told us this would be based on individuals' interests, previous occupations and history. They said, "I want to get residents doing things. For example, one lady on my unit used to get upset at a particular time of the day and used to tear up tissues. She often used to be seen frantically folding them and after a while this would calm her. I spoke with her and she used to work in a restaurant/hotel so I gave her the napkins for the next meal to fold. Now she does this regularly when she gets agitated and it calms her. I am sure there are people who could get more involved in the home in areas like maintenance and laundry. I am developing a form which I can use to collect the information on individuals' life stories and hobbies".

A staff member on Beech said, "There tend to be a lot of individual activities, or smaller group activities such as music and art [on this unit]. We have rummage boxes in the lounge for individuals to use, each with different items in. We are in the process of setting up designated areas, following input from an Admiral Nurse, as it is good to have different areas to aid with memory. We have the 'park area' when you come into the unit and are going to do several more".

We saw an activity schedule displayed on the wall in Astley unit. This included bingo, pamper day, arts and crafts. The bingo was replaced on the day of the inspection with a reminiscence session occurring instead. This was based on the topic of washday. The session started by the facilitator staying traditionally wash day was on a Monday, but today is Tuesday - it may have been useful to match the session with the day it occurred on. The facilitator had a trolley with several 'wash day' items on, including tongs and soap, which she used to talk through the wash day process. The facilitator read from a pre-printed script and it appeared as if this was the first time the session had been held as she was unfamiliar with what was on the script and how it linked to the objects. The objects were then passed around with residents commenting on them. The activity took an hour and from their expressions and mannerism all who took part enjoyed the activity.

We were told by the acting manager that there was a fun day arranged for the home later in the week.

The eight care plans we looked at were person-centred and reflected the individuals' needs, preferences, background, family, wishes and personality. We saw records of people's activities within their care files.

The service's complaints policy was prominently displayed within the entrance of the home and there was a complaints log which outlined dates of complaints and the current status and outcomes. There was also a suggestion box in the entrance of the home, but this was empty.

One relative told us, ""No complaints in regards to staff, they have been excellent from day one. Some do more than they need to. If [relative] wants anything from the shop they will go and pick it up for her, even as far as going in their own time after work and bringing it in the next day. Some staff have even come in on days off to take my [relative] out." Another relative said, "During meeting with manager today I raised an issue regarding my [other relative] who also lived here but passed away in February. The manager is going to look into this [issue raised] and will feedback to me in a couple of weeks when I get back from holiday".

Requires Improvement

Is the service well-led?

Our findings

We spoke with 17 staff. One staff member said, "I feel it is a privilege to work here". Another told us they felt very well supported by the acting manager. A third staff member said, "Everyone is very supporting on the unit but further up, not so much so. We have had one team meeting in the last 12 months, supervisions tend to be memos about changes. I have never had an appraisal or a meeting with anyone to discuss my performance and get positive feedback".

One health care professional we spoke with on the day said, "The people in charge [unit managers] know what is going on. They know why they are here and know the residents. I see a big difference since the new manager arrived. Staff seem happier; you don't hear the gripes you heard before".

There was a regular weekly visit from the area manager to provide support to the acting manager of the service. We also saw a manager's briefing from April 2016. This included information on the forthcoming Care Home Open Day, dementia care, nurse re-validation, End of Life project, customer care and involvement and actions required.

As well as the daily handover meetings a number of staff meetings had been held on each unit. The minutes on file were clear and concise. Issues addressed included medicine administration, 'resident updates', activities, and the Service Improvement Plan. We saw that the '3pm MAR meetings' were discussed and the importance of attending these was clearly emphasised in the minutes. One of our SPAs was in attendance at the meeting on the day of the inspection. They found this to be effective in picking up problems quickly. Staff told us they thought the MAR meeting was useful and had helped to improve accuracy.

A Quality Evidence File was examined as part of our inspection. This contained a number of documents including a 'Quality Manager Home Visit Sheet' from March 2016, which had been completed for all sites. A number of minor issues had been recorded but only some basic actions recorded. It was not consistently clear if any of the identified actions had been fully completed. We spoke with the acting manager who stated that any actions carried out following these visits were not recorded within a centralised monitoring plan. She said they would have been actioned and the evidence would be recorded in separate files. However, it was hard to evidence and track if the actions identified had been addressed and this did not provide assurance of quality monitoring or improvement.
There was evidence of sporadic audits across all four units over 2014/2015 with basic action plans plus signed completion dates. There was also evidence of improved quality metric records recording since March 2016.

An April 2016 Quality Metrics Report was examined. The acting confirmed that the information included was recorded by each unit lead and reported back to her for input into the computer. In March 2016 and between October 2015 and February 2015 these had not been completed. The acting manager was aware of this.

The Quality Metric Reports examined included statistics on; nutrition, pressure ulcers, nutrition, mortality,

medication errors, GP reviews, bed rail use, safeguarding referrals, DOLS applications, infection causes (e.g. UTI), accidents and incidents, complaints figures and themes plus compliments and concerns. The statistics were not broken down per unit and this may hinder effective triangulation, consistent monitoring, lessons learned and action planning.

A weekly Quality Information File was examined, this contained a mix of information from each unit including weekly weight records. It was confirmed by staff that these files were also held within each unit.

The home had held a 'Health Quality Assurance and Health and Safety Committee' meeting on the 27 April 2016. An 'Infection Prevention and Control Audit Suite' tool/form was observed from 15 April 2016. This had identified areas for improvement and basic action were noted. However, there were no dates for completion or space to record responsible leads.

Completed, basic 'Environmental Audits' and 'Clinic Room Audits' were seen but there were no recorded leads or dates for action. Completed audits was seen from April 2016 on laundry and kitchen areas, some minor issues were noted but there were no clear actions or completion deadline dates.

However, we found that overall the collation of quality data had improved since March 2016 and a variety of audits had been conducted.

We looked at the home's falls analysis. The Clinical Service Manager (CSM) advised that he now analysed falls in more detail; using the company's documentation he had modified it to a single sided A4 form. This looked at number of falls by unit, location, day/time, witnessed or not, injury, dementia, GP/Advanced Nurse Practitioner reviewed, A and E attendance, hospital admission. This provided rich meaningful data to assist in monitoring trends, improvements or deterioration but had only recently been introduced, so there was not yet a great deal of statistically relevant information available. The service would benefit from collating the data captured on falls incidences on a regular quarterly overview to promote discussion at senior team and management meetings. This would help to identify trends and therefore drive further improvement in the management and prevention of falls.

All accident forms were sent to the CSM who undertook a review and investigation (where relevant) and this included a map of where the incident occurred. We assessed three people who used the service who had a high risk and evidence of falls. The information was gained from the accident forms and followed up using the reporting tool and collation tool. The care records and care plan were cross-referenced. We found that all three individuals had received timely and appropriate response from the carers/nursing staff at the time of the fall/near miss. The carer/nurse in charge had conducted the relevant and appropriate reassessments and revised care plans and the CSM had conducted a review in a timely manner.

A Quarterly Health and Safety Audit Checklist was examined from 27/04/16. This was an overall report for all four units. This contained a good range of quality information with actions including audits/check lists for safety, reporting incidents, moving and handling, equipment safety, bedrails, slips, trips and falls, chemicals, infections and diseases, falls, hot surfaces, work related stress general environment and general welfare.

'Competent Care Assistant – Safeguarding Assessment forms were seen. These were fully completed with good questions and relevant answers.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always being administered safely. Medicines not being given in a timely way due to long medication rounds, medicines trolley left unlocked and accessible on occasions, a nurse requesting another staff member to secondary dispense medicines, some medicines not disposed of in a timely manner, recording inconsistencies across units. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (g) the proper and safe management of medicines