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?	**Inadequate**
Is the service effective?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 and 28 April 2015. After that inspection we received concerns in relation to staffing levels, the safe management of medicines, serious injuries and safeguarding. As a result we undertook a focused inspection to look into those concerns. During the inspection we identified additional concerns in relation to how the service was working within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bedford Nursing and Residential Home on our website at www.cqc.org.uk

This inspection took place on 30 December 2015 and was unannounced. At our last comprehensive inspection the service was rated 'requires improvement' overall and there were no breaches of the regulations identified.

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 named houses, each with 30 beds. Astley and Lilford both provided residential care; Kenyon and Croft provided general nursing care, and Beech and Pennington provided support and nursing care to people living with dementia. The home is situated in a residential part of Leigh and is close to the town centre and local amenities.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found there had been breaches of four of the 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 are currently considering our options in relation to enforcement and will update the inspection report once any action has concluded.

Since our last inspection we received information that indicated a high number of nursing and senior staff had left the home. Staff working at all the houses other than Lilford consistently told us there were not sufficient numbers of staff deployed to meet people's needs. Relatives we spoke with also expressed concerns that people were being put at risk as there were not sufficient numbers of staff to provide care safely.

We reviewed records relating to unobserved falls, including some falls that had resulted in injury. Both staff and relatives told us they thought insufficient staffing levels had contributed to such incidents. A nurse at one of the houses had asked a relative to report concerns that they were not able to support their family member according to their care needs, and insufficient staffing levels to the local authority safeguarding

team. The provider arranged for one to one support for this person prior to the end of our inspection.

Staff told us staffing levels had not changed at the home, but that the needs of people living there had changed over time. People had dependency assessments in their care files. However, it was not clear how these were used to determine staffing requirements. Staff told us they had raised concerns about staffing levels at meetings but had been told the staffing levels were sufficient.

There was a reliance on agency nursing staff, particularly to cover night shifts. Some relatives and staff expressed concerns to us about this in terms of continuity and standards of care provided. We spoke with an agency nurse who told us they felt they were not adequately prepared before starting their shift.

We found some issues in relation to the safe administration of medicines. There were gaps in the administration records and we found evidence that two medicines had not been administered as prescribed. Records relating to the application of creams were inconsistently completed.

Accident reports had not always been completed for people who had sustained falls and risk assessments and care plans had not always been reviewed following a fall. This meant the service was not able to demonstrate that it was taking appropriate steps to manage and reduce risks to people.

Staff were aware of how to identify and report any safeguarding concerns. We found one concern that had been raised by a relative had not been referred to safeguarding as the service was waiting for a statement to be submitted. We were assured a safeguarding referral would be made if required.

Applications to deprive people of their liberty had not always been made to the supervisory body when they had been required. The service was also unable to demonstrate it had acted in accordance with the Mental Capacity Act 2005 when taking a decision to administer one person's medicines without their knowledge (covertly).

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff consistently told us they found staffing levels to be insufficient. They told us this could impact on the care people received.

We found evidence of poor management of falls. Accident reports and records of post-incident observations had not always been completed. We found some people had sustained injuries in unobserved falls.

We found gaps in records of medicines administration. There was also evidence that two medicines had not been administered as prescribed.

Is the service effective?

Inspected but not rated

The service had not made DoLS applications for all people who required them. We found evidence that one person's liberty was being restricted without lawful authority.

The service could not demonstrate it had undertaken a process to ensure it was acting in a person's best interests when administering medicines to them covertly.

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.

This focussed inspection took place on 30 December and was unannounced. The inspection team consisted of two adult social care inspectors and a specialist advisor who was a registered nurse. The team inspected the service against two of the five key questions we ask about services: Is the service safe and is the service effective?

Prior to the inspection we reviewed information we held about the service. This included notifications the service is required to send us about safeguarding, deaths and other significant events. We looked at any feedback we had received about the service that had been submitted via 'share your experience' forms on the CQC website, or that had been provided to our contact centre. We also reviewed any correspondence and feedback we had received on the service from the local authority quality assurance team.

During the inspection we visited all six houses that make up Bedford Nursing and Residential Home and carried out observations of the care provided. We spoke with 31 staff, which included 27 care/nursing staff and hostesses, two clinical service managers, the area manager and the registered manager of another service who was providing cover for the home whilst the registered manager was on leave. We also spoke with six relatives and two health professionals who were visiting the home at the time of our inspection.

We reviewed documents relating to the care people were receiving including 14 care files, medication administration records (MARs), risk assessments and daily records. We also reviewed documents related to the running of the home such as records of audits and staffing rotas.

Inadequate

Is the service safe?

Our findings

Since our last inspection on 27 and 28 April 2015 we had received information of concern from whistle-blowers, relatives and the local authority about staffing levels and the high level of use of agency nursing staff at the home. Information shared with us indicated that since our last inspection a number of nursing staff had left the home, as well as both 'clinical service managers' (CSMs). The clinical service managers in post at the time of our visit were both new to the role.

Staff told us there was frequent use of agency nursing staff to provide cover at the houses providing nursing care. We were told this was particularly the case for night shifts. We looked at rotas, which confirmed agency nursing staff were frequently used. The provider told us there were 409 hours of nursing staff vacancies out of a total of 1001 allocated hours. Four staff we spoke with raised concerns about reliance on agency staff as they felt agency staff were 'less on board' and did not have the same knowledge and experience as permanent staff. One member of staff said agency staff were encouraged to work at the same houses whenever possible, but that as non-permanent staff they could struggle to cope with the workload. They said this could impact on what other staff were able to manage during their working day.

We spoke with relatives of people living at Pennington, Kenyon, Croft, Beech, and Lilford houses. Relatives of people living at Croft, Kenyon and Lilford houses did not express any concerns in relation to staffing. However relatives of people living at Pennington and Beech expressed a number of concerns. One relative we spoke with expressed concerns about the competence of agency staff to meet their family member's needs. Another commented; "It's good. It is short staffed and they use agency nurses a lot, but permanent staff are good." We spoke with one agency nurse who told us they had not worked at the house they were covering for around six to seven weeks. They told us they had had a handover from the nursing staff on shift before them, but that they didn't feel this was adequate given the needs of the people they were required to provide care to.

Other than on Lilford and Croft houses, staff working at the remaining houses consistently raised concerns with us about levels of staffing at the home. Staff told us they thought there were not sufficient numbers of nursing or care staff to always meet people's needs in a timely way. Staff told us the staffing levels at the home could impact on their ability to provide adequate supervision and support to people when they needed it. Staff in Pennington house said the quality and safety of the service was compromised due to insufficient staffing levels. They told us they felt they were not always able to adequately supervise people who were at risk of falling due to also having to support people who could present aggressive behaviours towards other residents.

One relative told us they had observed altercations occurring between residents and as a result had to alert staff. Another staff member and a person's relative told us their family member had received an injury, which had not been observed by staff. Both felt that staffing levels had been a contributing factor in this person sustaining unexplained injuries. Shortly after the inspection we were contacted by another relative who had concerns that insufficient staffing levels at the home had contributed to their family member having unobserved falls, one of which resulted in an injury requiring a hospital visit. We had reviewed

documentation during the inspection in relation to this person, which showed there had been three unobserved falls/incidents in the eight days prior to the date of the inspection. This had been referred by the home to the local authority quality assurance team who deal with certain safeguarding incidents. We also reviewed documentation relating to two other serious injuries that had recently occurred and been unobserved by staff. These injuries had been notified to CQC and the local authority safeguarding team.

Staff on Beech house told us people would sometimes have to wait for support due to insufficient numbers of staff on duty and they also had concerns about their ability to provide adequate supervision. Staff on Beech, Astley and Croft houses told us they were sometimes called to provide assistance at other houses, but said this could also impact upon the care people in the house in which they were working received. The provider told us there were additional staff available, such as activity co-ordinators and hostesses who helped provide care to people. However, staff said the times of day these staff were present at the home were limited and that absences of these staff were not always covered. Staff also told us the current staffing levels were having an impact on the staff teams in terms of workload and stress.

We spoke with one relative who told us they had been contacted by a nurse at the home who had told them they did not feel they were able to meet the needs of their family member due to current staffing levels on Pennington house. This relative expressed concerns to us about staffing levels and a referral to the local authority safeguarding team had also been made. We raised this issue with the area manager during our inspection who arranged for one to one staffing to be provided to ensure this individual's needs could be met. This relative told us staff at Pennington had not been aware of who they could contact for support within Bupa when they had been experiencing difficulties in the registered manager's absence. When we arrived at the home for our inspection we found staff were unaware of who the 'site cover' should be or who they could contact in a more senior position should they require support. Staff told us emergency contact numbers were usually provided over the Christmas period, but that this had not occurred in this year. We spoke with the manager of another home who was present during the inspection. They told us staff had been informed at a meeting that they were providing cover for the home and they were unsure why this had not been passed on to all staff.

Staff told us that concerns in relation to staffing levels had been raised with the registered manager, but that staffing levels had not changed. The area manager told us and we saw that people had dependency assessments in their care files. They told us the dependency assessments were used to help determine staffing requirements at weekly meetings for each house. We spoke with one staff member who told us that whilst these weekly meetings did take place, they had been informed there was a set number of staff available for each house. We looked at minutes from these regular meetings and saw that staffing was discussed. The provider told us the home had been fully staffed, however, it was not clear from the minutes that the needs of people living in the individual houses had been considered to help determine the numbers of staff required.

These issues were a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure sufficient numbers of staff had been deployed to meet people's needs.

We saw there were personal risk assessments in people's care files relating to areas of risk such as falls, malnutrition and pressure sores. We saw people had care plans and assessments in place in relation to care required to prevent skin break-down and the occurrence of pressure sores. At Pennington House we found that records of repositioning were not being kept for all people and staff initially told us they required support with this. We reviewed the care plan for one person, which stated staff were required to support them to reposition using a slide sheet when in bed. There were no records of repositioning available for this

person and staff then told us they did not require this support. We also found the care plan for another person did not accurately reflect the equipment that they required in relation to managing pressure sores. The repositioning records for another person living at a different house had been completed inconsistently and did not demonstrate this person had received pressure care as their care plan detailed was required.

We looked at the care file for one person who had moved to the home approximately one month prior to our inspection visit. We found this person's care plan had not been completed and no risk assessments had been completed since they had moved in. There was no falls risk assessment or care plan in place that related to mobility, despite this person's pre-admission assessment stating they were at high risk of falls. The home's falls policy stated the risk assessment and care plan in relation to mobility should be completed within 24 hours of admission. We also found documentation that indicated this person had sustained at least two falls since moving to the home. We saw a record that indicated emergency services had been called following one fall and that this person had a suspected head injury. A decision had been reached in this person's best interests not to admit them to hospital. We asked to see the accident report and record of post-injury observations carried out. These could not be located by the service.

We saw another person had bruising on their face and we were told by a staff member that they had recently sustained a fall. We looked at this person's care records and saw there had been a body map completed. However, it was not clear from the accident form whether this injury was sustained in the accident that was documented or was as a result of a separate incident. This person's falls risk assessment and associated care plans had not been reviewed following recent falls, which meant the provider was not able to demonstrate they had taken appropriate actions to reduce any risk to this person. We spoke with a clinical services manager about a third person we were aware of who had sustained a recent injury from a fall. They were able to tell us what measures had been put in place to reduce the risk of any future injury to this person. However, we found this had not been accurately recorded or reflected in the care plan. There were also no records that hourly night checks were taking place as this person's falls risk assessment detailed were required.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to appropriately assess and manage risk to individuals.

We saw medicines were being kept safely at all of the houses. However, at one house there were gaps in records relating to fridge temperatures in November and December 2015. It is important that medicines are kept at the correct temperature to ensure they remain effective and safe to use. Controlled drugs are medicines that are subject to additional legal requirements in relation to their safe storage, administration and destruction. We saw these medicines were being kept in appropriate storage and records were being completed as required.

Since our last inspection in April 2015 we had been notified by the service of four medicines errors that had been referred to safeguarding. Two of these errors involved agency nurses. We reviewed records relating to the administration of medicines and identified some issues. We found repeated gaps in the medicine administration records at all the houses other than Kenyon. In some instances we found the medicines had been given but not signed for. However, in two instances we found people had not received their medicines as prescribed. In one instance the application of a weekly patch used to provide pain relief had not been administered on time on two subsequent occasions. This would have placed the individual at increased risk of experiencing pain. Shortly after the inspection we received a notification from the provider informing us that the week following us having identified these errors, this medicine was administered three days early. This showed the provider had not leant from previous mistakes and had not implemented robust systems to prevent a re-occurrence. The provider also informed us that procedures such as contacting the GP had not

been followed in relation to these medicines errors. They informed us they had made a referral to the local authority safeguarding team and had identified other appropriate actions such as contacting this person's GP and reviewing the process for checking and administering medicines.

The service used a 'blister pack' system for the people who used the service to store their medication. A blister pack is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the home. The pack has a peel off plastic lid that lists the contents and the time the medication should be administered.

In Astley House we found a box of medicines awaiting disposal in the treatment room. We looked at two 'blister packs' and saw that medicines remained in the plastic packages. We found the corresponding MAR charts, which contained staff signatures indicating that the medicines in question had been administered. We spoke to a member of staff present about this matter, but they were unable to explain why the medicines remained in the package, whilst records indicated they had been administered.

We saw MARs did not always have a photo of the person they related to attached to those records. From the MARs we reviewed we found two were missing photos on Pennington, 15 on Beech, seven on Croft and four on Kenyon. Photographs are needed to help staff identify people. This was important on the day of our visit as we found the service were using agency nursing staff, who may not have known the people they were supporting.

In records we looked at relating to the administration of prescribed creams we found repeated gaps and omissions. This meant the service could not demonstrate that the medication had been administered in line with the prescription. We found there was limited information recorded to guide staff as to where to apply creams to ensure people were given the correct treatment. When information was available, we saw the records showed that staff had not applied creams properly. For example, we looked at one person's records, which directed that prescribed creams should be administered morning and nights. The last recorded entry was 25 December 2015. It was therefore not possible to establish from some records if people had been given their medicines as prescribed.

We were told some aspects of quality and safety monitoring such as audits of medicines had slipped whilst new staff were settling into their roles. We saw the monthly audit of medicines had not been completed in November and was overdue for December. We saw daily checks of medicines were carried out by staff. However these were ineffective as they had failed to identify issues we came across during the inspection such as gaps in records of administration.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medicines.

Prior to our inspection we had concerns in relation to an increase in the number of notifications the service had been sending us in relation to safeguarding incidents occurring at the home. We had also viewed minutes from a meeting between the registered manager and the local authority. Concerns were raised at this meeting that an alleged safeguarding incident had not been referred to the local authority safeguarding team, and had instead been handled internally. There had also been a delay in the registered manager being informed of the concerns in the first instance.
One relative we spoke with during the inspection told us they had raised a safeguarding concern with one of the managers and they were uncertain what had been done as a result. We spoke with the manager who told us this concern had not yet been reported to the local authority safeguarding team as they were waiting

for a statement from a witness to the alleged incident. The area manager assured us the incident would be appropriately followed up and said the allegation may have been better handled by seeking initial statements from staff involved. We followed this allegation up with staff at the home on 27 January 2016 as we had not received a notification regarding the allegation. The provider told us they had received a statement from the witness on 07 January 2016 and the manager providing cover for the home confirmed the concern was sent to the local authority safeguarding team on 28 January 2016. This delay in action shows there were not effective systems and processes in place to immediately investigate allegations of abuse. This was a breach of Regulation 13 (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with demonstrated a good understanding of how to identify and report any safeguarding concerns they may have. We saw numbers for the local authority safeguarding team were displayed in the offices in the houses. Staff told us they had received training in safeguarding and we confirmed this by looking at training records.

The houses at Bedford Nursing and Residential Home were clean and tidy. We found hand gel dispensers were adequately stocked and there were sufficient supplies of personal protective equipment (PPE) such as gloves and aprons.

Staff were able to tell us the procedure they were required to follow in the event that an emergency evacuation of the home was required, for instance if there was a fire. Staff told us they had received regular training in fire safety, which we confirmed by looking at training records. There was a file kept at the entrance to each house, which contained details of procedures to follow in an emergency and emergency contact. We looked at the emergency 'business continuity plan' at Pennington House. This had not been updated since 2013 and some of the contact details such as the registered manager were out of date.

Inspected but not rated

Is the service effective?

Our findings

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).

On arrival at the home we were made aware by a relative of an incident the previous night where their family member had been attempting to leave the house. We confirmed with the nurse who had been on duty that this was the case and that that person had been prevented from leaving to ensure their safety. Records relating to this person's care also indicated they had attempted to leave the house the week prior to our visit. We saw this person had a capacity assessment in place that indicated they had 'variable capacity', however the assessment was incomplete. We asked one of the clinical service managers (CSM) if this person had an authorised DoLS in place. They were uncertain, but could find no record of a DoLS application having been made. This meant the service was unlawfully depriving this person of their liberty. The CSM confirmed they had made an urgent application for DoLS during our inspection.

We looked at the care plan of another person and they had an NHS mental health care plan in place. This indicated that prior to their hospital discharge they had a DoLS in place, and the care plan stated providers should update the DoLS as required. This person's pre-admission assessment also indicated a DoLS was required. The CSM could find no record that an DoLS application had been made for this person. The house manager on another house told us they had been unable to make any DoLS applications due to time constraints. This meant there was a risk that people were being provided with care that was unlawfully restrictive.

These issues were a breach of Regulation 13 of The Health and Social Care Act (2008) Regulated Activities (Regulations) 2014 as the provider had not ensured people were not being deprived of their liberty without lawful authority.

We reviewed records relating to one person we were told was being administered medicines covertly. This means medicines were given without their knowledge or consent. We saw the pre-admission assessment stated they should receive medicines covertly. However, this person's capacity assessment had not been completed since they moved to the home around one month prior to the date of the inspection. There was also no record that there had been any consultation with family, a GP or pharmacist around the decision to administer medicines covertly, or that could demonstrate this decision had been made in the person's best interests. This was contrary to the homes medicines policy and was a breach of Regulation 11 of the Health and Social Care Act (2008) Regulated Activities (Regulations) 2014 as the provider could not demonstrate

decisions were being made in people's best interests in accordance with the MCA.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 as it was not able to demonstrate that decisions had been made in a person's best interests

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not operating effective systems and processes to ensure any allegations of abuse were immediately investigated and acted upon Regulation 13 (3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as the provider had not done all that was practicable to assess and mitigate risks to people. Reulation 12 (1) (2)(a)(b) Medicines were not managed safely. Regulation 12(1)(2)(g)

The enforcement action we took:

We issued a warning notice. The provider is required to become compliant with the regulations by 12 March 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that lawful authority had been sought before depriving people of their liberty. Regulation 13(1) (5).

The enforcement action we took:

We issued a warning notice. The provider is required to become compliant with the regulations by 12 March 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably competent and experienced staff deployed to meet people's needs

The enforcement action we took:

We issued a warning notice. The provider is required to become compliant with the regulations by 12 March 2016