Advinia Care Homes Limited

Bedford Care Home

Inspection report

Battersby Street
Leigh
Lancashire
WN7 2AH

Tel: 01942262202

Date of inspection visit:
17 January 2018
18 January 2018
22 January 2018

Date of publication:
20 March 2018

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?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of Bedford Care Home on 17, 18 and 22 January 2018. This was the first inspection of Bedford Care Home since it had been re-registered with the Care Quality Commission in December 2017. The re-registration had taken place as part of a restructuring of the company. Bedford Care Home was one of 22 homes being sold to another provider and the registration changes were part of this process.

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

Bedford Care Home is a large care home with 180 beds operated by Bupa. The home is divided into six different units, each with 30 beds. Astley and Lilford cater 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 close to the town centre. At the time of the inspection there were 160 people living at Bedford Care Home.

During the inspection we identified seven breaches in five of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment; including the management of medicines, staffing, meeting nutritional and hydration needs, person centred care and good governance. You can see what actions we told the provider to take at the back of the full version of this report.

We have also made a recommendation about staffing levels and how these are determined, to ensure enough staff are deployed to safely meet people's needs.

At the time of the inspection the home had a registered manager. 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.

People we spoke with told us they felt safe. Relatives were also satisfied with the safety of their family members and were complimentary about the care provided. The home had detailed safeguarding policies and procedures in place, with clear instructions on how to report any safeguarding concerns to the local authority. Staff had received training in safeguarding and knew how to identify and report both safeguarding and whistleblowing concerns.

We noted issues with risk management, particularly in regards to the action taken by the home when specific risks had been identified either by professionals or internal assessments. Concerns were also identified with people's access to and use of the nurse call system, should they need to request assistance

when in their room. The home took steps to address this particular issue during the course of our inspection. We also found inconsistencies with the management of people's weight and referrals to the dietetic service, as well as the adherence to dietetic guidelines.

We saw the home had systems in place for the safe storage and administration of medicines. Overall the completion of the medication administration record (MAR) was done consistently. Staff authorised to administer medicines had completed the necessary training and had their competency assessed. However our review of medicines management highlighted gaps in some documentation such as topical medicine charts. Self-administration documentation was not always clear and we found a lack of guidance in place for some medicines and medical devices.

On each day of inspection we found the home to be clean with appropriate infection control processes in place. We saw infection control audits were completed as per the policy and toilets and bathrooms contained appropriate hand hygiene equipment and guidance, with personal protective equipment (PPE) readily available and worn by all staff when necessary. Wash basins had been fitted in people's bedrooms, to minimise the risk of cross contamination.

We received mixed feedback from staff, people living at the home and their relatives about staffing levels. The number of staff indicated on the home's system for determining staffing levels, matched the number of staff deployed on each unit and tallied with the rota, however feedback from people and staff indicated these levels were not sufficient to meet needs, especially at busier times.

All staff spoken with displayed a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We found the home was working within the principles of the MCA and had followed the correct procedures when making DoLS applications. We saw evidence best interest meetings had been held where necessary, with outcomes documented within care files.

We identified issues with the documentation and monitoring of people in receipt of modified diets. Supplementary charts, such as food, fluid and positional change records had not been completed consistently. We also found the procedure for managing and providing people with thickened fluid was not consistent, with inconsistencies noted in the information and guidance available to staff across the units.

On one unit we saw a person had been provided with food contrary to Speech and Language Therapy (SaLT) guidelines. We were told this was a recording issue and not an accurate reflection of what the person had eaten.

We received positive feedback about training provision from the staff we spoke with. The home used a matrix to monitor training completion and had an action plan in place to ensure staff completed required or overdue sessions. However staff spoken with provided mixed feedback about the completion of supervision meetings. We were unable to evidence meetings had been provided in line with company policy and guidance. Where staff had completed supervision meetings, the majority had been work related supervisions focusing on an area of practice they needed to be mindful of or where issues had been noted.

The majority of people we spoke with were complimentary about the food provided. We found the meal time experience to be positive, with people being supported to eat where they chose. Staff encouraged people throughout the meal and provided support as required and as per people's needs and wishes.

Throughout the inspection we observed positive and appropriate interactions between the staff and people

who lived at the home. Staff were seen to be patient, caring and treated people with dignity and respect. People who used the service and their relatives were complimentary about the staff and the standard of care received. During conversations staff displayed a good knowledge of the people they supported, their likes and dislikes as well as the importance of promoting independence wherever possible.

We looked at 32 care files in total and 14 in detail. We saw these contained detailed information about the people who used the service and how they wished to be cared for. Each file contained a range of personalised information, along with care plans and risk assessments to help ensure people's needs were being met and the care that they received was person centred. However although care files were detailed, we did uncover a number of inconsistencies and conflicting information. For example it was not always easy to identify each person's current needs and ability due to the way care plans had been updated. We noted care plan reviews had been completed but had not identified the issues we found.

Observations of activity provision at the home, showed a large focus on the completion of 1:1 sessions, which meant the majority of people, especially on some of the units, had little in the way of activities and stimulation throughout the day. A lack of resources, both in terms of staffing hours to support activities and in equipment and materials, was a contributory factor to this.

A detailed review of the home's end of life policies and procedures highlighted some concerns. We found a lack of end of life care plans and guidance for staff to follow when people were at this stage of their life. Policies and procedures available did not provide practical guidance for staff, who we identified, lacked training in this area.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were scheduled to be completed on a daily, weekly and monthly basis and covered a wide range of areas including medication, care files, infection control and the overall provision of care. We found completion of these audits to be inconsistent across the units. Provider level audits had also been carried out consistently. Over the last three months, these had identified similar issues to those we found during the inspection, however we were unable to evidence action had been taken to address the issues raised, as this was either not recorded or not detailed on the homes improvement plan.

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

Not all aspects of the service were safe.

Action was not always taken when issues had been identified either by professionals or internal systems and processes.

We identified concerns with people's access to and use of the nurse call system, should they need to request assistance.

Medicines were stored and administered safely, however we noted some gaps in documentation and management of 'as required' medicines.

People we spoke with told us they felt safe living at Bedford Care Home.

Staff were trained in safeguarding procedures and aware of how to report concerns.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Supplementary charts were not completed consistently, which meant it was not always possible to confirm what people had eaten and drank or how often they received pressure relief.

We found inconsistencies in the information and guidance provided to staff regarding the thickening of people's fluids.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully, although we found supervision had not been provided in line with company policies.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in care plans

Is the service caring?

Good

The service was caring.

Both people living at the home and their relatives were positive about the care and support provided.

Throughout the inspection we observed positive interactions between staff and people. Staff members were seen to be kind, respectful and treated people with dignity.

Staff had a good understanding of the people they cared for and were actively involved in promoting people's independence.

People were able to make choices about their day such as when to get up, what to eat and how to spend their time.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Assessments of people's needs were completed and care files contained personalised information about people including their background and life history, which ensured care provided was person-centred.

Some care plans we viewed contained conflicting or contradictory information, which meant it was difficult to determine those people's current needs and abilities.

Most people we spoke with knew how to complain. We saw all complaints received had been investigated and outcomes documented.

Although the home provided an activity schedule, co-ordinators spent the majority of their time completing 1:1 sessions, which impacted on the provision of activities to all people living at the home.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Audits and monitoring tools were in place and used to assess the quality of the service; however completion of these varied across the units.

Provider level audits were completed regularly and had identified similar issues to those found during inspection. However the homes improvement plan did not reflect the audits findings or detail how these issues would be addressed.

The home had a clear management structure in place, with each

unit being assigned a manager who oversaw the day to day running of the unit.

Staff told us they felt supported by their unit manager and felt able to raise concerns.

Meetings with staff, people and relatives were held, although the completion and frequency varied across units.

Bedford Care 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 inspection took place on 17, 18 and 22 January 2018, the first day was unannounced.

The inspection team consisted of three adult social care inspectors from the Care Quality Commission (CQC), two specialist advisers (SPA's); a Pharmacist and a nurse specialising in end of life care and two Experts by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses health and/or social care services.

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the quality assurance team at Wigan Council.

During the course of the inspection we spoke to the registered manager, head of care, clinical services manager and 30 staff members, which included nurses, unit managers, care assistants, hostesses and activity co-ordinators. We also spoke to 27 people who lived at the home and nine visiting relatives.

We looked around each of the six units within the home and viewed a variety of documentation and records. This included 10 staff files, 32 care files, 34 Medication Administration Record (MAR) charts, supplementary charts, meeting minutes, policies and procedures and audit documentation.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Bedford Care Home. Everyone we spoke with told us they did. Some people had recently been either in hospital or at another care home, and used this as a benchmark to qualify their responses. One person told us, "Yes I'm safe, staff popping in all the time to check." Another said, "Yes I'm safe. I like it. I put my hand up to ask staff for help." A third stated, "I've not been here long, but yes I'm safe." We asked visiting relatives for their views, one told us, "Yes, she is very well looked after, safe and well. Her belongings are also safe. We had an issue with clothes going missing. I complained it got sorted." Another said, "Yes very safe, nothings too much trouble." A third stated, "Very safe here, no question. All needs are met here."

During the inspection we identified concerns in relation to risk management. Specifically where risks had been identified; the appropriate action had not always been followed to mitigate the risk. For example, we looked at a person's care plan that was identified as 'high risk' of falls. The care plan indicated that the person was to be referred to the falls team for assessment if they had two or more falls. We looked at the person's falls diary to determine how many falls had been recorded. We noted seven events of the person being found on the floor or having fallen had been recorded between April 2017 and November 2017. It was documented on 31 May 2017 that a falls referral was required but there was no evidence in the person's care file to determine that a falls referral had been made. Three further suspected falls had occurred since 31 May 2017 and when we asked the unit manager whether the person had been referred, they were unable to determine whether this had occurred. This meant there had been a possible delay in making a referral to the falls team to ascertain assessment and mitigate the risk of further falls.

Through observations during the course of the inspection and by talking with people who lived at the home, we found inconsistencies in people's access to 'call bells' to alert staff to the fact they needed assistance. We saw five people being cared for in bed who were unable to access the nurse call system, either because this was on the floor or out of reach, whilst other people told us they did not have this facility in their room. One person we spoke with told us, "I don't have a buzzer, I shout them." Another stated, "I don't' have a buzzer. I know night staff check me in the night, as I hear my door opening." We were told some people were unable to utilise the nurse call system, or were not aware of it, due to their cognition or because they were living with dementia. In light of this we looked to see if both a lack of access to the nurse call system or an inability to use it had been risk assessed. However in the 32 care files we viewed, we found this had not been done consistently. On one unit, we saw two hourly checks had been carried out and documented to account for the fact many people were unable to use the call bell. However this system was not used elsewhere in the home.

We raised this issue with the management team on the first day of inspection. When we returned on the second day, we noted new documentation had been introduced to assess people's ability to access and use the nurse call system, along with a reminder to ensure care plans reflected people's abilities. We saw this information had started to be included in people's care files.

We looked at 32 care files and saw each person had a Malnutrition Universal Screening Tool (MUST) in place;

this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated monthly and the documentation reflected people's changing needs. However, we found inconsistencies in the action taken when the MUST score indicated the need for a dietetic referral. Whilst referrals had been made for the majority of people, we saw one person was documented as having lost 13.2kg in five months. This was in excess of 10% of their original body weight and should have facilitated a referral to the community dietician. We asked the unit manager who was unable to demonstrate the referral had been made.

For people with dietetic recommendations in place, it was not always possible to confirm this had been followed. Whilst on some units the provision of supplements, milkshakes and other fortified foods had been clearly documented, on others we were unable to confirm people had received these.

We also identified some concerns with weight monitoring. One person's care plan stated they needed to be weighed monthly; however during the whole of 2017 this had only been done on five occasions. Another person, who was documented as being at high risk on the MUST, had not been weighed since September 2017. We were told by staff this was due to not having the correct equipment on the unit which had been discussed with management. When we raised this with the registered manager and clinical services manager, we were told the correct equipment was available but had not been requested.

This is a breach of Regulation 12 (1)(2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as where risks had been identified; the provider had not always taken appropriate action to mitigate the risk and people's ability to summon assistance in an emergency had not been consistently assessed or managed.

We looked at the way medicines on each of the six units were managed. This included observing medicines being administered, speaking to the nurses who administered them and looking at medicine related documentation. Overall, we found medicines were available and given to people as prescribed. When observing medicines being administered, we noted people were treated with dignity and patience and there was a good relationship between people and staff members, which enabled people to receive their medicines as per their personal preference.

We found medicines were safely secured in trolleys which were locked when unattended. We looked at 34 medicine administration records (MARs) and found these had been completed fully and were up to date. Each MAR included the person's photograph and allergy status, to help identify the person and reduce the risk of them being administered something harmful.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found CD's were stored and recorded in the way required by law. Controlled drug records across the home were inspected with no concerns identified.

We noted people's medicines had been reviewed and optimised by the local Clinical Commissioning Group (CCG) pharmacist in November 2017, with action points generated and displayed by the home for reference and to promote improvement. We also saw medical advice information from the pharmacy who supplied medicines to the home had been displayed in the clinic rooms for reference.

However we identified some gaps in medicines documentation, for example some topical medicines did not have a chart in place to record their administration. We also found that topical medicines charts did not always correlate to the MAR, so it was not always clear exactly what medicines had been prescribed, when they should be administered and if they had been administered consistently. We also found self-medication

documentation was not always clear, as this lacked the necessary detail to ascertain people's specific self-administration abilities, such as their ability to safely and effectively use an inhaler.

Although the home had guidance in place for the use of most 'when required' (PRN) medicines, such as paracetamol, we found a lack of guidance in place some medicines and medical devices, such as nebulisers. This meant staff did not have the information available to know when and how to administer these medicines or devices, to safely meet people's needs.

Daily and weekly audits were in place to ensure medicines had been administered safely and as prescribed and paperwork completed correctly. Completed audits were stored in the main office, with each unit having a designated file for these. We looked at the files for all six units and found two contained no medicines audits. For the remaining four units, despite guidance indicating 25% of people's medicines on each unit should be audited per week, to ensure everyone's was checked over the course of a month, this had not been done consistently, with at times only 10 – 15% being audited per week.

This is a breach of Regulation 17(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not maintain accurate, complete and contemporaneous records in relation to medicines and complete consistent and effective auditing of medicines management.

We looked at the home's safeguarding systems and procedures. Safeguarding's were managed centrally via either the registered manager or head of care. The home had a dedicated safeguarding file which contained guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully. We noted the correct local authority reporting procedures had been followed for all incidents. The safeguarding file did not contain a log or tracker to document referrals, action taken and any outcomes. We raised this with the head of care, who sent us a copy of the tracker, which we were informed had been stored elsewhere. The tracker listed safeguarding referrals made by the home, date submitted, type of investigation and whether upheld or substantiated. However we noted some safeguarding issues we had been notified about were not included on the tracker, which suggested this was not a contemporaneous record of all safeguarding related matters.

Staff we spoke with displayed a good understanding of safeguarding procedures and were clear about what action they would take if they witnessed or suspected any abusive practice. Staff members also confirmed they had received training in safeguarding vulnerable adults and this was refreshed. One member of staff said, "If anybody flags up an issue, pressure areas, bruises, anything new, these should be reported to the nurse and then reported to the clinical lead. The clinical lead does the referral and decides which tier alert is required." A staff member told us, "Safeguarding is very important. Abuse can be physical, financial, keeping things away from people, shouting at them. Lots of things fall under abuse. I would never tolerate any kind of behaviour and would report it immediately. We have a speak up leaflet which each staff member got which tells us how to report any concerns. There are also posters around the building and policies on safeguarding too." A third stated, "I have done safeguarding training, which is refreshed. I would report any concerns straight away to the manager."

We looked at 10 staff personnel files to check if safe recruitment procedures were in place. We saw robust recruitment checks were completed before new staff commenced working at the home. The files included proof of identity, two references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people. We saw staff were sent an offer of employment once the recruitment checks were completed. The service also had effective processes in place to validate the registration status of the nurses employed at the service.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. Overall the premises were clean throughout and free from any offensive odours. We saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. Personal protective equipment such as gloves and aprons were available throughout the home. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. We looked at the laundry facilities and found suitable industrial equipment was available. We saw the home had been inspected twice in the last 12 months by the local authorities' infection control team, following which an action plan had been generated by the home to address concerns noted. We were provided with a copy of the plan and noted positive progress had been made, including a process of refurbishment as areas of the home were 'tired' and in need of re-decoration.

We looked at the processes in place to maintain a safe environment for people who used the service, their visitors and staff. We found health and safety checks such as water temperature monitoring and legionella prevention were carried out on a regular basis. Fire risk assessments were evident along with a record of fire systems, emergency lighting and fire alarm checks. Contingency plans were in place detailing steps to follow in the event of emergencies and failures of utility services and equipment. Records also showed arrangements were in place to check, maintain and service fittings and equipment, including bed rails and wheelchairs.

We received mixed feedback from people using the service and their relatives about staffing levels within the home. Some people told us staff were visible and attended to them; but felt that at busy times there wasn't enough of them on duty, whereas others had no concerns about the number of staff deployed. One told us, "I would say there is enough staff. They are busy though. You have to be patient." Another stated, "There appears to be enough staff on." A third said, "Not enough staff, especially when it's busy." One relative told us, "It can seem short staffed sometimes." Whilst another said, "There seems to be enough staff on."

The majority of staff we spoke with told us more staff were needed to safely and effectively provide care, especially on the units which had step down beds or supported people living with dementia. One told us, "Staffing is not sufficient. People have high needs on this unit so we need a minimum of five carers but we don't always have this. The office isn't interested when short staffed." Another said, "When we have five care staff in a morning, we are okay. It's busy but we can manage. However, we can be left with only three care staff in a morning and this isn't safe. The step down residents are complex and they [the office] often don't understand their needs. We have had to just get on with it though." A third stated, "As this is an EMI unit it's really hard. There's no way one staff can always remain in the lounge as we should." A fourth told us, "Staffing depends on needs, they [Bupa] work it out by numbers, rather than the safety aspect and what we actually need to support people properly, especially those with complex needs and dementia."

Some staff spoke more positively, however told us capacity was a factor. One said, "When the unit is full an extra staff member would be better, as we would have time to chat to people rather than just do routine tasks. Would be nice to spend quality time with the residents." Another told us, "If fully staffed, then we are okay on here. When we are one down, don't think it's safe."

The home completed dependency assessments for all people who used the service in order to determine their level of need, and then utilised a nursing and care needs calculator to assist in determining the number of staff needed to meet people's needs. We looked at staff rotas for all six units within the home and saw staffing levels provided reflected the numbers recommended by the tool. However we noted guidance for the care needs calculator stated it should be used, 'as part of decision making regarding staffing. Information should be used to help to decide if staff deployment is satisfactory. You may need to increase or

decrease hours to meet needs'. We saw no evidence additional assessments had been carried out to ensure the staffing numbers suggested by the tool were sufficient to meet needs. We also saw the home currently maintained a reliance on agency staff to cover shortfalls on the rota, with 51 shifts being covered by agency staff between 27 December 2017 and 12 January 2018. We did note active recruitment was in place to fill staff shortages.

We recommend the home considers the use of additional assessments to support the nursing and care needs calculator in determining safe and effective staffing levels across all units.

We looked at how accidents and incidents were managed at the home. An accident and incident file was kept centrally which contained a log, detailing the specifics of each accident or incident, who was involved, and action taken. We saw where accidents had occurred, these had been investigated and preventative measures put in place to keep people safe. Monitoring of trends had also been completed, for example how many accidents had been the result of slips, trips or falls. We saw incident and accidents were also logged on an electronic system (Datix) and review forms had been completed online and forward to the provider for collation and further monitoring.

Requires Improvement

Is the service effective?

Our findings

We noted two people on one unit had been identified as requiring a modified diet. Both people's speech and language therapy (SaLT) recommendations indicated they required a soft diet. One person required syrup thick fluids whilst a second person was able to have normal fluids. However, we found there was contradictory information contained within each person's care files regarding their dietary needs. The care plan for person one was dated after the SaLT assessment but indicated the person's dietary requirements were a pureed diet and custard thick fluids, whilst the evaluation section of the care plan stated a soft diet and syrup thick fluids. The second person's care plan was written in September 2014 and had not been updated following the SaLT recommendations. Their care plan indicated normal diet and normal fluids. However, the evaluations completed between June 2017 and December 2017 documented that the person continued to require a soft diet and normal fluids.

We looked at food and fluid documentation across the home and found this to be inconsistent. For example when a meal had been declined there were no details to ascertain what meal had been declined and whether an alternative had been offered in line with the person's likes and preferences. We found gaps on people's food charts, which meant it was not possible to confirm if they had eaten anything on specific days. Some people's fluid intake was being monitored, however neither the monitoring sheet or the care plan contained guidance on the recommended daily amount the person should be drinking and actions to take should they not achieve this amount. As a result people had been recorded as drinking small amounts per day with no action taken to'push' fluids. There was also some ambiguity that arose during discussion with staff regarding who was responsible for completing food records. It was determined if the care staff had sat with the person and provided support whilst the person ate their meal, then that staff member completed the record, otherwise the hostess completed the food record. This was suggested as a possible reason for the inconsistencies in recording of food and fluids.

We looked at how the home cared for people at risk of skin break down and pressure sores. Each person had a skin integrity care plan in place. We saw pressure risk assessment tools were completed and when people had been identified as being at risk, we saw pressure relieving equipment had been implemented. Body maps had been used to record any sores or skin breakdown, with wound plans generated and followed, including the completion of wound care reassessments on a weekly basis.

We tracked five people who had a Waterlow score which was indicative of the person being at high risk of developing pressure areas. The Waterlow score is a tool used to assist in assessing the risk of a person developing a pressure ulcer. The National Institute for Health and Care Excellence (NICE) recommend that adults who have been assessed as being at high risk of developing a pressure ulcer should be offered and supported by staff to reposition themselves to minimise the risk of skin breakdown. We found the positional charts for two people had not been completed consistently.

One person's chart indicated they had not been supported to change position from 05.15 to 20.15 on 09 January 2018, when this should have been done every four hours. On 16 January 2018, there were no entries made from 09.45 to 21.10. Another person who was on two to three hourly positional changes, only had five

changes documented over a 24 hour period between 12 January and 13 January. Our observations of further positional change charts indicated completion and consistency varied across units, for example on one unit each of the six people's records we viewed had been completed consistently over the last two weeks, whereas on two other units we identified the gaps listed previously. Staff told us positional changes occurred as per the care plan and we found no evidence to indicate people's wounds or skin integrity had been impacted upon through a lack of positional changes.

This is a breach of Regulation 17(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not effectively monitor risks to people living at the home or maintain accurate, complete and contemporaneous records.

Some people required their drinks to be thickened as they were at risk of choking and aspiration. We found the management of this process varied across units. Each unit had a hostess, whose job was to provide people with drinks and snacks throughout the day. On some units we noted hostess files had been set up which clearly listed each person's name, their dietary needs, if they required thickened fluids, their food and drink likes and dislikes and whether they required assistance with eating and drinking. This helped ensure the hostess and other care staff knew how to safely support each person with nutrition and hydration. However this practice was not consistent. On one unit we found no procedure in place for ensuring thickened fluids were administered safely. We spoke with the hostess who produced a paper towel out of her pocket on which a care assistant had scribbled the names of people who were on thickened fluids. The hostess stated, "They have given me this to help me." The hostess was also unsure whether people had their own tins of thickener, or used one tin for all.

On one unit we found a person had not been provided with food as per the recommendations of the Speech and Language Therapist (SaLT). This person was assessed as requiring a 'soft diet'. Both the Royal College of Speech and Language Therapists and The British Dietetic Association's guidance for Category D diets states food needs to be soft, tender and moist with no hard, tough, chewy, fibrous, dry, crispy, crunchy or crumbly bits and no skins or outer shells. We noted this person's food charts indicated they had been given; roast dinner, jacket potato, pink wafers, maltesers, cheese and onion pasty, and fish and chips. Each of these foods, as recorded, is contrary the guidance. We identified the issue with the unit manager who felt the food records were not an accurate record of what the person had received, however could not evidence the person had been given the correct diet.

This is a breach of Regulation 14(2)(4)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people's dietary and hydration needs had not been managed effectively.

During the inspection a mixed picture emerged about the quality of the food. We asked 17 people for their views on the meals provided, 12 were complimentary, telling us food "was nice" and they "enjoyed it," whilst five others reported it was "average" or "not very nice". These people told us food was hot and given in sufficient amounts but not particularly tasty or imaginative. We observed the meal time experience across units and found this to be managed effectively. A daily menu was available which contained a choice of hot and cold dishes across the three meals given per day.

The dining area was nicely presented with glass ware, place mats, napkins and condiments for those who wanted to eat at the tables. Staff escorted these people to the dining area and sat with those who needed extra support. People were offered a choice of drinks including tea, coffee, juice and fresh milk as well as being asked what they wanted to eat. Meals were served from a hot trolley with food temperatures taken before service. Staff were attentive during meal times, for example we saw one lady who was struggling to eat her meal at first, until staff provided support and encouragement, following which they person

proceeded to eat their meal independently. People were also supported as per their preferences. We noted one person's care plan stated they liked to be supported to eat their pureed meal with a teaspoon and we observed this being done.

The people who lived at the home and their relatives told us staff had the right knowledge and skills to provide effective care. One person said, "Staff know what they are doing." Another stated "Staff are good; they know what they are doing." A relative told us, "The staff look competent to me."

We asked staff for their opinions on the training provided by the home. One told us, "Training is good, it is monitored and we have to go on it." Another stated, "They send us on all kinds of training, definitely provide enough. We have to review session regularly." A third said, "Training is good. We get lots of training I have recently done moving and handling and fire training." We also spoke to agency staff that were on shift during the inspection, one told us, "The service include me on additional training. In February I am due to attend tissue viability training." One of the unit managers said to us, "Care staff [are] encouraged to complete NVQ 2 [in health and social care], although some have declined." We were told support was provided to staff who wished to complete qualifications such as NVQ's (National Vocational Qualification).

We looked at the homes staff training documentation. A training matrix was in place to document what session's staff had completed and date of expiry. Compliance was monitored and audited on a monthly basis, with staff being requested to complete any required sessions. We looked at an additional training file, which contained details of training completion to date. We noted 78% of staff were up to date with all sessions, with 20% overdue and the remaining 2% assigned to complete required sessions. We saw the home had a plan to ensure outstanding training was completed for the remaining staff.

Upon commencing employment each staff member completed an in depth induction programme, before they could work with people living at the home, which covered all mandatory sessions. One staff member told us, "It was a week's training in Rochdale, followed by three 12 hour shifts where I shadowed." We saw evidence that the Care Certificate was in place for people without a background or experience in care. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

Staff provided us with mixed feedback regarding the completion of supervision. One told us, "Yes we have this fairly regularly." Another said, "I am up to date with my supervisions, they are very good and feel I have my say." Whereas a third stated, "We haven't had supervision for a long time. The last appraisal I had must have been over three years ago." A fourth told us, "Don't think I have ever had one and been here for a few years." Whilst a fifth said, "Yes we have had these, but couldn't tell you when last one was." Two other staff we spoke with had worked at the home in excess of a year but had yet to receive supervision and didn't know what an appraisal was, as these had not been discussed.

Each unit manager was responsible for the co-ordination of supervision meetings with their staff members. Each unit had a matrix in place, to document when meetings had been completed. We looked at the matrix for each unit and noted some units completed meetings more consistently than others. It was also noted that supervision meetings took two forms, one type involved meeting with staff to discuss specific work related issues such as completion of documentation or training, whilst the second was an opportunity for staff to discuss how they are feeling and if they needed any support. It was apparent from the matrixes; the majority of supervisions had been the first type, with few staff being provided with the opportunity to seek personal support and guidance.

Documentation following supervision meetings was stored in staff's personnel files which were stored in the

main office. We checked the records of 14 staff members at random and noted none of these staff had completed more than two meetings within the last twelve months. Of these 14, five had not had a meeting since 2016, three had not completed a meeting since March 2017 and one had no supervision records on file at all. We also compared the personnel records of two people against the matrix and found this did not match. For one person the matrix stated supervision had been completed in October and December 2017 and January 2018, however the two records in the personnel file were dated February 2017 and January 2018.The second person was recorded as having completed supervision in September and November 2017, however the last record in their file was dated June 2016. We found no evidence the home completed any overarching monitoring of supervision completion, to ensure meetings were completed as per company policy.

This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff had not received appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), chiropodists, district nurses, Tissue Viability Nurses (TVN's) and speech and language therapists (SaLT). People confirmed they received support with their health needs, one said to us, "I can ask for a doctor if I need one." A second stated, "Yes, my needs are met, I can see a nurse or the doctor."

The home had a number of step down beds spread across three units. Step down beds are used for people who are medically well enough to be discharged from hospital but not ready to return home due to either requiring on-going therapy or need to regain their confidence, such as with mobilising or completing activities of daily living. We saw community matrons who were part of the hospital discharge team were based at the home, tasked with facilitating discharges from hospital beds into Bedford Care Home. We spoke to the matrons who told us their role involved working closely with staff on the units containing step down beds. We were told the relationship with staff was positive, albeit they felt at times people had become de-skilled during their stay due to the level of support received. Historically therapists had been assigned to the step down beds, to support people with maintaining skills and developing independence, however this did not occur anymore, which placed greater responsibilities on the care staff.

We observed handovers were completed at the start of each shift. As with other areas of practice the completion and content of handovers varied across units. For example on one unit each person was discussed, with any new information or changes clearly identified. This ensured staff had the necessary information to provide effective support. However on another unit the information provided was brief and did not provide any information relating to people's personal care needs, which would be relevant for a night to day shift handover. We also found some inconsistencies with how staff were made aware of their duties and responsibilities. On some units daily organisation charts were used, which indicated which room's staff were responsible for, who was in charge of medicines, positional changes and meal times and when breaks were to be taken. However on others, following handover there was no discussion with the staff regarding the plans for the shift and no clear instructions or duties documented.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Within people's care files we saw that potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention utilised. These covered a range of areas including place of residence and use of bed rails.

We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One staff member told us, "This is when someone can't make decisions for themselves. Usually marked on the board in the office and in care files if a DoLS has been granted." Another said, "DoLS is used when not got capacity to make decisions. Used to protect people and make sure things are in their best interest."

At the time of the inspection, 48 DoLS applications had been submitted to the local authority, however only 19 assessments had been carried out and authorised. Each unit had a DoLS matrix, to track applications made and granted, however it was not always documented if outstanding applications had been chased up. We were told this had occurred, but had not been recorded consistently on some units' matrixes.

We looked at how the home sought consent from people. Care plans contained a choices and decisions over care section, which contained consent information. We noted there was recognition of people's ability to consent via non-verbal communication and gestures, and the difference between a person's ability to make simple daily decisions such as what to wear as opposed to more complex ones such as managing their finances. During the course of the inspection we observed numerous examples of staff appropriately seeking people's consent before providing care and support. Each person we spoke with told us staff sought their consent, with one saying, "They are always asking and checking." Another stated, "Staff always ask me first."

During the inspection we checked to see whether consideration had been given to ensuring the units specifically catering for people with dementia were dementia friendly. The corridors on one unit were light and airy with plain flooring and walls, which had contrasting coloured handrails to make them easier to identify. On the other unit the walls had been decorated in brick effect wall paper, with plain flooring and contrasting handrails. In both units we noted people's bedroom doors were painted the same colour and predominantly contained only small name tags, with little in the way of photographs, pictures or other memory aids in place to help them identify their room. We saw old photographs and memorabilia had been displayed and themed areas with painted murals or decals had been developed, these included a corner shop and a post office.

Good

Is the service caring?

Our findings

People spoke positively about the staff telling us they were kind and caring. One told us, "The staff are very good, spot on, lovely." Another said, "They are very nice and caring." A third stated, "Very nice girls, very friendly and helpful. I am treated well." Relatives also told us they were happy with the care provided to their loved ones. One said, "Yes, mum is very much cared for. I'm happy she is here. " A second told us, "I'm very satisfied, couldn't be better.[Relative] is very well looked after." A third stated, "Always looks looked after, clean clothes, showers are done, hairdresser comes, always smells nice."

It was apparent from the inspection that visits from family and friends were encouraged and they were observed to be made welcome and offered refreshments. Those that stayed for long periods were familiar to staff, and gave positive feedback about the home, the regular checks and the care offered by the staff. One relative reported they could visit any time and did so every day, adding "nothing is too much trouble for the staff."

People we spoke with felt their care was focused on their individual needs. One person, supported by their relative during the discussion, said the positive care and support they had received had enabled them to revert back to eating solid foods, rather than be fed via percutaneous endoscopic gastrostomy (PEG) tube. The relative was also positive about this, telling us how everyone, including external professionals, were working together to support this continued transition.

We asked the staff how they maintained people's dignity and respect. One said, "When providing personal care, shut curtains and close doors." A second told us, "Be polite, use towels to cover people and maintain modesty, shut doors, close curtains. I try to develop relationships with people, so feel more comfortable." A third stated, "I would always respect a person's right to privacy. I would knock on the door first before entering, introduce myself and ask if they want to get up."
We saw staff were vigilant when doors were open to ensure people's dignity was maintained. On one unit we noted that a person's leg was hanging out their bed and they appeared uncomfortable. A member of staff also noted this and went straight in the person's bedroom. We heard them say "You can't be comfortable, let me help you and we'll get you tucked in and settled."

Whilst speaking to staff we asked them how well they knew the people they cared for and how they knew what they wanted. One told us, "This information is in their care file, we have to read this. We also ask the residents." A second said, "We speak to them, ask their family and find out what they want."

Over the course of the inspection we spent time observing the care provided in all areas of the home. Staff interaction with people was friendly and caring and people appeared calm and relaxed in the presence of staff. We observed many positive interactions between people and staff, as well as staff being responsive to people's needs. For example we saw staff intervene when the sun was shining into the face of a person, making them more comfortable and enquiring after their line of vision to the television. For another person, who according to their care file was prone to seizures, staff went to great lengths to make sure the person wasn't sat under the lights and remained in a darkened area, to keep them safe. We noted another person

who was distressed and shouting out throughout the inspection. Staff responded quickly, kneeled down and took the person's hand in theirs and provided reassurance.

The home provided support to many people living with dementia. From our observations it was apparent staff members understood people who lived with dementia. People were able to live within their own world, walking around and busying themselves. We saw one lady happily wandering around wearing an outdoor coat. Staff allowed this person to do so, just periodically checking they were okay. Another person wished to sit in the middle of the room, which staff were happy to facilitate. A third person wanted to move dining furniture around, in an attempt to organise the dining area. Although staff were mindful of this person's safety, and intervened when other people approached the area, they let the person continue, again checking they were okay. Each person was observed being treated with dignity, compassion and respect.

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "Encourage them. We have one lady who can do more that she lets on, so we try to encourage her to do what she can for herself, so she doesn't lose her skills." Another stated, "Let people do the things they can manage, and just help with what they can't." During the inspection, we saw this approach in practice. We observed one person ask staff for a drink, this person was encouraged to make it themselves with the carer shadowing, in case they needed some assistance.

Staff were mindful of the importance of catering for people's diverse needs, whether these be sexual, spiritual or cultural. At the time of inspection nobody living at the home had any specific cultural requirements, however one staff said, "If anybody has any religious needs such as praying at certain times of the day we would most definitely respect that. We would ask where their preference would be and we would honour whatever room they needed." A staff member also told us, "We would always accommodate any married couples. If needs be we would put two beds into one of the bigger rooms so they could share a room."

People and relatives we spoke with also confirmed their needs had been met. One stated, "My mum has a priest that comes in every week to give communion. It's important to Mum There is never a problem with this. We are very happy."

Requires Improvement

Is the service responsive?

Our findings

During the inspection we looked at a total of 32 care files, 14 of which were in detail. We saw initial assessments had been completed which included; a summary of medical information and care needs, social information; interests and hobbies, daily routines, likes and dislikes, skills and abilities, strengths, relationships, culture and religion. This meant staff had the necessary information prior to people moving in to the home to formulate plans based on people's needs.

We saw evidence of a person centred approach within the main care files. At the front of each file was a 'my day, my life, my portrait' document which included information about 'what's important to me at this time.' The document provided details about the person's background, hobbies, interests and where they liked to be during the day. This personalised information was supplemented by other sections in the care file. Each person also had a 'what does a normal day look like' document, which covered a range of areas including senses and communication, choices and decisions over care, lifestyle, healthier happier life, moving around, skin care, wound care and future decisions. The document included key safety risks for each area and provided staff with detailed information about how to care for each person. This information was supplemented by a 'my day, my life, my details' document, which provided additional information about people's cultural and religious needs, life histories, background information, employment history, interests, likes and dislikes.

We found a range of care plans in place for each person covering all aspects of care. Care plans detailed people's ability and level of functioning in each area, along with their likes and dislikes, what they were able to do for themselves and what support they required. This ensured staff had the information necessary to meet people needs in a personalised way. Alongside the standardised care plans, which we saw in all the care files viewed, we saw some people had 'additional plans of care', which covered issues or areas specific to that individual, such as risk of aspiration, DoLS and epilepsy. This ensured each aspect of their care needs had been addressed.

From speaking with staff, it was apparent they were knowledgeable about people's individual needs and were motivated to ensure people received care that was person centred. Staff told us person centred care involved it being, "Just for that person, and that person only, " and ensuring they, "Treated people differently and not the same, as everyone has their own tastes, choices and wishes."

However despite the detail contained in care plans, we did note a number of inconsistencies and conflicting information, which made it difficult to accurately determine the person's care needs or current abilities. Some of this was due to updates being recorded on additional sheets, which meant the initial page of the care plan often contained out of date information, despite this being the first section one would read when looking at the care plan. For example one person's care file had been updated due to a decline in their mobility, however the front of the care plan still stated they were able to walk, which was no longer the case. In another care file we found conflicting information in relation to the person's communication. It stated in their care plan the person was unable to communicate due to a stroke. However their 'my day, my life, my portrait' stated they could communicate. We also noted an entry in the care plan review notes dated

January 2018, which stated the person continued to 'chat with staff'. We saw a person's 'moving around' care plan stated they required repositioning, however their 'my day, my life, my portrait' stated they were independent in this area. This person had no repositioning charts in place and staff told us this person was able to reposition themselves, which meant the care plan was not an accurate reflection of this person's needs.

Care plan reviews had been completed on each of the care files viewed, however none of the issues we noted had been identified, with staff recording that care plans were accurate and up to date. We also found no evidence within care files, that people or relatives had been involved in reviews. Some of the relatives we spoke with told us they had been consulted and were kept up to date with any changes, but this had not been captured within the care file.

As part of the inspection we looked at the activity programme provided by the home. The home employed four activity coordinators, who covered one unit each and shared the remaining two between them. Over the course of the inspection we spoke with three of the coordinators, who told us they each worked between 20 and 25 hours per week on activities. We were told a yearly plan was completed, which covered what would be provided each day, which ranged from 1:1 activities with people cared for in bed, or who could not manage group activities, through to group sessions and outings. One of the co-ordinators told us on the last Friday of the month, they took people to a local club, where they played bingo, took part in a raffle and had lunch. We were told they tried to take different people each time. We were told that funding provided for activities was extremely limited. This impacted on the ability to purchase equipment or materials and the type of activities which could be completed. As a result the home relied on donations and raffles in order to book entertainers once or twice a year.

Engagement in and completion of activities was documented in a designated section of people's care files. It was evident from talking to the activity co-ordinators, they were familiar with the people they supported. Records viewed demonstrated that people's interests and preferences had been assessed and activities matched accordingly. From looking around the units, we saw the presence and quality of activity boards, used to advertise daily activities and upcoming events, fluctuated. We saw one unit did not have one in place, we asked about this and was told it had been taken down over the Christmas period and had yet to be put back up.

People we spoke with told us there was little to do during the day. One person said, "I can go for a walk round the unit if I want to, and we have a hairdresser who comes in, but don't get out much." Another said, "It can be boring in the day." A third stated, "I like to sing to myself, that keeps me busy, nothing much else going on." We asked two people who were sitting together about activities, they both laughed and said to us, "It is so boring, but you get used to it."

Our observations over the course of the inspection reinforced people's views. We saw people sat for long periods in the lounge area, either watching television or looking around, with no evidence of diversional therapies or activities taking place. Stimulation tended to be provided by visits from family and friends or brief interactions with staff. On the first day of inspection we noted one activity co-ordinator was supporting staff in the satellite kitchen, rather than carrying out activities with people. From speaking to the co-ordinators and looking at people's care files, it was apparent some daily activities had been completed, however due to the number of 1:1 sessions which needed to be completed within the home and the limited capacity available; the co-ordinators only provided up to 100 hours activity time per week for up to 180 people, this took up the majority of the coordinators time and resulted in the majority of people having no structured activities to occupy their time.

We looked at the management of end of life provision within the home. At the time of the inspection, there were no people within the home identified as receiving end of life care, nor were any people identified as deteriorating. However, the cohort of the people within the home were predominately frail and elderly. Two people on one unit had a GP statement of intent in place, however we were told both people were currently stable, eating and drinking and staff believed the statement of intent was no longer required.

We looked at the documentation and information in place around end of life care. Due to the changing needs of people within the home, an important part of the care planning process would be to offer advanced care planning discussions with people, their relatives or legal representatives, such as lasting power of attorney (LPA). One of the unit managers told us, "We have three advanced care plans in place. It is difficult sometimes with people who are unable to make their own choices around this. We do speak to families but that's not something we always do on admission as it's not a nice subject to speak about." It was clear from the care files we viewed across all units, advanced care planning discussions had been completed infrequently. It was not always clear whether this had been attempted but declined, or nor yet discussed, as this information was not consistently recorded.

As no-one within the home was receiving end of life care, we looked at the documentation in place for the two people with an active statement of intent. We saw one person was a Roman Catholic, however the care plan did not say how their religious or spiritual needs would be incorporated as part of the end of life process. We also noted a continuous communications record of conversations with family or next of kin regarding the GP statement of intent had not been maintained. People and their families should be involved in end of life care decisions to the extent they wish to do so, this decision, along with any communication should be clearly recorded in the care plan.

We discussed with the clinical services manager, whether there was a plan of care used for people at or nearing end of life care, as neither person had one within their files. From discussions it was apparent there was no formal plan in place or utilised. Staff we spoke with confirmed this. The home should be able to demonstrate they have a developed an action plan for end of life care. People's needs for end of life care should be regularly assessed and reviewed, with this being detailed in their care plan.

We found there were no policies or procedures available on one of the units relating to end of life care best practice. We were told Bupa management had asked for the files to be archived or shredded, in preparation for the sale of the home to another provider. We were advised by the clinical services manager that the policies were available on another unit. We visited this unit and saw they had an end of life file in place, however just this contained information produced by Wigan and Leigh Hospice, which the home had previously been involved with as part of a pilot scheme. We asked for the home's policies which would underpin the information in the file, however we were told there were no policies available or in place for this. We were then referred to the BUPA one place system, which is an online resource. We located an end of life care policy, however this did not provide any practice guidance for staff to follow and didn't align to the Wigan and Leigh information file.

We asked what recent training staff had received in relation to end of life care, including the use of a syringe driver. When someone is at end of life, there may be occasions when the oral route for medication is not the best option, in which case a syringe driver may be used. End of life training was not included on the training matrix, with these records stored separately. We found the records to be incomplete. We were told by the head of care that nursing staff had arranged training directly with the hospice, which was one of the reasons for this. They added that the hospice had maintained a record of training completion, which the home had requested but not yet received. We were later sent the names of 10 nursing staff that had completed syringe driver training, albeit no documentary evidence was available.

In regards to overarching end of life training for all care staff and nurses, the records provided showed a total of 22 staff had attended training facilitated by the hospice, which is less than 16% of those employed. Of these 22 only five had completed all 12 modules, and only one of these was a nurse, who take the lead in the provision of end of life care.

Following the first day of inspection, the home took steps to improve the provision of end of life care, including the distribution of NHS England's 'Ambitions for Palliative and End of Life Care' framework, which focusses on six ambitions. Each ambition includes a statement from the point of view of a person nearing the end of life. Each ambition is underpinned by a series of steps, which need to be delivered to achieve the related ambition. The home had also investigated end of life training provision through the National Gold Standards Framework.

The issues identified in relation to care plans, activity provision and end of life care are a breach of Regulation 9(1)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as care files did not always accurately reflect people's current needs and abilities and did not capture that people, or those acting lawfully on their behalf, had been involved in reviewing care plans and ensuring these met needs and remained relevant. The provider failed to facilitate an activities programme, which met all people's social and recreational needs. The provider also failed to ensure end of life care plans had been completed, discussed and reviewed with the relevant people and had the necessary systems and processes in place to provide effective end of life care.

We looked at how complaints were managed. There was a complaints policy and procedure in place which had contact numbers for CQC and the local authority. Although the complaint's procedure was on display within the units, this was not done so prominently and often in the entrance area, which people had limited access to.

People told us they had not had reason to complain but would speak to staff if they did. One said, "I've no complaints, if I did I would say." Another stated, "I have no complaints. If I did I would tell one of the staff." When asked if they would raise a matter to improve the care or suggest a change, most people we spoke with indicated they would, although were unaware if there was a formal procedure for raising issues or complaints.

The home had a designated complaints file which was held centrally in the registered manager's office. We noted ten complaints had been received in the last 12 months, two relating to care, two to the environment, two about administration issues, along with individual complaints relating to the laundry, medicines management and alleged abuse. We saw appropriate responses to each complaint had been provided along with any actions taken.

Requires Improvement

Is the service well-led?

Our findings

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 the registered provider, 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.

The home had a clear management structure in place. The registered manager was supported by a head of care (HoC) and clinical service manager (CSM). The HoC and CSM oversaw the daily running of the home, feeding back issues to the registered manager. Each of the six units also had a home manager in place, who oversaw the day to day running of their particular unit.

The staff we spoke with provided mixed views about whether the home was well-led and managed and if they felt supported. Some staff described feeling supported by their immediate line managers, namely the manager of their unit, but less so from the registered manager and the management team. Comments included, "I am very happy to say the manager listens to me, if I had any concerns I feel able to raise them", "I feel things are dealt with appropriately by the unit manager" and "Yes, the manager on here is very supportive, I think this unit is well run." However one staff member said, "There are no rules or procedures followed. Staff need to know and be held to account when we get it wrong. You can't run a care home and not address issues. People are off sick but it isn't addressed." Another stated, "We're left to our own devices. The office staff which includes the management don't care." A third told us, "There's nepotism amongst management. It's wrong." Whilst a fourth stated, "Confidentiality is non- existent. It would be round the units what you'd told [registered manager] as you were leaving the office." A fifth staff made similar comments, stating, "I don't feel I could go to the registered manager and tell them if I had a concern. They're not renowned for maintaining staff confidentiality and things soon spread through the units. We hear things we shouldn't about other staff."

When speaking with people who lived at the home, due to the nature of the management structure, either the manager of each unit was identified as being in charge, or people told us they were unsure. One person said, "I know who is in charge by face, we have a meeting on Monday's after tea." Another told us, "Yes, she is in that office over there, she's nice." Whilst a third stated, "I couldn't say who it is." Relatives told us they knew who was in charge, however tended to deal with the manager on the unit, rather than the registered manager. One told us, "Yes, I know who the registered manager is." A second said, "I know who the manager is, I can go and talk to them if needed."

When speaking with staff we asked about the visibility of the registered manager and the management team, which includes the HoC and CSM. Staff told us the registered manager rarely visited the units, however the HoC or CSM attended frequently. Comments included, "Don't see matron a lot, [CSM's name] comes on a few times a week, if not daily", "We've possibly seen [registered manager] once on here in past year" and [Registered manager] doesn't really come on here. It's once in a blue moon when she does, [Hoc] and [CSM] are here regularly though."

Staff told us team meetings were facilitated, however these were infrequent and varied across the different units. One staff told us, "Yes, we have these fairly regularly, last one was just before Christmas." Another said, "We've had two team meetings since the new unit manager started. That's the most we've ever had." A third stated, "Not for a while, can't honestly remember when last one was." A fourth said, Yes, we have team meetings, these are about once a year."

The home policies and procedures indicated meetings should have been held quarterly, however we were unable to evidence this had taken place from the records on file. We saw between one and two meetings in total had been recorded for each unit over the last 12 months. We also noted separate meetings for nursing and senior staff and for night staff had been held on one occasion, in July and October 2017 respectively. We did not see any overarching monitoring in place to ensure quarterly meetings had been facilitated.

We looked at resident and relative meeting completion within the home, to assess people's involvement in the running of the home and whether their views were listened to and acted upon. We saw three meetings had been held in 2017, in June, July and September, albeit these had been on individual units rather than as a home overall. The home had 'you said… we did….' boards up in the main reception area and on some of the units which captured comments and suggestions people had made and what the home had done to address these. We noted no dates were included on the boards to indicate when the feedback or suggestion had been made, to ensure it was still relevant. For example in response to comments to improve end of life care, the board in reception stated the home was working alongside Wigan and Leigh Hospice, however this was no longer the case.

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copies were always available.

The home used a range of systems to assess the quality and effectiveness of the service. Bupa have a filing system in place called 'operational essentials', with a large proportion of the files linked to a specific area of auditing, monitoring or governance. For example File 3 covered compliance, governance and clinical risk, File 3b covered medication compliance and governance and File 4 covered metrics (quality assurance checks). The system's purpose was to ensure every area of care provision was being monitored and audited, with issues identified and action points generated.

We found limited auditing and quality monitoring information on the units, with the majority of information stored centrally. However each unit had a 'Friday file', which was an internal auditing process that looked at weight management, pressure care management, staffing and dependency levels, medicines management, supervisions and appraisals. We noted these audits were not being completed consistently across the home. On one unit the last dated entry in the file was 14 September 2017, whereas on another whilst the file was up to date, the only audits which had been completed were related to pressure care, care plan reviews and weight monitoring.

We looked at the File 3's for each unit and found the audits and monitoring which should have been contained either missing or had been completed inconsistently. For example two units' files contained no medication audits whereas care plan audits, which had been done on each unit, had only been carried out on a small number of files and fluctuated in terms of frequency.

We saw either the HoC or CSM completed daily 'clinical walk rounds' which allowed them to observe the provision of care on each unit. Each 'walk round' was documented and looked at a number of areas including a review of the handover, any people with clinical concerns such as falls issues or safeguarding

concerns, medication administration and documentation, nursed in bed checks and also ensured the 'resident of the day' process had been completed and documented correctly. These audits were to be completed daily, however records showed they only took place on week days. We also noted between the 19 December 2017 and 19 January 2018, which was a 31 day period only 14 walk rounds were recorded as being completed.

The home had a 'resident of the day' programme in place which involved completing a review of a person's care every day on a rolling rota basis. The schedule was based on room numbers, for example Room 1 on each unit would be done on the 1st of the month and so on. This process ensured people's care was meeting their needs and their wishes were being met. Evidence to show completion of the resident of the day had occurred, was via a simple tick sheet, which listed the person's name, room number and a space for staff to sign.

Other internal audits and monitoring in place included 'general manager quality metrics' which measured care across four main themes. This was done by reviewing a number of areas including pressure care, nutrition, medication, safeguarding, DoLS, accidents and incidents, complaints and meeting completion. Weekly clinical risk meetings were held with the home manager from each unit, during which nine areas were discussed including admissions, safety, nutrition and hydration, medical conditions which could impact on care and any incidents that had occurred. Action points were generated along with who was responsible and date for completion.

The provider also carried out regular audits, including a 'monthly home review and smart audit', which was completed by the area director. Each audit covered two units within the home and looked at eight areas including the operational essentials information, environment, daily life and catering. The last audit had been completed in December 2017 and had focussed on Beech and Kenyon. Every six months a quality and compliance inspection was carried out at the home by the provider. The inspection was based on CQC's key lines of enquiry (KLOE's), which are; is the service safe, effective, caring, responsive and well-led and covered all aspects of service provision. For each area the home received a rating of either red, amber or green along with feedback on positive areas of practice observed and issues which needed to be addressed. We saw these audits had been carried out in May 2017 and November 2017.

From looking at both the latest 'monthly home review and smart audit' and the one completed in November, along with the findings from the last quality and compliance inspection, we saw these had identified a number of the same issues we had found during the inspection. For example, operational essentials and File 3's not being up to date, clinical walk rounds not happening at weekends, medication audits not being up to date, queries about whether supervisions had taken place, gaps in supplementary charts such as food, fluid and position change charts, orientation boards not being up to date; the board on one unit had been found to be out of date, it had still not been altered when we inspected and the lack of night visits being carried out.

The home had a home improvement plan (HIP) in place which was used to record action points or issues noted via the auditing process along with what was being done to address these. We saw the HIP covered seven set areas, skin integrity and wound care, medication management, infection prevention and control, MDT working, quality and governance, supporting staff and recruitment and retention. We looked at the last two updated plans, dated November 2017 and January 2018 and saw they either did not include the issues identified on the providers audits or did not specify what had been done to address these issues. As a result we found no evidence the home was addressing issues or concerns raised in relation to the provision of care or support of employees.

This is a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not have effective systems and processes in place to make sure the assess and monitor service provision and evidence they had taken appropriate action without delay, where progress was not achieved as expected.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care files did not always accurately reflect people's current needs and abilities and did not capture that people, or those acting lawfully on their behalf, had been involved in reviewing care plans and ensuring these met needs and remained relevant. The provider failed to facilitate an activities programme, which met all people's social and recreational needs. The provider also failed to ensure end of life care plans had been completed, discussed and reviewed with the relevant people and had the necessary systems and processes in place to provide effective end of life care.

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 Where risks had been identified, the provider had not always taken appropriate action to mitigate the risk and people's ability to summon assistance in an emergency had not been consistently assessed or managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's dietary and hydration needs had not been managed effectively, including following professional recommendations relating to modified diets.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not effectively monitor risks to people living at the home nor maintain accurate, complete and contemporaneous records in relation to risk and medicines management and complete consistent and effective auditing of medicines management. The provider did not have effective systems and processes in place to make sure the assess and monitor service provision and evidence they had taken appropriate action without delay, where progress was not achieved as expected.

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 Staff had not received appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.