Bupa Care Homes (CFHCare) Limited

Bedford Nursing and Residential Home

Inspection report

Battersby Street
Leigh
Greater Manchester
WN7 2AH
Tel: 01942 262202
Website: www.bupa.co.uk/care-services/care-homes/bedford-nursing-and-residential-home-leigh

Date of inspection visit: 27 and 28 April 2015
Date of publication: 08/07/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 27 and 28 April 2015 and was unannounced. We last inspected Bedford Nursing and Residential home in November 2013 when we found the service to be meeting all standards assessed.

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 nursing care, and Beech and Pennington both provided for people living with dementia. The home is situated in a residential part of Leigh and is close to the town centre and local amenities.

Summary of findings

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. There was not a registered manager at the time of our visit. A new manager had been recently recruited and was in process of registering with the Commission. .

During our inspection visit we observed two chairs that were in a poor condition and had torn covers exposing the interior foam. Although these were covered with throws, the chairs would have been difficult to keep clean, and were not in a suitable condition for continued use. Action was taken whilst we were conducting the inspection to remove these chairs and we were told new chairs were in the process of being ordered.

We found there were good systems in place to manage risk to individuals. We saw people had risk assessments in their care plans and actions had been taken to minimise risk where possible. Staff had a good understanding of safeguarding procedures and were aware of signs to look out for that might indicate abuse or neglect.

Medicines were administered safely, however we found that cream medicines were not always being accurately recorded. This meant it was not possible to tell if people had received this medicine as prescribed. We also saw the service was keeping out of date stock of homely remedies at one of the houses, although these had not been administered to anyone. There was also no risk assessment in relation to one person who was self-administering a medicine. We have made a recommendation about the recording and risk assessment of medicines.

We saw there were sufficient numbers of staff to meet people's needs and staff responded quickly to people who required assistance.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw the service was meeting the requirements of the MCA and DoLS, including carrying out best interests decisions involving other professionals and family members where required. However, not all staff had an understanding of the MCA and DoLS .

People had varied views on the quality and variety of the food offered. The acting manager told us this had been identified as an area for improvement and we saw a number of actions had been taken or were underway to improve food. This had included the introduction of nutrition champions, the introduction of snack boxes and the recruitment of a new kitchen manager.People told us the staff were kind and caring and we observed good, friendly interaction between staff and people living at the service. Staff communicated respectfully and effectively with people living at the home.

People's wishes in relation to end of life care had been identified and documented in their care plans. We saw people's families had been involved in this process where appropriate.

The care plans we reviewed had been fully completed and we saw that they had been regularly reviewed. People's preferences and choices in relation to their care had been recorded. However, two people told us they were not supported to bathe in line with their preferences. We also saw records of bathing were not completed consistently on one of the houses, which would make it difficult for staff to keep track of when people were last supported and ensure their preferences were met.

Each house received the support of an activities co-ordinator. We saw there were a range of activities on offer and staff also encouraged people to engage in games and social interaction.

Staff felt well supported and thought the service was well led. One of the houses had been without consistent management for some time. However, we saw that a new house manager had been recently recruited. Staff told us they felt they worked well as a team and felt they received the support they required.

We saw there were thorough and effective processes of quality assurance and audits were in place to monitor the quality and safety of the service provided. Where shortfalls or areas for improvement had been noted clear actions had been identified and followed up.

Summary of findings

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.

We saw two chairs were being used, which were in a poor condition and had the interior foam exposed. The provider acted quickly to remove the damaged chairs when pointed out.

Medicines were generally administered safely. However, some improvements were required to ensure the application of cream medicines was being recorded accurately and consistently.

The service had effective systems in place to assess and manage risks to individual's health and well-being.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

We received a varied response when asking people what they thought of the food on offer. We saw the service was taking action to improve the standard of food on offer. This had included introducing snack boxes and meals to celebrate significant events throughout the year.

People had capacity assessments in place and we saw best-interests decision making processes were followed and documented where significant decisions needed to be made in relation to someone's care and they lacked capacity.

Some staff were not able to tell us what deprivation of liberty safeguards (DoLS) were, although more senior staff did demonstrate a good understanding. People told us they were confident staff were well trained and competent. Staff told us the training on offer was good and they felt confident in carrying out their role.

Is the service caring?

Good

The service was caring.

People told us they had developed good relationships with the staff members. Relatives told us they were made to feel welcome.

We observed positive interactions between staff and people living at Bedford nursing and residential home. Staff were observed to be patient and kind when delivering care.

People's wishes in relation to end of life care were well documented when people had been willing to discuss this area of care. Relatives had been involved in discussions where appropriate.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive.

Summary of findings

Each house had support from an activity co-ordinator. A range of activities were offered including bingo, nail care and dominoes.

Care plans were fully completed and regularly reviewed. However, we saw one care plan had not been updated to reflect the use of a new piece of equipment.

People's preferences were clearly recorded in their care plans and we observed people being given choices throughout the inspection visit. Two people told us they were not able to bathe in line with their preferences however, and recording was inconsistent in this area.

Is the service well-led?

Good

The service was well-led.

There were thorough audit systems in place to monitor the quality and safety of the service. Actions were identified and communicated where any improvement was required.

One of the houses had not had a consistent manager for some time. We saw a new manager had been recently recruited and staff felt they received the support they required.

Staff told us they felt they worked well as a team and thought there was a positive culture at the home.

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 inspection took place on 27 and 28 April 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, two specialist advisors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had experience of residential care homes. The specialist advisors were a registered nurse with expertise in dementia care, and a pharmacist.

Before the inspection took place we looked at information we held about the service. This included any notifications the service is required to send us, such as notifications of safeguarding incidents, serious accidents and other significant events. We also contacted the local authority safeguarding and quality assurance teams and Wigan Healthwatch for any feedback they had about the service.

During the inspection we visited five of the six houses. We did not visit one of the houses (Beech) as this was closed due to an outbreak of diarrhoea and vomiting. We looked around all areas of the remaining houses including the communal areas, bathrooms and treatment rooms. We also looked around the laundry and main kitchen, which were located in a separate building. We spoke with 21 staff including 13 care staff, two nurses, one domestic, three house managers, the clinical services manager, and the acting manager. We also spoke with two healthcare professionals who were visiting at the time of our inspection.

We spoke with nine relatives and 15 people living at the home. As not everyone living at the home was able to tell us about their experience of living there, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spent time observing support over meal-times and within communal areas throughout the visit.

We viewed a range of records relating to the care people were receiving. This included 19 care plans, minutes from staff and residents' meetings, staff rotas and records of complaints. We looked at eight staff personnel files and also looked at records relating to servicing, maintenance and quality assurance.

Requires improvement

Is the service safe?

Our findings

People living at Bedford told us they felt safe and they believed their possessions were safe. Comments we received included; "I'm quite safe here, I can't grumble, they look after me very well" and "I like it here, you just feel comfortable, safe and looked after".

Staff told us there was sufficient specialist equipment available to meet people's needs, and we saw most equipment was in good condition and well maintained. For example, we saw that hoists were regularly serviced by an external contractor as well as the service carrying out monthly checks of all hoists and slings. However, we observed two bucket type chairs that were in use were in poor condition and the interior foam was exposed. One of the chairs was located in a person's bedroom and we were told it was used to provide them with the support they required. Although the chair had been covered with a loose throw, the condition of the chair would have made it very difficult to clean. This would have posed a risk in terms of infection prevention and control.

Staff told us the issue had not been raised with the acting manager, although it had been raised with the previous manager. We showed the acting manager the chair who agreed it was not in a suitable condition to be in use. It was removed immediately and the acting manager told us they would check the condition of all chairs and order replacements as needed.

We saw personal emergency evacuation plans (PEEPs) were in place to inform staff what level of support was required for each person in the event of an emergency evacuation. We saw these had been reviewed regularly and were colour coded red, amber or green to allow staff to quickly and easily identify support requirements. We spoke with a member of staff about the procedure they would follow in the event of a fire or other emergency. They demonstrated a thorough understanding of the procedure and we saw this was consistent with the documented procedure.

Risk assessments in relation to falls, nutrition and pressure care were in place in people's care files and these had been regularly reviewed and acted upon where any risk had been identified. We were told there were also regular clinical risk meetings with the clinical services manager. We saw minutes from these meetings and could see they were an effective way of monitoring and managing any risks to people's health and well-being.

We reviewed procedures and practice in place to ensure people received their medicines in a safe way. Staff were able to tell us how they administered medicines in a safe way, including when medicines were being administered by a percutaneous endoscopic gastronomy (PEG). We saw that there were 'when required' (PRN) protocols in place, which would help ensure staff were aware of when PRN medicines might be required by the person they were prescribed to. We observed part of one of the medicines rounds and saw that medicines were administered following safe procedures. Medicines were kept securely in the treatment room or in the medicines trolley during the medicines round. Controlled drugs are certain medicines that are subject to stricter legal controls to ensure their safe keeping and administration. We saw the service was meeting legal obligations in relation to the storage and administration and recording of these medicines. We saw two homely remedies kept at one of the houses were out of date. Homely remedies are medicines that can be given to people on a short-term basis without the need to obtain a prescription. Although these had not been administered to anyone, it was poor practice to keep out of date stocks of medicines. This was highlighted to the manager.

We reviewed medication administration records (MARs) and saw that these had been accurately completed and indicated people had received their medicines as directed by the GP. However, records in relation to the application of creams were not being completed consistently or accurately. One person told us they had been receiving a pain relief gel daily as required, however there was no record to show that this person had received their medicine as prescribed. The provider carried out comprehensive audits of medicines and we saw the inconsistent recording of topical creams had been identified and was awaiting action. The service was also unable to provide evidence that a risk assessment had been carried out in relation to one person who was self-administering a medicine and in relation to another person who had taken medicines out with them for the day.

Requires improvement

Is the service safe?

We recommend that the service reviews relevant guidance such as that produced by the National Institute for Health and Care Excellence (NICE) in relation to the issues we have identified.

The registered manager told us staffing levels for each house were assessed on a monthly basis using a dependency tool in conjunction with reviews of people's care plans. Staff told us staffing levels were flexible dependent on need, and that additional staffing would be provided if someone required support to attend an appointment or was receiving one to one support. The service had a bank of staff they could use in order to cover shifts if required. During the inspection we saw there were sufficient numbers of staff on duty to provide people with the support they required. We observed staff responded quickly to any requests for assistance. We were present in the communal areas of the houses on two occasions when the emergency call bell sounded. Staff arranged who would respond and who would provide cover for the communal area quickly and efficiently.

Most of the staff we spoke with demonstrated a good knowledge of safeguarding and were able to tell us how they could recognise potential signs of different forms of abuse or neglect. We saw the houses had copies of the local authority safeguarding policy, which would help ensure staff were able to follow the correct procedure when reporting any concerns. Staff told us they felt confident that any concerns they reported would be taken seriously and acted upon. All the staff we spoke with were also aware of the company's whistleblowing procedure, and we saw posters were displayed around the houses with details of how staff could whistle-blow. This showed that procedures were operated effectively to ensure all concerns would be taken seriously and were able to be escalated if required.

The houses we visited all were clean and well presented. We were informed that one domestic was assigned to each house and we saw there were daily, weekly and monthly cleaning schedules in place that had been completed appropriately. We noted a slight odour in two of the houses coming from either the chairs or carpets. The housekeeper told us there was no cleaning schedule for cleaning the carpets, but that this was done on a regular basis and as it was identified this was required. The acting manager told us they were also in the process of ordering new chairs. We saw staff wore appropriate protective equipment (PPE) when providing personal care, serving meals and working in the kitchen. This would help minimise risk of spread of infection.

Requires improvement

Is the service effective?

Our findings

We received a mixed response when asking people what they thought of the food on offer. Around half of the people we spoke with said they enjoyed the food. We received comments such as; "The food is pretty good. Every day there's a different menu, there's always something I like" and; "The food is fine. I had three sandwiches and the soup for lunch. It was lovely". The other half of the people we spoke with were less positive and talked about a lack of variety. One person said "The food is just about passable. I don't think that there's much choice. I ordered omelette and chips the other day and got beans", and another person said "The food? It's the same old rubbish".

We saw people's food and drink preferences were recorded on admission. People were offered a choice of meal and the houses had small kitchens and could offer alternatives if required. Staff had a good understanding of people's nutritional support needs and we saw support was provided as detailed in people's care plans. However, one member of kitchen staff was not aware of the difference between soft and pureed diets. We did not see any evidence people had received inappropriately prepared food and we were told hostesses would liaise with support and kitchen staff to ensure people received the correct meals. We saw that food was sent from the kitchen that would be suitable for people receiving pureed diets.

We observed people being supported with breakfast and mid-day meals. We saw that hostesses served the meals in the houses and the hostess we spoke with was knowledgeable about people's dietary requirements. We saw orders were taken by the hostess for meals in advance, however we were told people could choose something else should they change their mind. Staff told us they would provide a visual choice of meals to people who were not able to communicate choice verbally. We also saw there was a pictorial menu available that could be used to provide choice in advance. We saw that tables were set with knives and forks and condiments were available. People received the assistance they required to eat and drink and the meal time had a relaxed feel.

The registered manager told us they had recognised that food was an area where improvements could be made. They told us the kitchen had been without a manager for some time, and to help improve standards they had brought in a kitchen manager from a nearby home to assist two days per week. On the second day of our inspection the registered manager was undertaking interviews with the aim of recruiting a new kitchen manager. We also saw that a number of other improvements had been implemented, such as offering different meals for special events, home baking and snack boxes. The service had also introduced nutrition champions who attended meetings and cascaded information and tips about providing good nutritional support to other staff. Staff were aware who the nutrition champions were, and agreed this role was useful and had had a positive impact on people's nutritional support.

Staff we spoke with had a good understanding of people's health care needs. Records of visits by other professionals were kept in people's care plans and showed a range of services had been involved in meeting people's healthcare needs. We spoke with a GP and district nurse who were visiting the home at the time of our inspection. Both were positive about the home and told us staff acted on their advice. The GP told us "The knowledge of the staff is better than average, their thinking is good, I'm often impressed by their knowledge". One person we spoke with told us "They call out the doctor if it's needed. They don't waste any time." We saw people's weights were recorded routinely. There was a comprehensive system in place to monitor any changes in people's weights and we saw appropriate actions such as fortifying diets or making a referral to a dietician or speech and language therapist were made if required.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Around half of the staff we spoke with had limited understanding of what DoLS was, and the training matrix indicated that a large proportion of staff had not undertaken recent training in MCA and DoLS. However, more senior staff did demonstrate a good knowledge of MCA and DoLS and we saw the service was acting in accordance with the legal requirements. We saw records that indicated DoLS applications were being submitted to the local authority where it had been identified that a

Is the service effective?

person lacked capacity and restrictive practice was required to ensure they received the care and support they needed. The service was complying with the conditions of the DoLS authorisations we reviewed.

We saw care plans contained capacity assessments relating to specific decisions and it was recorded when capacity may vary at different times. The service had carried out and documented best interests meetings that had been held in order to make certain decisions on behalf of people who lacked capacity. For example, we saw best interests meetings had been held in respect of decisions relating to covert (hidden) administration of medicines and dietary intake. These meetings had involved appropriate other people such as GPs, pharmacists and family members.

Staff spoke positively about the range and quality of the training provided at the home. Staff said they had undertaken a range of training including health and safety, infection control, moving and handling, end of life care, behaviours that challenge the service, dementia and diabetes. Additional training was provided to support staff in particular roles, for example, a new activities co-ordinator was attending external training on how to provide exercise sessions. During our inspection training in skin integrity was being undertaken for some staff at the home. The training matrix indicated that the majority of mandatory training was up to date. We observed staff respond appropriately if a person showed signs of agitation or aggression and people and relatives we spoke with said they were confident that staff were competent and knowledgeable.

There was some inconsistency in both how staff supervisions were carried out and in how they were recorded. The acting manager told us staff had an annual appraisal and they aimed to carry out six supervisions in the year. Some staff told us they had not had recent supervision and copies of supervision records were not always in staff files as they should have been. The acting manager told us they were aware supervisions had been taking place as a number of group supervisions had been completed recently. On one of the houses there was not a supervision tracker to indicate when supervisions had taken place. This house had not had a consistent house manager for some time, although one had been recently recruited. However, all the staff we spoke with felt they had received adequate support to carry out their role effectively and told us they could approach other house managers or one of the clinical service managers if they had any issues or support needs. One member of staff told us; “I can go to anyone and ask them [the managers] anything. They have always got time for me”.

We found the different houses were well kept and homely. Two houses, Pennington and Beech, were designated as providing dementia care. We visited one of these houses and saw some adaptations had been made to the environment to make it more dementia friendly. This included different coloured doors for bedrooms and bathrooms, themed areas/corridors and some directional signage. The dementia houses also had access to safe garden areas, which would allow people to access outside areas safely. It was noted however that some improvements could be made to these areas, such as ensuring surfaces were level and of the same construction to make them safer and more accessible to people with impaired vision or mobility. Some bedroom doors had people’s photos on them, which would help them locate their rooms. However other bedrooms only had names on them and these were not always easy to see. We saw there were also some limited adaptations on other houses to help support people living with dementia to retain independence in their home. For example, there were pictorial signs on bathroom doors and some bathrooms had contrasting colour toilet seats, which would help people with impaired vision locate the toilet.

Staff told us, and we confirmed by looking at the training matrix that staff had received training in dementia. This included basic training and many staff had completed additional more in-depth dementia training. One of the activities coordinators we spoke with told us they had attended specific training on providing activities for people living with dementia. The acting manager told us there was no dementia lead at the home as such. They showed us a guide associated with the training and told us one of the primary aims of the training was to get people to look past someone’s dementia.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and treated them with respect. We saw interactions were natural, friendly and respectful. It was apparent from our observations that staff knew the people they provided support to well and had developed good relationships with them. One person told us; “The carers are absolutely fantastic, 150%, they’re lovely. What’s more, they don’t pick and choose who they’re kind to. They treat everyone the same”. Another person told us; “We have a laugh and a joke. I’m treated respectfully”. We saw one person visiting a member of staff who worked on a different house who they got on well with. Staff greeted this person with enthusiasm and made them feel very welcome. We were told this person walked over every day.

Relatives told us they were made to feel welcome and felt their family members were well cared for. One relative said; “The staff are fantastic. You can’t fault them. They’re very approachable. They make me feel very welcome, always ask me if I want a drink when I arrive”. Three relatives told us they had not been involved in developing their family member’s care plan, although we saw relatives were involved in their family members care in other ways. We saw a record of contact with friends and relatives was kept in people’s care files, which showed the service was in regular contact with relatives. One relative told us “I feel that I’m kept well informed. They always telephone me to let me know of any changes, but don’t panic me”.

Staff told us time was spent with all new admissions discussing their needs and giving them information about the home. We saw that information was displayed around the home including information about advocacy services, activities programmes and meal-times. We saw that blackboards were used in some of the communal areas to display the day and date, however, these were not always updated until after breakfast. This could cause confusion for some people especially for people living with dementia.

We observed one of the activities co-ordinators spending time with one person and their visitor discussing their interests. The activities co-ordinator was writing down questions as an effective way of communicating with this person who used the service. We observed three occasions of staff supporting people using a hoist. On each occasion staff communicated what they were doing clearly and effectively, and spoke with the people being supported reassuringly throughout the process.

We saw there were pain scale assessments in people’s care files that were reviewed regularly and would allow staff to monitor if anyone might require additional pain relief to be prescribed. We observed the nurse who was carrying out the medicines round offered pain relief to people who might require it, and took time to explain what the medicine was for. We saw staff acted kindly and reassuringly to a person who was feeling unwell, and this person was also offered pain relief to help relieve the symptoms they had.

We asked staff how they ensured people’s privacy and dignity was respected. They told us they would ensure people were covered when providing personal care and that they would knock on people’s doors before entering. They also told us people could go to their rooms when they wanted. We observed staff following such good practice throughout the day.

We saw people’s needs, preferences and wishes in relation to end of life care had been considered and documented. The records showed that family members had been involved in discussions where appropriate. Some of the care plans we reviewed had detailed instructions in place in relation to end of life wishes. Where people had been unable or unwilling to discuss preferences in relation to end of life care, we saw that this was clearly recorded. Where this had been the case we also saw care plans identified a 72 hour plan would be put in place when these people required end of life care in order to help ensure consistent, good quality care.

Requires improvement

Is the service responsive?

Our findings

We saw the service was in the process of transferring care plans to the provider's new format. The acting manager told us they thought the new format was more 'person centred' to meet individual's needs. They told us they were encouraging more involvement of people in developing their care plans as well as more description in them. One of the ways of doing this had been to start keeping care plans in people's rooms where this had been agreed by the individual. This encouraged staff to update care plans and complete records with the people they were about. Consideration had been given to ensuring risks of privacy; confidentiality and safe keeping of records were balanced against the benefits this arrangement would bring.

The care plans we looked at had been fully completed and regularly reviewed. However, one care plan we reviewed detailed how a particular piece of equipment should be used to support a person with pressure care. We found a different piece of equipment was now in use, but the care plan had not been updated at that time. This had not affected the care this person was receiving, but could lead to confusion in relation to how this person should have been supported appropriately. We saw there were set timescales for completion of different parts of the care plan when someone moved into the home, and completion was checked by the clinical services manager.

Staff told us they had opportunity to read people's care plans and told us this was a useful way to help get to know people along with speaking with the person and any family members. Staff told us they had time between shifts to provide a handover where they would discuss any updates, changes or issues. We saw written briefings of any updates were also produced to ensure all staff were updated with any changes.

Care plans contained social histories and detailed preferences in relation to a range of areas including bathing, personal care, medicines and food. Staff told us people could choose when they got up and went to bed, what they wanted to wear and when they had a bath or shower. We observed staff asking people what they wanted to watch on TV and asking people what they would like to drink. However, two people we spoke with told us they weren't always supported to bathe in line with their preferences. One person told us they would like a bath more often but that this was only possible if their keyworker was in. Staff told us keyworkers supported people to bathe, but that if they were off this would be communicated to other staff and should be picked up. We were told a record of bathing should be made in people's daily notes and saw this was the case in most instances. These records indicated people were supported with bathing regularly. However, on one house we found support with bathing/showering was not being recorded consistently in two people's daily notes we reviewed. This meant the staff could not be sure about how frequently they had received assistance with bathing.

Each house had part time support from an activity co-ordinator and we saw there were planned programmes of activities on display. During our inspection visit we observed activities such as bingo, nail care, a memory game and dominoes taking place. We spoke with one of the activity co-ordinators who told us other activities included arm-chair dance, cookery, cinema afternoons and outings to the shops or other days out. We saw staff engaged people in activity such as singing and dancing when they had the opportunity, and also encouraged social interaction between people, for example by setting up games and encouraging people to join in. One relative told us their relatives spiritual needs were met by the service. They said; "[Relative] has communion on Sundays and they get the Church newsletter, which they like".

We saw the complaints policy was clearly displayed around the home and in the main reception area. The staff we spoke with knew how to handle and record complaints appropriately. We saw a record of complaints was kept on each house and this detailed any actions required to resolve any complaints and showed when these had been completed.

We were told surveys of residents and relatives were carried out annually and we saw there were feedback forms that people could complete available in the reception area. We were told relatives and residents' forums took place every four months on each house, however not all relatives were aware of such meetings taking place. Staff told us residents meetings took place regularly and we confirmed this by looking at minutes of the meetings. The minutes showed topics such as the complaints procedure, daily life and privacy were discussed. Staff told us about a 'resident of the day' system that was in place. This involved a different person being

Requires improvement

Is the service responsive?

nominated each day and involved a staff discussion and review of their care and support. It also triggered a phone-call to relatives to discuss their satisfaction with the service.

Good

Is the service well-led?

Our findings

There was not a registered manager in place at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager of the home had been in position for around three months at the time of our visit. They told us they had submitted an application to register.

The acting manager told us they had given feedback based on their initial impressions of the home when they had first joined the service. This had been fed into action plans for all the houses, which they told us was regularly followed up as a standing agenda item at head of department meetings. We saw records that indicated this had been communicated to the staff on the houses. This would help ensure the acting managers expectations and identified areas for improvement could be set out and addressed from the outset.

The acting manager was supported by two clinical service managers and there was a house manager for each of the six houses. The acting manager told us one of the houses had been without a regular house manager for some time, and a staff member told us there had been three house managers who had not stayed in position for very long. They said this had been confusing as you didn't know who you were working under. However all staff said they felt they had the support they required and could approach other house managers, the clinical service managers or acting manager if required. A new house manager had recently been appointed who told us they had found all staff including the care staff, the acting manager and clinical service managers to be very supportive of them.

Nearly all the staff we spoke with felt the home was well-led, that they were well supported and that management treated them fairly. Although one member of staff had felt they had not received effective support within their immediate management chain, they told us once their issue was escalated to more senior management that they did receive good support. Staff said they felt any concerns or suggestions they raised would be listened to and acted upon. One staff member told us; "I can go to anyone and ask them anything. They have always got time for me".

Staff told us that staff meetings took place on a regular basis, and we saw minutes from meetings to confirm this. Meetings were also carried out with the house managers, head cook, housekeeper and clinical service managers. This would help ensure information and expectations were effectively shared across the whole home. A staff survey was also conducted and included an analysis that enabled the service to benchmark itself against other services operated by the provider.

All the staff we asked about the culture of the home told us they thought the home had a good culture. Staff were clear about their roles and most spoke positively about their jobs. Staff told us they felt they worked together well as a team. One member of staff told us "The culture I think is very good. Everyone is friendly and approachable. The staff really care about the residents".

During the inspection visit we saw the clinical services manager and acting manager conducted 'walk arounds' and collected information from the houses in relation to any significant events and people's well-being. The acting manager told us they had an open door policy and wanted to encourage more people to come over to the reception and office areas in the home. This would help encourage effective and open systems of communication. We saw the acting manager was visited by a person living at the home at one point in the day and joined them in their office for a drink. The relatives we spoke with felt that staff and the house managers were approachable.

We looked at the systems and processes the service had in place to monitor the quality and safety of service provision. We saw there was a very comprehensive audit system in place to monitor a wide range of areas relating to service delivery. Audits were carried in areas including medicines, pressure care, nutrition and hydration and care plans. We saw that where any risk or need for improvement was identified that this was fed-back to the responsible staff member to action. Actions were then followed up to ensure completion. This would help ensure people received consistently good quality and safe care. The acting manager also showed us a performance report they were provided with. This contained a high-level summary of indicators of the performance of the home across a variety

Good

Is the service well-led?

of measures, including clinical measures, environmental measures, involvement and complaints. This would allow the acting manager to easily monitor the performance of the home.

We looked at care plan audits and saw there were general checks as well as a more in depth audit that was carried out. This included providing a red, amber or green (RAG) rating and percentage score for the care plan. It was noted that a large number of the care plans had been given a red rating. The clinical services manager explained that this was due to staff getting used to the new care plan format, and they felt like standards were improving. We saw that practical actions and advice were fed-back to staff to enable them to improve the quality of care plans.