Bupa Care Homes Limited

Bedford Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Bedford Care Home on 17 and 18 May 2017. This was the first inspection of Bedford Care Home since it had been re-registered with the Care Quality Commission in January 2017. The re-registration had taken place as a business entity to reflect changes to the providers named responsible people. This did not create any changes to the overall registration of the home.

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 units cater for people who require personal care and support, Croft and Kenyon units look after people with mainly physical nursing needs and Pennington and Beech units 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 161 people living at Bedford Care Home.

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.

We found the home to be clean with appropriate infection control processes in place. The home employed 17 housekeepers working across units with detailed cleaning schedules in place. The laundry was housed in a central area separate to the units and had robust systems in place to ensure cross contamination of soiled and clean laundry did not occur. We saw infection control audits were completed regularly 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.

Each person we spoke with told us they felt safe. Relatives were also satisfied with the safety of their family members, commenting positively on the good standard of 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 were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

We saw the home had systems in place for the safe storage, administration and recording of medicines. The completion of the medication administration record (MAR) was done consistently and the home had effective systems in place for the administering of topical medicines. Staff authorised to administer medicines had completed the necessary training and had their competency assessed. The home carried out a range of medicines audits and monitoring, including a post medicine round review, which involved checking all medicines had been administered and recorded, enough stock was in place, variable dose medicines had been recorded accurately and any handwritten entries followed protocol.

All staff demonstrated 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 of best interest meetings being facilitated and care plans had been drawn up to reflect any conditions stipulated by the local authority when granting DoLS applications. At the time of our inspection there had been 37 applications made to the local authority.

Staff were complimentary about the training provided by the home, regarding both induction and on-going refresher sessions. A new online system had recently been introduced which allowed staff to complete additional training in their own time. Staff told us they received reminders when refresher training was required to keep their skills and knowledge up to date. The home had links with external professionals and organisations that also provided training in the home, including Wigan and Leigh Hospice.

Staff confirmed they received supervision and team meetings were completed, however we saw there was some discrepancy in regards to the frequency and consistency of both across the six units.

Meal time observations showed these to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation where appropriate and encouraged people throughout the meal. Support was provided in a sensitive and caring way, with staff assisting people to eat at their own pace. People told us they received enough to eat and drink and were offered a good choice of meal options, with alternatives available. We saw nutritional assessments were in place and special dietary needs catered for. People's weights had been tracked with referrals made to dieticians as required.

Throughout the inspection we found staff to be caring, attentive, professional and approachable and we saw people were treated with dignity and respect. This was supported by verbal feedback from both people living at the home and their relatives. Staff demonstrated a good knowledge of the people they supported and were mindful of the importance of promoting independence.

We looked at 17 care files which contained accurate and detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, along with a range of personalised information which helped ensure their needs were being met and the care they received was person centred.

The home employed six activity coordinators, who planned and oversaw the activities completed within the home. We observed a range of different activities being completed during the inspection, although noted differences between the units, with more one to ones being completed on some, which left the rest of the people residing there with little to do during these periods of time. The home documented activities and displayed photographs of the different events that had taken place.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were 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 saw evidence of action plans being implemented to address any issues found. Additionally the provider completed six monthly inspections of the home, providing a detailed report, along with positive feedback and areas for improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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.

Regular checks and monitoring was completed to ensure the all premises and equipment was safe, in good working order and fit for purpose.

Staffing levels were appropriate to meet people's needs and reviewed regularly to ensure they remained sufficient.

Medicines were stored, handled and administered safely by staff who had received training and their competency assessed.

Is the service effective?

Good

The service was effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully.

The service worked closely with other professionals and agencies to ensure people's health needs were being met.

All staff spoken with 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.

People's dietary requirements were being met, with effective monitoring in place to identify any additional input which may be required.

Consideration had been given to ensuring the environment was suitable to people living with dementia, with appropriate décor and a range of aids, adaptations and pictorial signage in place.

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 friendly, kind and respectful and took time to listen to what people had to say.

People were able to make choices about their day such as when to get up, what to eat and how to spend their time. Staff had an understanding of the importance of promoting independence.

The service had worked closely with the local hospice, to help improve practices and knowledge in relation to end of life care.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed. People told us they were involved in decisions about their care and asked what they wanted.

The home had a robust complaints procedure in place, with all complaints being investigated and outcomes documented.

The home provided a range of activities for people living at Bedford Care Home, although this did vary across the units.

Is the service well-led?

Good

The service was well-led.

People living at the home, relatives and staff said the home was well-led and managed and they felt supported by management.

Audits and monitoring tools were in place and used regularly to assess the quality of the service.

Bi-annual provider inspections were also completed, to ensure the service was meeting the requirements of the Health and Social Care Act 2008.

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 and 18 March 2017 and was unannounced.

The inspection team consisted of three adult social care inspectors and a medicines inspector from the Care Quality Commission (CQC), a specialist adviser (SPA) who was a Pharmacist and an Expert 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, the head of care and twenty staff members, which included nurses, house managers and care assistants. We also spoke to seventeen people who lived at the home and six visiting relatives.

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

Good

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 confirmed they did, with one telling us, "I have always felt very safe living here. I am checked in the night and I like that. It shows they care". Another said, "As far as I am concerned this is a safe home. I did fall once and the staff came to me straight away". A third stated, "I feel safe here, yes." Relatives we spoke with also told us they had no concerns about the safety of their family members.

We looked at the home's safeguarding systems and procedures. Safeguarding issues 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 saw a tracker was in place for all referrals which ensured the correct procedures had been followed and necessary professionals and organisations notified, along with the outcome of any investigations. We noted the correct local authority reporting procedures had been followed for all incidents.

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. One staff member said, "There are lots of different types of abuse such as physical, verbal, financial and emotional." A second member of staff stated, "Things like not giving people their tablets and bullying also fall under safeguarding." A third stated, "I have never needed to make an alert but would not hesitate to do so. Signs of abuse would be unexplained marks on skin, changes in behaviour and if people were scared of certain staff. I would document everything and tell the manager." A fourth told us, "We have a policy and procedure in the office and we have details of other agencies we can ring such as safeguarding or the police. Signs of abuse would be isolation, body language or general changes in behaviour."

Staff members confirmed they had received training in safeguarding vulnerable adults and this was refreshed. One staff member told us, "I have done training in this; they send us questionnaires to test out knowledge. The training has to be refreshed regularly." Another said, "I have done this training a few times, gets refreshed." A third stated, "We do safeguarding training every year."

The service had recruitment procedures designed to protect all people who used the service and ensured staff had the necessary skills and experience to meet people's needs. We looked at ten staff personnel files and found 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 robust processes in place to validate the registration status of the nurses employed at the service. One nurse told us, "It is the nurse's responsibility to renew our registration. This is the expectation of the conduct of someone who holds a professional registration. However Bupa also remind us too."

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. 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. The bathrooms were well kept and surfaces were clean and clutter free. 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 noted the laundry areas were clean and had robust procedures in place to ensure cross contamination of soiled linen and cleaning aids was avoided. The service employed three laundry assistants each day who each worked staggered shifts to ensure the laundry was appropriately staffed throughout the day. We spoke with two laundry assistants who confidently and knowledgeably informed us of the daily routine and how to prevent cross contamination.

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. The maintenance person told us it was the responsibility of the maintenance team to ensure these had been done. The service employed a maintenance team and a gardener on a full time basis. The head of the maintenance team told us, "I attend a meeting each morning with the registered manager and heads of each department. We discuss and feedback issues about any jobs which need to be completed. I then prioritise the jobs and delegate to the maintenance team."

Both people using the service and their relatives told us there were enough staff employed to meet their needs. One person said, "If I need anything, I call them and they come." Another said, "Oh yes, there's plenty of staff." We received mixed feedback from staff, with some telling us more staff were required and others stating the home had sufficient staffing, however all spoken with confirmed people's needs were being met with current levels. One told us, "We usually have four carers on shift which is enough to meet needs, we had five today which was great." Another said, "It's alright some days, others not as good, if people phone in sick for example, but either way we've got enough to meet people's needs." However a third stated, "In my opinion no, and I did speak to the manager about this the other day as we are very dependent on agency nurses. I still think people receive good care though, but it could be done quicker." A fourth said to us, "I think we are understaffed, used to have five carers and a nurse, now got four carers and two nurses, it did drop to three carers but the manager raised this and it got put back up to four; saying that we have a good team and everything gets done, we're able to safely meet everyone's needs."

The home completed weekly dependency assessments for all people who used the service in order to determine their level of need, and then utilised a dependency screening tool to determine 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 dependency tool. We asked the registered manager how they covered gaps due to sickness or other absence. They told us, "The home managers cover sickness on their units, if they can't they will let me know. We aim to staff at 120% to allow for any shortfalls." We saw both agency and bank staff were available to cover nursing shortages.

We looked at how accidents and incidents were managed at the home. The head of care was the home's lead in both these areas. A designated accident and incident file was in place which contained a detailed log, containing 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. For example; observations had commenced or referrals made to the falls team. A falls / incident checklist was in place to ensure all steps had been taken to both deal with the issue at the time and also to ensure a review was completed afterwards.

We looked at how the home protected people deemed to be at risk of falls. Falls risk assessments had been completed and provided good detail about the level of risk presented to people and actions staff needed to follow. The assessments had been reviewed and updated each month by staff to ensure the information was still relevant. Where people had fallen from bed during the night we saw appropriate assessments had been completed to establish if bed rails were required to keep people safe. Where this had been the case we saw bed rails were in use. The staff we spoke with had a good understanding of people deemed to be at risk with regards to their mobility. For example, we observed two people attempt to mobilise without their Zimmer frame, however staff had recognised this as a risk and gently reminded the people to use their frame to prevent them from falling. Sensor mats were also used in bedrooms as necessary. This altered staff when people attempted to get up from bed who may be at risk of falling.

People's care records contained identified areas of risk. Risk assessments were in place for a range of areas such as; moving & handling, pressure care and choking. Each person also had a safety care plan in place, which included information about any systems and equipment in place to maintain their safety. For example, if a hoist was used to assist with transfers, the care plan detailed which hoist and the type and colour of sling, to ensure staff used the correct equipment.

We looked at the way medicines were managed and watched people being given their medicines in all six units in the home. All the nurses and care staff we observed administered medicines safely and in a kind and patient way. They asked people if they needed medicines that were prescribed for them only 'when required'. Extra information to help staff decide when to offer a person their 'when required' medicine, (PRN protocols) were filed with the person's medication administration record (MAR). This helped ensure medicine was used safely and the person gained maximum benefit. Protocols were also in place for people prescribed a thickening powder for their drinks due to difficulty swallowing and risk of choking or aspiration.

The home had a medicine policy describing how medicines should be managed. Audits were carried out to check that staff handled medicines safely. Managers had found some concerns in one unit in the home and were supporting staff to make improvements.

We looked at the medicine administration records (MARs) belonging to 82 out of the 161 people living in the home. We found that overall records about medicines were carefully completed. Handwritten records on MARs were signed by two people; checking by a second member of staff reduces the chance of a mistake. Some people were prescribed a moisturising or barrier cream. Carers were signing a separate chart when they applied these creams and the records we saw showed that people's skin was cared for properly. However, carers also applied some medicated creams. People may be harmed if staff who are not nurses, and not appropriately trained, apply creams that are only available on prescription. We raised this with the registered manager who had addressed the issue when we returned the following day.

Medicines were kept safely and storage facilities were clean and tidy. The temperatures of rooms and refrigerators where medicines were stored were monitored and recorded to ensure that medicines were safe to use. Medicines that are controlled drugs (CD's); and subject to tighter legal controls because of the risk of misuse, were stored and recorded in the way required by law. Staff regularly checked CD stocks, which is good practice to prevent mishandling and to find any recording errors promptly. The stock balances of the sample of controlled drugs we checked were correct.

Good

Is the service effective?

Our findings

People living at the home told us they enjoyed the food and received enough to eat and drink. One said, "The food is good, I like it." Another told us, "I am a fussy eater, but the food here is generally very good". A third stated, "I like the food. If you don't want something then the staff make you something else." Relatives were also complimentary, commenting on how nice the food looked and smelled, with some stating they had sampled meals which they found very tasty.

We observed the meal time experience during the first day of inspection and saw that it was positive for people using the service. Each unit had its own dining area, which people were encouraged to use, however people's individual needs and choices were also respected, and we saw people eating in both the lounges and their bedrooms. Dining tables had been set properly prior to meal times, with each containing tablecloth, napkins, cutlery and condiments. Menus were clearly displayed and alongside breakfast, lunch and evening meals, they also included 'night bite' options, should people be hungry in the evening. There was at least two main options available at all mealtimes, with alternatives provided if people did not like or wish to have either.

For people who required assistance at meal times, we observed the staff supporting them to be calm and caring in their approach. Staff went at the person's own pace, waiting for confirmation from them, either verbally or non-verbally, that they were ready for the next mouthful. People's care files contained detailed information about their dietary requirements. Each unit also had a 'hostess file' in place, which contained a list of each person, their dietary requirements, fluid intake needs, likes and dislikes and what assistance they required. During meal times we saw people's wishes and needs had been followed.

We looked at how people were supported to maintain good nutrition and hydration. We found people had eating and drinking care plans which informed staff about the support they needed to provide and if people were deemed to be at risk. 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 regularly to reflect people's changing needs.

Staff had made referrals to external agencies such as Speech and Language Therapy (SaLT) and dieticians as necessary and their guidance and advice was available in the care plans we looked at, such as if people required soft or pureed diets. A nurse told us that all food was fortified with additional items such as cream, butter and cheese to help people gain or maintain their weight, however where people needed to lose weight, this would be altered to suit their needs.

We saw people's weights were closely monitored. In one person's care file we saw they had suffered significant weight loss. This had been tracked and a referral made to a dietician. Weight monitoring charts were in place and the person's weight kept under review. Supplements had been prescribed by a consultant and were being administered as per pharmacy instruction each day. This person's journey in relation to their weight loss and referrals to professionals had been clearly documented throughout the care file. We observed this person being provided with snacks, as per dietician recommendations, however noted these

had not been consistently documented on the daily food diary, which was raised with the manager who agreed to address this issue.

The home had monitoring charts in place to document what people had eaten and drank throughout the day as well as specific fluid monitoring charts for people who were identified as being at risk of dehydration or requiring support to access fluids. We noted some issues with consistency across the units, with staff not always recording the actual amount of food eaten, or documenting the provision of snacks or supplements, which people confirmed they had received. To address this issue, one unit manager had completed sample charts for staff to refer to.

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 and corresponding Waterlow risk assessments in place. This provided staff with information about if people were at risk, if specialist equipment was needed such as pressure relieving cushions and mattresses and details about people's continence and nutritional needs which could impact on their skin. We found several people required turning/re-positioning in the night and staff maintained accurate records of when this was done which was every two to four hours during the day and night. Nurses also maintained records of when dressings had been changed and if there were any concerns noted. Photographs of any wounds were also taken which is deemed to be good practice.

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, "If I don't feel well staff look after me." Another stated, "I can have a doctor when I need one. They have nurses as well which is good."

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, "The staff are brilliant and really can't do enough for me. It seems to me like they do receive good training." Another said, "The staff are spot on. They work well together and very much seem to know what they are doing."

We asked staff for their opinions on the training provided by the home. One told us, "There is plenty. I've recently done end of life, tissue viability, safeguarding, infection control and moving and handling. They keep on top of it well." Another stated, "I have just refreshed on my moving and handling and fire training. I am up to date with all other training. A list is displayed in the office so we know where we are up to and we are told when we are due." A third said, "You can always ask for additional training and they will arrange. They are very supportive like that." A fourth told us, "You have to keep up to date with training. They are very strict with this. It's only right though."

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 saw staff had completed training in a number of areas relevant to their role, including moving and handling, infection control and safeguarding. Upon commencing employment each staff member completed an in depth induction programme, before they could work with people living at the home. The registered manager told us, "Induction training is a comprehensive programme consisting of a week's classroom training, run by the area trainer, which covers all mandatory sessions. On the second week staff shadow within the home, we can extend the shadowing period if needed."

We saw evidence that the Care Certificate was in place at the home. 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, "My supervision is regular. I always have them with the nurse or unit manager." Another said, "I am up to date with my supervision. I find them very useful." A third stated, "Yes, we have these regularly, my last one was a couple of months ago." However a fourth told us, "I wouldn't say they are that frequent and I haven't had one for a while. That goes for both clinical and standard supervision." A fifth stated, "I have not had supervision since last year." A sixth said, "Yes, we have supervision though not as often as we should have. I have had three and an appraisal in the last 18 months."

We were told that each unit manager was responsible for the co-ordination of supervision meetings with their staff members. Each unit had a matrix in place, documenting when meetings had been done and when the next meeting was due. From looking at the matrices, it was apparent that some units completed meetings more consistently than others, which would account for staff's mixed response. The inconsistency had been picked up by the service and we saw an action plan had been put in place to address this.

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. We spoke with a nurse on Croft unit who said if people required a DoLS then they tended to reside on one of the dementia units, namely Beech and Pennington. Throughout the home, we found staff had carried out mental capacity assessments where necessary, with monthly care plan evaluations done to ensure there were no changes. During the inspection, we observed one person telling staff they wanted to leave and return to their home address. Staff acknowledged this request and quickly established the person had capacity to state where they wanted to reside. As a result, staff contacted their social worker to review the placement, with the intention being to source more suitable accommodation. 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.

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, "DoLS is required if a person is being held against their will in the home and they also lack capacity. Also if a person was trying to leave and the doors were locked." Another said, "The MCA is about determining whether someone has capacity to make decisions for themselves, if not these need to be made for them in their best interests." A third stated, "DoLS stands for deprivation of liberty, this is when a person's liberty is taken away. We have a lot of people on DoLS here."

At the time of the inspection, 37 DoLS applications had been submitted to the local authority, however only six assessments had been carried out and authorised. We saw evidence that action had been taken to chase up the outstanding applications. We saw the head of care completed a DoLS matrix, which detailed the person's name, date of application, date of follow up if the outcome was delayed, date outcome received and whether the application had been granted.

We looked at how the home sought consent from people. Care plans contained a choices and decisions over care section, which included a mental capacity assessment to determine if each person had the capacity to consent to their care and treatment. Depending on the outcome, either the person themselves or their representative had signed the consent form. Recognition had been made about people's ability to apply 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 staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like to participate in the activities on offer. Each person we spoke with told us staff sought their consent, with one saying, "We get choice, yes. Staff always check first." Another said, "They always knock before coming in."

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. Information boards were in use which displayed the day, date, season and day's weather. 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 no photographs, pictures or other memory aids in place to help them identify their room. Some people had created their own name tags during an art & craft activity, albeit these were all the same design. We saw old photographs and memorabilia had been displayed and themed areas with painted murals or decals were being developed, these included a corner shop and a post office, for which a post box was being made, to enable people to post their own letters. We noted an internal audit had identified memory boxes had not been replaced outside people's rooms after re-decoration and an action point generated to rectify this as soon as possible.

Good

Is the service caring?

Our findings

The people we spoke with said they liked the staff and found them to be kind and caring. One told us, "I would say the care is very good here. They do anything they can for me and I feel very well looked after." Another said, ""It's brilliant here. The staff can't do enough for you and I have a lot less worries since living here." A third stated, "The girls are great, very pleasant they are." A fourth told us, "The staff are lovely; they can't do enough for me."

Relatives also told us they were happy with the care provided to their loved ones. One said, "I have no worries about [my relative] being here, the staff are brilliant." Another said, "I am happy so long as Mum is happy and she is. If anything needs doing it is done. Nothing is any trouble. I have no concerns."

We asked the staff how they maintained people's dignity and respect. One said, "Obtain consent and explain exactly what you are about to do. I always close doors and curtains we place a sign on the door saying care is in progress." Another stated, "Knock on doors before going in and let people make the choice of what they want. It's important to respect their decision as much as possible." A third said, "Close doors, close curtains, be discreet. Treat people how I would want to be treated." People we spoke with confirmed they were treated with dignity, respect and were given privacy at the times they needed it.

Whilst speaking with staff we asked them how well they knew the people they cared for and how they knew what they wanted. One told us, "By monitoring and observing, see what people want, offer them choices." Another said, "By asking them and it's in the care plan, it explains in there exactly what people have said they want." A third stated, "Look through the care file, ask the person themselves, or their family if they are unable to tell you themselves."

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. Staff acknowledged people on entry to the lounge area, wishing them a good morning and enquiring how the person was. People were offered choice and staff accepted and acted on their wishes. We did not observe anybody looking unclean or unkempt. People's hair was tidy and people we spoke with had clean teeth and finger nails. One person told us, "I decide what I want. I can have a bath when I want. It's usually a couple of times a week."

On one unit we were told a person who had recently moved into the home had been desperately missing their husband. We noted the husband visited and was able to stay for the majority of the day with staff making them their lunch and ordering them a taxi when they were ready to go home. On another unit a person became distressed when her husband left after his visit, staff took time to sit with the lady holding her hand and providing reassurance. This continued for over an hour, until the lady finally settled.

We observed staff members ensuring they were at eye level with people when engaging in conversation, even if this involved kneeling down or pulling up a chair before engaging people in conversation. Appropriate physical contact by the staff was observed, such as hand holding or placing their arm around

someone whilst speaking discreetly with them. Throughout the inspection people responded positively to the interactions with staff and care being given.

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "Encourage people to walk if they are able to, rather than just getting them a wheelchair straight away. At meal times as well, I will try to get people to hold their own cutlery and let them to try to eat." Another said, "For one gentleman I always wash his back because he can't reach, but he does his front because he is still able to." A third stated, "I let people do what they can manage and only assist where needed." One of the people we spoke with told us, "When I have a shower, they give me the sponge so I can do myself, which helps keep me independent."

We observed staff promoting people's independence where necessary for example we overheard one saying to a person, "Do you want to walk a little bit first rather than using the wheel chair straight away?"

People's end of life care was dealt with in a sensitive way. When appropriate, and where people had chosen to, documentation was in place to ensure their end of life wishes were considered. This included decisions around resuscitation, which was clearly documented and reviewed by a GP where appropriate. We saw the home had been actively working alongside Wigan and Leigh Hospice to help improve practices and knowledge in relation to end of life and palliative care, and had recently been awarded 'most improved home of the year' at the recent Care Home awards, organised by the hospice. The commendation stated, 'Staff in the home showed great commitment, dedication and enthusiasm for acquiring skills and knowledge to provide a high standard of end of life care to residents.'

Good

Is the service responsive?

Our findings

The people we spoke with told us they liked living at Bedford and were happy with the care they received. One person said; "The staff are lovely girls, they work hard." Another said, "If I ever need to talk to someone they are always here to listen." A third stated, "Nothing is too much trouble. I love it here, it's my home."

From the beginning of the inspection we saw evidence of person centred practice, with people being able to determine how they spent their time. One person told us, "I get up and go to bed when I want, there is no hassle." We heard staff passing on information between themselves about people who had chosen to stay in bed, making plans to return later to see if they were ready to get up. People attended breakfast, and other meals, at a time of their choosing, with food being set aside to facilitate this.

We asked staff members how they ensured care provided was person centred. One said, "From experience, it's about getting to know the residents, sit and chat to them, people will the tell you what they want." Another told us, "For everything I do, I ask the person what they would like. I make sure it's all about them, you need to take your time with people."

We saw that people received care that was personalised and responsive to their individual needs and preferences. Each care file contained a pre-admission assessment, and although this was a standardised document to ensure all relevant information was captured, contained additional information specific to each individual. This information was then used to assist with broader care planning.

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 information about the person's background, family tree, memories, favourite things, 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 lifestyle, choices, skin care, safety, washing, dressing, eating and drinking. The document included key safety risks for each area and provided staff with detailed information about how to care for each person. We did note some inconsistency in the quality and quantity of background information, however in most cases this was due to the person being unable to provide this, and a lack of or no family involvement, meant staff could not ask them either.

For people with no verbal communication skills or ability, care files also contained information about how these people did communicate; whether this was through body language, hand or facial gestures, to ensure staff were aware of this information and ensure people were listened to.

We found a range of care plans in place for each person covering all aspects of care. Care plans contained further evidence of personalisation, as they explained 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 way they both wanted and needed.

Although care files followed a standardised format, we saw evidence additional care plans had been drawn up to address areas not covered by any of the sections. For example one person had a plan in place around the risk of aspiration and had requested food be provided by teaspoon, we observed their wishes being met, another person had a plan in place covering the conditions stipulated on their DoLS authorisation, to ensure staff were aware and adhering to these.

People we spoke with and their relatives told us they were asked about and involved in care and care planning. One person told us, "I am asked what I want." Another said, "I am involved in my care." Relatives told us they were involved with decisions about their family member and anything important was discussed with them. One relative told us, "Nothing is done without them speaking to us, as Mum can't talk." Another stated, "If [my relatives] care needs change, they talk it through with us."
Each care file contained a section to capture people's involvement in discussions and reviews of their care, despite people and relatives confirming this occurred, we noted these sections were not completed consistently.

As part of the inspection we looked at the activity programme provided by the home. The home employed six activity coordinators, who worked from a central hub, rather than a specific unit, as had previously been the case. Co-ordinators worked across the units providing activities based on the schedules in place. Each unit had a large activity board on display, which detailed the activities for that week, although due to decorating work, the board on one unit had been taken down and not yet put back up.

We noted a difference in the activity completion across the home and the way co-ordinators were allocated. For example, on one of the units, where people were more independent and mobile, we observed two co-ordinators facilitating a karaoke / sing along session. People were engaged and enjoyed taking part, and several people requested to have a drink of beer which was provided. Whereas on one of the dementia units, we saw just one co-ordinator completing one to one sessions with people who were cared for in bed, meaning that the rest of the people on the unit, did not have any scheduled activities during this time. We discussed this with the registered manager who said they would meet with the co-ordinators to ensure their time was used effectively.

People told us they regularly played bingo, completed quizzes and had visiting artists perform for them. A relative told us they were encouraged to take part in activities, "We went out as a family with the home to a lovely park. My husband is coming home for the day next week. The home has done everything they can to make this happen."

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. The procedure was also displayed in the entrance area of each house. People told us they had never had reason to make a complaint but would feel confident in doing so. One said, "If I wasn't happy I would say, don't worry about that." Another told us, "Yes I have said if somethings not right, they're very good about it. It's changed straight away." Relatives also confirmed that any concerns raised had been addressed and the staff and management were 'very approachable'. We looked at the complaints held on file and saw an appropriate response had been sent by the provider along with any actions taken.

The home also maintained a record of compliments where people had expressed their gratitude with the service they received. We looked at a sample of these, some of which read; 'Please pass on our sincere thanks to all of the staff for treating our family member so well since he has been at this care home. It is very much appreciated by all of the family' and 'I visited the home today and observed a member of staff assisting with drinks and fluids. The member of staff was helpful, respectful and gentle throughout. Best

practice was definitely observed'.

Good

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 felt that the home was well-led and managed and they felt supported. One told us, "The management here are very approachable. I find them very supportive as well. I enjoy working at this home and have no desire to move on." Another said, "Really good from my point of view and they come onto the units quite often. Things always get sorted out if there are any concerns." A third stated, "We don't tend to see the registered manager very often but [head of care] and [clinical service manager] are always popping in." A fourth added, "Yes, definitely. Anything I am struggling with I can go to the management."

Due to the nature of the home, people we spoke with either identified the home manager on the unit as being in charge, or told us they were unsure, however they recognised both the HoC and CSM when they walked onto the unit, which evidenced they were regular visitors to each unit. Relatives told us they knew who was in charge and felt the management team were "very good" and "really helpful" and felt listened to. One told us, "If anything is not right it's sorted out. It's very good here. I did have a problem with one of the staff, but it got sorted. I thought they had a bit of an attitude, that's not the norm though."

Staff told us regular team meetings were facilitated; however there was some discrepancy with the frequency of meetings across units. We were told meetings were quarterly, but could not evidence this from looking at individual meetings files on the units. Nevertheless all staff spoke positively, one said, "I recall the last one being around April time. They are consistent with them and they seem to be every two to three months. You can put your point across and we feel listened to." Another stated, "They are quite good at making sure team meetings take place. There is an agenda in place and they make an effort to make sure everybody can attend." A third told us, "Yes, they are every few months or so, although the last one was about five months ago. I find them useful and we can bring things up." Staff also told handovers were used to pass on information. We observed handovers on two of the units and noted these provided a detailed account of each person and any concerns.

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 copy 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 ensured every area of care provision was being monitored and audited, with issues identified and action points generated.

We were told the HoC and 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 issue 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. For any issues identified, we saw an action plan had been generated with details on who was responsible for completing and when.

The home had a 'resident of the day' programme in place which involved the completion of a comprehensive review of a person's programme every day on a rolling rota basis, with the person central to this. 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. We saw relatives had been invited by letter to participate in this process, however were told that many had chosen not to do so. This process ensured people's care was meeting their needs and their wishes were being met.

Other internal audits and monitoring in place included 'general manager quality metrics' which measured care across four themes, quality of care, leadership, life and environment. 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.

Every six months a quality and compliance inspection was carried out at the home by the provider. This provider inspection was based on CQC's key lines of enquiry (KLOE's), and the five questions we always ask about services; 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. The last provider inspection had been completed in January 2017. We reviewed the issues identified at that time and found the majority had been addressed. The only area still to be completed was the re-introduction of memory boxes outside people's rooms. The inspection had identified that the current auditing process was not always detecting issues in areas such as medicines and care plan audits, following which they had been amended to ensure they captured this information.

We noted there was not a schedule in place for both resident and relative meetings and as a result completion and frequency of these meetings varied across units. We viewed minutes from the last three meetings, held on two of the six units, and saw as well as discussing information relevant to the unit; people had had the opportunity to raise any issues pertinent to them.

We were told questionnaires were sent to people and relatives centrally by the provider, with feedback on the responses being provided to the home. The home had a number of 'you said…we did' boards on display, providing details of action taken to address people's requests or concerns. Examples included reducing the amount of agency staff utilised, which we noted had been reduced by 75% and on one of the dementia units people had said they missed being able to carry their own money. As a result people had

been provided with a handbag, small purse and artificial laminated £20.00 notes.

We found accidents; incidents and safeguarding had been appropriately reported as required. We saw the registered manager and head of care ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and copies of all notifications submitted were kept on file.

Certificates and awards were on display within the reception area of the home. We noted that at the recent care home awards, hosted by Wigan and Leigh Hospice, the head of care had been awarded deputy/support manager of the year award. We also noted that one of the units had received the 'good holistic care' award, for being the staff team that had gone the extra mile.