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Bridlington House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15 August 2017 and was unannounced. Bridlington House provides care and support to people living with mental health needs. The service is a large detached house and accommodation is situated over three floors in six single and eight shared bedrooms; four single and two shared rooms have en-suite facilities. There is a dining room, a large sitting room with a pool table, a conservatory and a small quiet room. Bathrooms and toilets are situated on the ground floor and first floor. At the time of the inspection, there were 16 people using the service.

At the last inspection on 19 and 20 December 2016 we had concerns about how medicines were managed, the cleanliness of the service and the timeliness of replacing damaged furniture. We issued a warning notice for governance and the provider had to be compliant by April 2017. We received an action plan which told us how the provider was to make improvements and we checked out the progress with it during the inspection.

The service 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 registered manager had started a quality assurance system of checks and audits. Whilst a lot of improvements have been made in the overall governance of the service, there are still some issues to address and we have asked these to be completed straight away.

We found improvements had been made in the management of medicines, which at the last inspection was mainly with counter-signing controlled drugs [those medicines that required more secure storage]. We saw these medicines were signed appropriately by two staff at the time of administration. We did find that there were some minor recording issues such as an inconsistent use of codes when medicines were omitted and there could be clearer guidance for staff when administering 'when required' medicines and those with a variable dose. We have made a recommendation about this in the text of the report.

We found the cleanliness of the service had improved and staff were more aware of managing infection prevention and control. Furniture and bedding had been replaced.

We saw people had assessments of their needs prior to admission to the service and staff completed risk assessments and care plans. Whilst some of these were person-centred and tailored to people's individual needs, others lacked important information. This meant staff may not have full and up to date information about people's needs. You can see what action we have asked the provider to take at the back of the full version of the report.

Staff confirmed they received supervision, support and training in order for them to feel confident and skilled when supporting people. The training record showed which staff had completed essential training,

however, there was no record staff had completed training in the specific needs of people who used the service such as mental health conditions, and substance and alcohol misuse. The registered manager told us staff had completed some of this training but the records could not be located. We have made a recommendation that this training be re-visited or an attempt made to obtain the certificates from the original trainer.

Staff were observed as kind and caring during their interactions with people and privacy and dignity were respected. However, we observed two practices that were institutional and limited choice, although carried out by staff with good intentions. We spoke with staff and the registered manager about these and they confirmed the practices were to cease straight away.

There were sufficient staff on duty to meet people's needs and although not assessed at this inspection, recruitment practices were safe at the last inspection.

Staff had received training in how to safeguard people from the risk of harm and abuse. They could recognise the different types of abuse and knew who to contact if they had any concerns.

We found people's health and nutritional needs were met. People who used the service were supported to attend appointments with community health professionals. Menus provided people with choices and alternatives. Those people with nutritional concerns were referred to dieticians for advice and treatment.

There was a complaints policy and procedure on display and people felt able to raise concerns with staff or the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were improvements in the cleanliness of the service and management of infection prevention and control. However, we are awaiting evidence that recommendations made at the last Legionnaires check have been completed.

People received their medicines on time although there were some minor issues with recording and guidance for staff. We have made a recommendation about this.

Staff knew how to safeguard people from the risk of harm and abuse and how to refer to other agencies if they had concerns.

Staff recruitment wasn't assessed at this inspection as it was found to be safe at the last inspection in December 2016. There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff told us they received training and support to enable them to feel confident when supporting people. We have made a recommendation about additional training and evidence to support it has been completed.

People were supported to access community health care professionals when required.

People's nutritional needs were met and they were provided with a varied diet.

The provider and registered manager worked within the Mental Capacity Act 2005 when there were concerns about people's ability to consent to care and support.

Is the service caring?

Good

The service was caring.

We observed the staff approach to people who used the service was kind, caring and friendly. People confirmed that staff respected their privacy and dignity.

We observed two practices within the service that, although staff felt were supportive of people's needs, were actually institutional. These have been addressed by the registered manager.

People's personal information was held securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had assessments of their needs completed and care plans produced. We found in some instances the care plans and risk assessments lacked information in order to guide staff in how to meet people's needs.

There was a range of activities available for people to participate in. An additional member of staff had been arranged since the last inspection which helped when organising and supporting people with activities and trips out to local facilities.

People knew about the complaints procedure and felt able to raise complaints and concerns.

Is the service well-led?

Requires Improvement

The service was well-led.

We have judged this key question to be Requires Improvement, as to achieve good, improvements need to be sustained over a period of time.

A quality monitoring system had been implemented since the last inspection. This included audits, checks, meetings and questionnaires. We discussed with the registered manager, the need for action planning following minor shortfalls raised in meetings and questionnaires.

People who used the service and staff said the registered manager listened to them and they felt able to make suggestions.

Bridlington House

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 15 August 2017 and was unannounced. The inspection team consisted of one adult social care inspector.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with nine people who used the service. We spoke with the registered manager, three day care support workers and one night care support worker. We also spoke with the cook.

We looked at three care files for people who used the service and other important documentation which included medication administration records (MARs) for 16 people and daily notes of care provided to them. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service and staff were available when required. They also told us they received their medicines as prescribed. Comments included, "The staff are great and look after us well", "Yes, there are enough staff around. If you ring the bell, they come", "Yes, there are enough staff and you don't have to wait for care support", "Sometimes last year there was not enough staff at times but now there are always enough staff on duty", "I couldn't live anywhere else" and "Yes, the staff do speak to us in a nice way."

At the last inspection on 19 and 20 December 2016, we issued requirement notices for specific breaches in regulations. These related to cleanliness, infection prevention and control, and ensuring suitable furniture was available. We found improvements had been made in all of these areas. There was an acceptable level of cleanliness in bedrooms and communal areas. The laundry floor had been repainted and the basement was clean and tidy; a local fire safety officer had visited the premises in January 2017 and declared that this area was now safe. Seven bed bases and mattresses had been replaced and new washable flooring had been fitted in one of the bathrooms. Staff had access to personal, protective equipment such as gloves, aprons, hand gel, liquid soap and paper towels.

We asked to see the last stored water safety check used to prevent Legionnaires and found this had several recommendations outstanding from a risk assessment carried out in 2016. The registered manager confirmed a company had visited the service and addressed the recommendations but they, and the provider, could not provide any records about this. The provider told us they would ensure a company revisited the service to address the recommendations and evidence about this is to be forwarded to the Care Quality Commission when completed.

We found people received their medicines as prescribed and staff recorded controlled drugs [those that required more secure storage] safely, which was an issue at the last inspection. Two signatures were used at the time controlled drugs were administered and staff completed checks on stock balances. Medicines were stored in the staff office, which was cramped but also locked when not in use. The controlled drugs cupboard was used to store other items that the district nurses used, which left little room for the actual controlled drugs; these were stored in another locked cupboard but which was not rag-bolted to the wall. This was addressed on the day of the inspection. There were some minor recording issues with administration of general medicines. For example, codes were used to indicate the reason why medicines were not administered but these were not used in a consistent way, which could be confusing. There were also some medicines that were used when required [PRN] and others that had a variable dose, for example one or two at night or pain relief up to four times a day. We found the guidance for staff when making these decisions could be clearer. We discussed these issues with the registered manager who told us they would address them.

We recommend the provider seeks advice from the local medicines management team to assist in the development of clearer guidance for staff when administering 'when required' medicines.

We found there were sufficient numbers of care staff on duty to meet people's needs; this had been increased since the last inspection. Staff supported people to maintain their mental health needs to enable them to be as independent as possible; some people required two staff to support with personal care tasks. The rotas indicated there were two staff on duty between 8am and 8pm and a third member of staff from 12 noon until 6pm. The registered manager worked 9am to 5pm during the week and was available on call at weekends. There was a cook 8am to 2pm each day and a domestic worker five days a week. There were two care staff on duty at night.

Staff were clear about how to safeguard people from the risk of harm and abuse. They had completed safeguarding training and in discussions, they knew the different types of abuse and the signs which might alert them to concerns. They said they would report any concerns to the registered manager who in turn was familiar with the referral system to the local safeguarding team. The registered manager had contacted appropriate agencies when required to discuss safeguarding concerns.

We saw risk assessments had been completed to guide staff in how to minimise the specific risk some people who used the service had. These included falls, alcohol misuse, smoking, individual physical and mental health conditions, medication and the use of equipment such as hoists and recliner chairs.

Staff recruitment was assessed at the last inspection in December 2016. It was found that new staff were recruited safely and all employment checks were in place prior to them starting work in the service. Recruitment practices were not assessed at this inspection. However, the registered manager told us they occasionally had agency staff [a domestic and care staff had been used recently], but there was only brief information about them. The registered manager told us they would contact the agency and obtain relevant paperwork about training and recruitment to satisfy themselves the staff had the appropriate skills to support the people who used the service.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us staff supported them to visit their GP or community nurse when required. They all said they thought staff were well-trained. Comments included, "Yes, very [well trained staff]", "Yes, when I had a fall, they transferred me safely" and "They are really good when you are poorly."

People told us they liked the meals, had sufficient to eat and there were choices on the menu. They also stated they were able to make their own decisions about aspects of their lives. They said, "I think the meals are good; there are choices", "The meals are very good", "First thing in the morning they ask what we want. There are two menu choices and plenty to eat." Other comments were, "Yes, I go out on my own, control my money and come in safe. I eat and drink what I like" and "You can't smoke in your bedroom and there is no alcohol on the premises but we are all alright with that."

Staff told us they received appropriate supervision and training and they felt able and equipped to meet the needs of people who used the service. Supervision records showed that staff had received at least one meeting with their line manager since the last inspection. Staff confirmed supervision discussions included any issues in the service, training needs, any problems they had and a discussion about goals and changes since their last supervision. They all confirmed the registered manager was supportive and approachable.

The training was a mixture of on-line training with questionnaires to test competence, face to face sessions and booklets to work through. We saw there were no records of staff completing training in the conditions affecting people who used the service such as mental health needs, alcohol misuse and substance abuse. The registered manager told us staff had completed mental health training but they were unable to find records. They said previous management had left some documentation in disarray and they were unable to locate specific training records.

We recommend training is revisited in specific areas such as conditions that affect the people who used the service or duplicate certificates obtained from the previous trainer to evidence this has been completed.

Care records evidenced people had access to a range of health and social care professionals. These included, GPs, psychiatrists, community psychiatric nurses, district nurses, dieticians, podiatrists, physiotherapists, the crisis mental health team and emergency care practitioners. In discussions, staff were clear about when to refer to health professionals and they described the signs that people's physical and mental health was deteriorating.

People's nutritional needs were met. Records showed two people had recently lost weight and they were under the care of a dietician; staff were fully aware of this and described the food supplements they were prescribed and how they tried to encourage a high calorie diet. We observed the lunchtime experience for people. Most people had their lunch in the dining room or the conservatory. There was plenty to eat with large portions served to people and a selection of cold juices; the cook brought in additional food and asked if anyone wanted second helpings. The meal looked hot and well-presented. We saw some people had an alternative to the main meal. The cook told us they had a list of people's likes and dislikes and they knew

who required a special low sugar diet due to diabetes. They told us they changed the menus weekly to ensure people had a variety of food.

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. We found the provider was working within the legislation. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided to them. They said all the people who used the service had the capacity to make their own day to day decisions. They said, "Sometimes [person's name] doesn't want to get changed so we chat to them, keep going back and distract them until they are ready" and "We ask people if they are okay with support."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the provider was working within the principles of the MCA. An application for a DoLS had been submitted to the local authority for one person and they were awaiting assessment. Staff told us the person had fluctuating capacity and this was checked out each time prior to the delivery of personal care.

Good

Is the service caring?

Our findings

People who used the service were complimentary about the staff team and described them as caring; they said their privacy and dignity was respected. Comments included, "They [staff] always knock on my door before entering into my room", "The staff are great", "Very nice staff" and "They [staff] are awesome."

One person was very clear that they really liked living in the service and asked me to indicate this in the report. They said, "You could be in a posh place but not be happy. I like this place and if this place is ever closed down, I'd sit in the garden and they'd have to bulldoze me out."

Staff were clear about how they promoted privacy and dignity. They said, "We close doors during personal care and knock on doors before entering" and "There are locks to toilets and bathrooms and people have keys to their bedroom doors."

We observed two practices that were institutional. For example, we observed people who used the service came into the dining room to have their mid-morning hot drink. When we asked why they had not stayed in the sitting room, they told us they were not allowed to drink their coffee or tea there. We also observed people were not offered biscuits with their mid-morning and mid-afternoon drink; people told us they were only 'allowed' these at suppertime.

We spoke with care staff and these practices were confirmed. Staff said they offered fruit mid-morning and afternoon instead of biscuits to help promote a healthy diet. However, during the discussion, they agreed people should be given a choice about whether they wanted to maintain a healthy diet or not. The practice of not taking hot drinks into the sitting room had 'always taken place' as they were concerned drinks could be spilt on the laminate flooring and cause a slip hazard. We discussed measures that could be taken to prevent this such as appropriate over-chair tables if people were at risk of spilling drinks. These practices were discussed with the registered manager and they said they would cease immediately.

Despite the two issues mentioned above we observed positive approaches and interactions between staff and people who used the service. Staff were friendly, professional and clearly knew people very well. They sat and chatted to them, asked them about their plans for the day and generally showed an interest in them.

Information was provided to people who used the service. This was included on notice boards throughout the service. People also told us that staff told them about planned activities, outings and meetings. They confirmed the cook came round each day and told them the options for lunch and the evening meal so they could make their choices.

We saw the registered manager had contacts for local advocacy services although no-one was currently using this service.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the office or the registered manager used their office upstairs. There was a

quiet sitting room to hold reviews of people's care needs or these could be held in their bedrooms. People's health and care files and medication administration records were held securely. Staff records were also held securely.

Records were also held in computerised form and the registered manager confirmed the computers were password protected. We could not see any evidence that the provider was registered with the Information Commissioner's Office, a requirement when computerised records were held. The registered manager told us they would check this out with the provider and complete registration if this has not already been done.

Requires Improvement

Is the service responsive?

Our findings

People who used the service confirmed staff were responsive to their needs and provided activities they could participate in. Comments included, "The staff help us to be independent", "I've seen my care plan but I don't wish to read it at the moment", "I read my care plan and my key worker is [Name]", "I'm happy with my room", "This is the best home I've been in" and "[Name of domestic staff] cleans my room everyday; my room is very quiet and I love it." Other comments included, "I go out to meet other people everyday", "I play bingo and do knitting", "We have exercises on Mondays, the pool table, a dart board and games if we want; there's plenty to do and we're not bored", "Some people go out on their own to shops and staff take us to museums and The Deep; we've been to Hornsea once so far this year" and "I like to do bingo, keep fit and reading."

We saw people had assessments of their needs prior to admission to the service. There was also a range of risk assessments completed for each person who used the service. The risk assessments covered a range of topics and on the whole were kept to date. However, we saw some risk assessments could contain more detailed control measures to guide staff in how to help minimise risk. For example, with one person's nutritional risk assessment and another person's mental health needs.

We saw some information in care files was person-centred and individualised to reflect people's preferences. For example, one person's document showed what was important to them and how staff could support them. The document recorded what they liked to have as a sandwich filling and how they liked them prepared at tea-time We saw this happened in practice on the day of inspection. Other people's care files also identified routines during the day and what would constitute the best or worst day for them, although at times these were very basic and not personalised. For example, in one file we looked at, the person would have the best day, 'When I have a good night's sleep' and worst day, 'When I have an unsettled night'. These did not provide full information for staff.

Care files did not always have sufficient information to show that needs were adequately planned to provide guidance for staff. We saw one person had nutritional concerns but did not have a care plan to guide staff in how to manage them. The person sometimes preferred to stay in bed until lunchtime so missed out on breakfast. Staff said they made sure they were offered meals throughout the day to compensate but this was not recorded anywhere. As the person's weight was low and often fluctuated, it was important staff responded to this and monitored food intake more effectively during these times.

There were other examples of care plans where staff would not have full information about how to support people in accordance with their needs or preferences. For example, one person's care plan to support management of their diabetes referred to staff monitoring their blood sugar levels prior to meals and reporting concerns to the district nurse. However, there was no indication of what levels of blood sugar would be too high or too low. The care plan to support the person's continence needs was basic and referred to ensuring the 'right type' of aids but didn't specify what these were. Similarly, there was no information about personal hygiene support following an incontinence episode. The care plan to support the person's behaviour, which could be challenging was also basic and lacked information to guide staff.

Another person was recently seen by a physiotherapist who prescribed an exercise regime but these had not been incorporated into their care plan.

Not ensuring people's needs were properly assessed and planned to ensure those needs were met was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

We saw there was a range of activities available for people to participate in if they chose to. These included board games, the use of a pool table and darts board, bingo, exercise sessions, visiting entertainers, outings to local facilities, trips to the coast and shopping. People also liked to do their own thing such as watching television, listening to music and knitting. Some people attended a local church each week. One member of staff was designated as activity coordinator and organised the activities for people; this was an improvement from the last inspection. They confirmed the service had use of a car for trips out.

The provider had a complaints policy and procedure on display. This detailed who to refer complaints to and timescales for acknowledgement and completion. There were also forms for people to complete if they had concerns. People who used the service told us they felt able to raise concerns. Comments included, "I'd go to [registered manager's name] if I had a complaint and staff always tell us to do this" and "I would tell one of the girls or [registered manager's name]." Staff knew how to manage concerns and complaints.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 19 and 20 December 2016 we issued a warning notice for governance, as we had concerns the quality monitoring system had failed to identify issues. At this inspection, we found improvements had been made although there was further progress to be made in some areas, for example addressing recommendations from a Legionnaires assessment, ensuring care plans contained full information and updating guidance for staff administering 'when required' medicines. The rating has been judged as Requires Improvement for this key question so we can monitor the service and ensure improvements are sustained over a period of time.

Since the last inspection, the registered manager had implemented a quality monitoring system, which consisted of audits, checks and surveys to gain people's views. We saw audits had been completed on the environment, potential health and safety areas, housekeeping, medication, cleanliness in the kitchen and laundry, and equipment such as wheelchairs and window restrictors. Shower heads had been disinfected and portable electrical appliances had been checked. Action plans had been produced when shortfalls were identified and these had been addressed with specific staff. Some areas required closer monitoring such as care plans and risk assessments.

The local authority contracts and commissioning team had visited the service three times since the last inspection and found improvements had been made in the areas they had identified as having shortfalls. The local fire service had also visited and stated the basement was now tidy and did not pose a fire risk.

We saw meetings had been held for people who used the service and questionnaires had been sent to their relatives and visiting professionals. There were no questionnaires sent to people who used the service yet but this was on the quality assurance agenda. There were some suggestions and minor shortfalls identified in meetings and surveys but no action plan to evidence these had been addressed.

We spoke with the registered manager about the culture of the service. They described having an open-door policy and encouraging people who used the service to raise concerns and make suggestions. The registered manager also said they completed a night shift once a month so they could talk to night staff, complete supervisions and observe practice. They described the provider as approachable and said they visited frequently to talk to staff and people who used the service.

People who used the service knew the registered manager's name and told us they were approachable and would listen to their concerns. Comments from people were, "I think the manager is very good", "He's very nice" and "He is a good manager; he's approachable. We have meetings every month, sometimes more if there is an emergency."

Staff confirmed the registered manager was supportive and approachable and they felt able to raise concerns if needed. They used words such as 'very understanding', 'helpful', 'listens' and 'a very good manager' to describe them. They said communication was good within the service and they had systems to ensure information was passed on between staff and to the registered manager. Staff spoke to us about the

values of the service and said, "We are focussed on ensuring the people who used the service came first."

The registered manager was now aware of their registration responsibilities in ensuring the Care Quality Commission and other agencies were made aware of incidents which affected the safety and welfare of people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care plans included full information about how their needs were to be met in a person-centred way.