The Bridgings Limited

The Bridgings Limited (Eston)

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

This inspection took place on 24 January 2018 and was unannounced. This meant the provider and staff did not know we would be visiting.

At the last inspection in January 2017 the service was rated Requires Improvement. We also identified a breach of regulation in relation to the safety of the premises and equipment. This was because tests of the fire alarm, emergency lighting and electrical installation had not been carried out by someone qualified to do so. We took action by requiring the provider to send us plans setting out how they would address this. When we returned for this latest inspection we found that action had been taken and the service was no longer in breach of regulation.

The Bridgings (Eston) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 11 people with learning disabilities or autism were using the service.

The care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also one of the owners and registered providers of the service.

Risks to people using the service – including from the premises and equipment – were assessed and monitored. Plans were in place to support people in emergency situations. The provider had systems in place to promote effective infection control. People's medicines were managed safely. Policies and procedures were in place to safeguard people from abuse. The registered manager and provider monitored staffing levels to ensure they were sufficient to keep people safe. The provider's recruitment processes

reduced the risk of unsuitable staff being employed.

Staff received a wide range of mandatory training in order to support people effectively. Newly recruited staff were required to complete induction training before they could work with people unsupervised. Staff received regular supervisions and appraisals. Staff applied the principles of the Mental Capacity Act 2005 (MCA). People were supported to maintain a healthy diet and to take control of their own food and drink. People were supported to access external professionals to monitor and promote their health. The premises had been adapted to make them suitable for the people living there.

People spoke positively about staff at the service, describing them as kind and caring. People were treated with dignity and respect and promoted their independence. The registered manager was able to describe how advocacy services would be arranged should they be needed.

People told us staff provided them with the support they needed and wanted. Care plans were personalised and based on people's support needs and preferences. People at the service were supported to access a wide range of activities and interests in the local community. The provider had a complaints policy in place, setting out how people could raise issues and explaining how they would be investigated. Staff received end of life care training, and policies and procedures were in place to support this should it be needed.

Staff spoke positively about the culture and values of the service. The registered manager told us about links they, people and staff had forged with the local community. The registered manager and provider carried out a number of quality assurance checks to monitor and improve standards at the service. Feedback was sought from people, relatives and external professionals. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

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.

Safety checks of the premises were carried out. Risks to people were assessed and mitigated.

Policies and procedures were in place to safeguard people from abuse.

People's medicines were managed safely.

Recruitment procedures were in place to minimise the risk of unsuitable staff being employed.

Is the service effective?

Good

The service was effective.

Staff were supported through regular training, supervisions and appraisals.

People's rights under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were protected.

Staff sought out and worked to best practice to deliver effective support.

People were supported to maintain a healthy diet and to access external professionals.

Is the service caring?

Good

The service was caring.

People spoke positively about the care and support they received and were happy to live at the service.

Staff treated people with dignity and respect and promoted their independence.

Procedures were in place to support people to access advocacy

services.

Is the service responsive?

Good

The service was responsive.

Care was personalised and regularly reviewed.

People were supported to take part in activities they enjoyed.

The service had a complaints policy and people and their relatives said they would use it.

Policies and procedures were in place to provide end of life care.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the culture and values of the service.

The registered manager carried out a range of quality assurance checks to monitor and improve standards at the service.

Feedback was sought from people using the service and their relatives and was acted on.

The Bridgings Limited (Eston)

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 24 January 2018 and was unannounced. This meant the provider and staff did not know we would be visiting.

The inspection team consisted of one adult social care inspector, a specialist advisor electrician and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider 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 contacted the commissioners of the relevant local authorities, the local authority safeguarding team and other professionals who worked with the service to gain their views of the care provided by The Bridgings (Eston).

During the inspection we spoke with five people who used the service. We looked at two care plans, four

medicine administration records (MARs) and handover sheets. We spoke with four members of staff, including the registered manager and three support workers. We looked at two staff files, which included recruitment records. We also looked at records relating to the day to day running of the service.

Good

Our findings

At the last inspection of the service in January 2017 we identified a breach of regulation in relation to the safety of the premises and equipment. Tests of the fire alarm, emergency lighting and electrical installation had not been carried out by someone qualified to do so. We took action by requiring the provider to send us plans setting out how they would address this. When we returned for this latest inspection we found that action had been taken and the service was no longer in breach of regulation.

The fire alarms, emergency lighting and electrical installation had been inspected and tested by qualified professionals since our last inspection. Other maintenance visits had been carried out and required test certificates were in place in areas including gas safety and legionella testing. The registered manager carried out regular checks to the premises and equipment to ensure they were safe for people to use. We did see that window restrictor checks were not included in these, and when we spoke with the registered manager they said they would change their policy to include them immediately. An annual risk assessment of the premises was carried out to see if improvements could be made to help keep people safe. Accidents were monitored to see if lessons could be learned to help keep people safe. For example, after one person accidentally dropped food on themselves changes were made to how staff helped people carry food to and from tables to reduce the risk of a similar incident occurring.

One person we spoke with said, "I like living here because it's safe." Another person told us, "I'm safe."

Before people started using the service a pre-admission assessment was carried out to identify any risks arising from their particular support needs. This covered areas such as communication and personal care. Where a risk was identified plans were put in place to reduce the chance of it occurring. For example, one person's risk assessment identified that they liked to walk out locally as much as possible but were not always able to do so safely on their own. Their care plan contained guidance to staff on how the person could be supported to do this safely, such as by staff walking out with them but at a short distance away so the person could enjoy some time to themselves. Assessments were regularly reviewed to ensure they reflected people's current level of risk.

Plans were in place to support people in emergency situations. Fire drills took place regularly, and one person we spoke with described to us the route they would take from their room to reach the fire exit. Staff received fire safety training, and fire fighting systems and equipment were regularly checked and serviced. Personal Emergency Evacuation Plans (PEEPs) were in place and were regularly reviewed. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who

cannot safely get themselves out of a building unaided during an emergency. The provider had a business continuity plan that contained guidance to staff on how support could be provided in emergency situations that disrupted the service, for example, the breakdown of essential equipment.

The provider had systems in place to promote effective infection control. Staff received infection control training, and policies were in place with guidance on good practice. The service had an infection control 'champion', who attended forums and training sessions provided by infection control nurses and shared the latest best practice with other staff. We saw that kitchen, bathroom and toilet areas were clean and tidy, and people were encouraged to assist with this by joining the cleaning schedule. This meant there were effective processes in place to promote infection control.

People's medicines were managed safely. One person we spoke with said, "I get my medicines when I want them." Staff received training in medicine administration and had access to the provider's medicine policy. This contained guidance on a number of topics, including medicine storage and disposal and the management of 'as and when required' (PRN) medicines. Guidance from the National Health Service and other professional bodies was also in place for staff to consult.

One person at the service managed their own medicines, and this had been risk assessed and was regularly reviewed. People's medicine support needs were recorded in their care plans and medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Each person's MAR began with a profile containing their photograph, GP information and details of any known allergies. This helped minimise the risk of the wrong medicines being given to the wrong person. MARs we reviewed had been correctly completed without gaps or errors. Protocols were in place for the management of PRN medicines where people used these. Medicines were safely and securely stored in locked cupboards or, where necessary, refrigerators. Storages temperatures were monitored daily to ensure they were suitable. One person at the service used prescribed controlled drugs, and these were securely stored and monitored. Medicine stocks were monitored to ensure people always had access to their medicines when they were needed.

Policies and procedures were in place to safeguard people from abuse. Staff received safeguarding training and had access to the provider's safeguarding policy. This provided guidance to staff on 'recognising the signs' of abuse and steps that should be taken to report it. There had not been any safeguarding incidents since our last inspection, but the registered manager was able to describe how these would be investigated under the provider's policy. Staff told us they would not hesitate to report any concerns they had. One member of staff said, "I'd be confident to report any concerns I had."

The registered manager and provider monitored staffing levels to ensure they were sufficient to keep people safe. Staffing levels were usually two support workers during the day and one support worker sleeping over at the service at night. Most people at the service were out during the day, at jobs, placements or community centres, and had been assessed as having low levels of dependency on staff. The registered manager said, "It's how we've always done staffing, with no problems. If we need to we just jiggle it around. There is hardly any turnover of staff." They went on to say that if people's levels of dependency increased staffing levels would also increase.

People and staff told us there were enough staff at the service. One person told us, "There are enough to help me." A member of staff we spoke with said, "We have enough staff." Another member of staff told us, "I'd say we have enough staff."

The provider's recruitment processes reduced the risk of unsuitable staff being employed. Applicants for

jobs were required to complete application forms setting out their employment history, provide written references and proof of identification. They also had to undertake a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people working with children and adults.

Good

Our findings

Staff received a wide range of mandatory training in order to support people effectively. Mandatory training is the training and updates the registered provider deems necessary to support people safely. Training was provided in areas including medicine administration, food safety, fire safety, health and safety, nutrition awareness, first aid and safeguarding. As people's support needs had developed or changed the provider had arranged related training to ensure staff had the relevant skills to meet people's needs. This included training in diabetes and dementia awareness. The registered manager monitored and planned training on a chart, and this showed that training was up-to-date. Training was regularly refreshed to ensure it reflected current best practice. The registered manager subscribed healthcare magazines for updates on latest national guidance and practice, and shared these with staff at the service.

Newly recruited staff were required to complete induction training before they could work with people unsupervised. This included an introduction to the provider's policies and procedures and completing an induction checklist to confirm they understood them, meeting people and working alongside more experienced members of staff. One member of staff we spoke with said they had felt supported through their induction process.

Staff spoke positively about the provider's training programme. One member of staff said, "We get so much training, which I think is a good thing." Another member of staff said, "I definitely get all of the training I want. We're always doing it."

Staff received regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff received four supervisions a year and an annual appraisal. Records of these meetings showed they were used to discuss any particular support needs the member of staff had, as well as areas of practice such as safeguarding and medicine management. One member of staff told us, "I am supported with supervisions and appraisals."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection two people were subject to DoLS authorisations. These were clearly recorded and monitored to ensure the registered manager applied for reauthorisations in good time should this be necessary. Where people were supported to make decisions or manage their affairs by Lasting Powers of Attorney or Deputies this was clearly recorded in their care records. Where possible people had consented to their care and had signed care plans to show this.

Even where people lacked capacity to make all decisions for themselves they were still encouraged to make as many choices as possible. For example, one person's care plan stated, 'I can make small decisions for myself but need staff support for more complex decisions.' During the inspection we saw the person making numerous choices with the encouragement and support of staff, for example, of the activity they wanted to do and what they wanted to eat. Staff we spoke with understood the importance of giving people as much control over their lives as possible.

People were supported to maintain a healthy diet and to take control of their own food and drink. People's dietary support needs and preferences were assessed before they started using the service and recorded in their care records. For example, one person's plan recorded that they were able to eat and drink on their own but may need help cutting tougher foods. People made their own meals, with the support of staff, and had a weekly meeting to create a menu for the following seven days. Throughout the inspection we saw people accessing the kitchen to make their own meals, drink and snacks. During lunchtime people told us about their favourite meals and how they liked to eat them at the service, including takeaway meals.

People were supported to access external professionals to monitor and promote their health. People's care plans contained records of visits to and from GPs, dentists, opticians and other professionals involved in their care. We heard staff talking with one person about their glasses, and asking if they could still see through them or would they like their eyes to be tested. This meant people had access to healthcare professionals when needed.

The premises had been adapted to make them suitable for the people living there. Handrails were in place for people to use when using the stairs and doors in communal areas were easy to push open so people could use them with mobility equipment. There were two communal lounges, which meant there was space for people to spend time out of their rooms and socialising with other people at the service. People's bedrooms were customised by them and reflected their hobbies and interests. One person we spoke with said, "They let you pick the wallpaper you would like. They won't say 'you have to have this or that.'"

Good

Our findings

People spoke positively about staff at the service, describing them as kind and caring. One person we spoke with said, "I like it here. The staff are good." Another person told us, "It's good. I like living here" and "The staff here are good." People were proud of where they lived, encouraged us to look around and showed us their rooms.

People were treated with dignity and respect. One person we spoke with said, "Staff listen to me." Staff knew people very well and had friendly but professional relationships with them. There was lots of laughter and joking in interactions between people and staff, but staff were always polite and courteous. Staff were able to anticipate when people might need support, and when they did so they asked people discreetly if they would like some help. Staff respected people's privacy and how they chose to spend their time, for example, if people wanted to do things on their own in communal lounges or in their rooms.

Most people using the service had few support needs, and staff encouraged them to be as independent as possible while always being available to provide assistance where needed. People were in charge of their own time and structured their day according to their own lifestyle and interests. Most people were out at jobs, placements or activities or were getting ready to go out when we arrived to begin our inspection. As people arrived home towards the end of the day they told us about the various things they had been up to. For example, one person had been at work and another person had been attending a forum for people with learning disabilities. One person got dressed for bed early as they wanted to be more comfortable. People clearly viewed the service as their own home, and treated it as such. One person we spoke with said, "They help us do things what we get stuck with." Another person told us, "It's a nice place to live, and you get loads of help."

Throughout the inspection we saw numerous examples of staff delivering kind and caring support. In one example we saw a member of staff asking a person if they would like help with shaving, which they said might help the person feel a bit better. The person smiled and nodded. In another example we saw a person joking with staff about how they would like a bag of crisps from elsewhere in the building, and how quickly staff should be able to run and collect them. Later in the day we saw a person and member of staff watching a programme about antiques on TV. The date an object was made was mentioned, to which the person responded that they had not been born then. The member of staff told the person they had been born for several years by then, which caused the person to agree and start laughing.

At the time of our inspection nobody was using an advocate and people were able to express their own

views and preferences. Advocates help to ensure that people's views and preferences are heard. The registered manager was able to describe how advocacy services would be arranged should they be needed.

Good

Our findings

People told us staff provided them with the support they needed and wanted. One person said, "Last month I couldn't walk, couldn't get out of bed. They came in my room, made me a cup of tea, anything I wanted they made it for me". Another person told us, ""They help us do loads of stuff."

Before people started using the service assessments of the support people needed were carried out, covering personal care, eating and drinking, mobility and communication. As well as people's physical needs these assessments also covered people's religious, cultural and spiritual needs and how they could be supported to maintain relationships. Where a support need was identified during the assessment a care plan was drawn up based on the person's preferences for their care. For example, one person's communication care plan detailed how the person could be supported to communicate effectively with staff and other people at the service. This emphasised how the person should be involved in decisions about their care as much as possible even though they could not always communicate verbally. Another person's care plan contained detail of how their learning disability could make them anxious and how staff could support and reassure them. Care plans were regularly reviewed to ensure they reflected people's current support needs and preferences.

Care plans also contained information about people's life history, interests, likes and dislikes and families. This helped staff who had not worked with the person before to get to know them as individuals and see beyond their support needs. Staff we spoke with were very knowledgeable about people living at the service, and could describe them and their support needs in detail.

Handovers were used to pass the latest information on to staff at the start of their shift. During our inspection we saw staff who had just started their shift talking with other staff about what people had been up to that day and any changes in their needs. This meant staff had the latest information on the help people wanted and needed.

The provider made policies, procedures and other documents available to people in an easy read format should they request this so they had access to as much information as possible.

People at the service were supported to access a wide range of activities and interests in the local community. This included volunteering at local services, attending groups associated with their hobbies such as a knitting group or spending time using local amenities. When at home people were able to choose how they spent their time, and during the inspection we saw some people watching a film on TV and others

playing games on their computer. There were photographs in one of the lounges of a holiday people and staff had taken to Blackpool, which one person told us everyone had enjoyed. One person we spoke with said, "It's good (the service) for going on days out." Another person said, "They just ask what we want to do."

The provider had a complaints policy in place, setting out how people could raise issues and explaining how they would be investigated. People told us they were aware of the complaint's process and would be confident to raise any issues they had. One person told us, "I don't have any complaints. I would say if I did." There had not been any complaints since our last inspection but the registered manager was able to explain how any issues raised would be investigated using the provider's policy.

At the time of our inspection no one at the service was receiving end of life care. Staff received end of life care training, and policies and procedures were in place to support this should it be needed.

Good

Our findings

Staff spoke positively about the culture and values of the service. One member of staff said, "I love it here. I love getting to know the people." Another member of staff said, "I would definitely recommend it." Staff said they felt supported in their roles and enjoyed and were proud to work at The Bridgings (Eston).

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager was a visible presence around the service, and carried out support work in addition to their management role. They had been at the service since it first opened and knew the people and staff well. The registered manager was knowledgeable about people's support needs and we saw they had friendly but professional relationships with people using the service. People spoke positively about the registered manager. One person told us, "[The registered manager] is as soft as a brush." Another person said, "[The registered manager] is good, nice."

The registered manager told us about links they, people and staff had forged with the local community. This included with the local library, a nearby theatre company, community centres and charity shops. Throughout the inspection we saw people coming and going from the service to attend groups and services they were interested in. The registered manager attended provider meetings hosted by the local authority in order to share ideas on latest best practice.

The registered manager and provider carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. These included checks of the environment, medicines, fire safety, accidents, care plans and training. Where these identified issues records confirmed that remedial action was taken. For example, a May 2017 medicine audit identified that a member of staff had not completed paperwork in relation to one person's medicines. A supervision was held with the member of staff to discuss their practice and reduce the chances of a similar mistake in future.

Feedback was sought from people, relatives and external professionals using an annual questionnaire. The questionnaire was available in an easy read format for people using the service to help as many people as possible take part. This had last been completed in 2017, and the results contained positive feedback. For example, one external professional had responded that they had no suggested improvements as, 'the quality of care and relationship staff have with my client is excellent and there is nothing they could do to

improve on any part of my client's care.' One person had responded, 'They promote independence as much as they can so I can live independently' and 'They really look after me well.'

Regular meetings were also held for people using the service and staff to obtain any feedback they had and to discuss ideas for improving the service. For example, at one meeting for people using the service there was a discussion about a washing up schedule to help ensure the kitchen area was tidy and everyone did their fair share. A staff meeting had been used to discuss Christmas gifts people might like and how they could be included in decorating the service.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.