Akari Care Limited

Bridge View

Inspection report

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Date of inspection visit:
17 August 2017
23 August 2017

Date of publication:
26 October 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Two adult social care inspectors carried out an unannounced inspection in the early hours of the morning on 17 August 2017. We returned for second day, unannounced on 23 August 2017. The inspection was in response to an alleged incident which took place at the service, the Commission made a decision under its own Handling Serious Incident Guidance, that it was necessary for it to attend the service and make inquiry into the incidents, as well as to assess the risk and compliance to people using the services.

The last inspection took place overnight on 16 May 2017 and we completed the inspection on 19 May 2017 which was announced. We found the service was breaching regulations, 13, 14 and 17, which related to safeguarding people, ensuring people received adequate nutrition and ensuring systems were in place to monitor the performance of the service. We rated the service as requires improvement in four key questions; is the service Safe? Effective? Responsive? and Caring? We rated the service as inadequate in one key question; is the service Well-led? The service had an overall rating of requires improvement.

We issued a warning notice in respect of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated activities) regulations 2014. We required the provider to take action and become compliant with this regulation by 25 July 2017. We served requirement notices for the other two regulations.

Since our last inspection the provider had sent us action plans and declared that all previous concerns had been addressed. We also made the decision to return to the service earlier than anticipated due to a number of anonymous concerns we had received and to check they were now meeting the regulations.

At a previous inspection in December 2016 we found the provider was breaching regulations 12, 17 and 18 in relation to safe care and treatment, staffing and good governance. We rated the service as requires improvement in four key questions; is the service Safe? Effective? Responsive? and Caring? The service had an overall rating of requires improvement. At March 2016 inspection we found the provider was breaching regulations 12 in relation to safe care and treatment. We rated the service as requires improvement in one key question; is the service Safe? At our first inspection, using this approach, in April 2015 we rated the service as requires improvement in three key questions and gave an overall rating of requires improvement.

Bridge View is spread over three floors, the ground and first floor providing nursing and residential care for up to 61 people, some of whom are living with dementia. At the time of our inspection there were 50 people living at the service.

The service has not had a registered manager in post since 26 June 2017. 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.

As at the last inspection we found that staff knew how to report safeguarding concerns. However, we found

that safeguarding systems and processes were not effectively followed. Where safeguarding, complaints and staff disciplinary investigations had been undertaken, not all were robust enough to protect people fully.

There was a high use of agency staff and despite undertakings by the provider to ensure agency staff always worked with a permanent member of staff this was not occurring. On 17 August 2017 there were one permanently employed nurse, senior carer and staff member on duty with one agency nurse and four agency care staff. Two of the agency care staff had never worked at the service previously and because of numbers of available permanent staff worked together. No manager, deputy manager or regional manager were overseeing the service.

On 23 August 2017 we found that no manager or deputy manager was overseeing the service. A clinical lead had taken up post three days earlier and was completing their induction but due to staff shortages was working as the second nurse. They had not completed training around the use of the electronic medication system (WellPad) so could not administer medicines. The bank nurse was in charge of running the service that day although they told us that a regional manager was available to call if they had problems.

The procedures in place to ensure any agency staff deployed were suitable to work within the service were not robust. No monitoring checks were completed by the provider to check that agency nurses remained registered with the Nursing Midwifery Council or to see that people had the right to work in the United Kingdom and had completed appropriate training. We found that four agency staff were overseas students so entitled to work 20 hours per week but some were on the rota for 40 hours in a week and no checks were made to see what other work commitments they had each week.

The provider had systems in place to monitor the quality of the service provided and improvements had been made, but staff had not always followed procedures in line with the action plans they had sent us. On each visit but staff could provide us with ones completed in recent months. Following our last visit we asked to see the latest audits and on 29 September 2017 we were sent a range of action plans and several audits, such infection control and medication audits for the service that were completed in July 2017. All showed that issues were found at the service but the home development plan the provider sent to us in September 2017 indicated the majority were expected to be resolved. The home development action plan however did not pick up on issues we found, for example, that there was a lack of information about of incident and complaint investigations.

We were aware the provider had installed a computer system, which staff needed to use for recording their review of the service but staff could not show us any information held on this system. They were unclear if any action had been taken to record information on this system. We asked for the recent investigation and associated action plans plus information on how the provider was overseeing the management of staffing levels. None was provided. We considered quality assurance systems were not robust as they had not found the issues we had during the inspection.

We found four breaches in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and these related to safeguarding service users from abuse and improper treatment, good governance, staffing and recruitment.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Steps had not been taken to protect people from the risk of abuse.

There insufficient skilled and experience staff deployed across the service.

Appropriate checks were not completed for agency staff.

Is the service well-led?

Inadequate

The service was not always well led.

There was no registered manager working at the service.

There appeared to be a culture within the service which was not conducive to a positive staff team.

The provider had a quality assurance programme in place but staff had not always completed them or maintained the actions they should have followed.

The provider was not always submitting the required notifications.

Bridge View

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.

Two adult social care inspectors carried out an unannounced inspection in the early hours of the morning on 17 August 2017 and during the day on 23 August 2017.

A Provider Information Return (PIR) was submitted in March 2015 but this has not been refreshed. A PIR 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 reviewed information we held about the service, including all of the concerns we had received over the period of time since the last inspection. We contacted the local authority contracts and safeguarding teams. We checked the notifications we had received, including those for serious injuries, deaths and safeguarding incidents. Notifications are reports about incidents or events which the provider is legally obliged to send the Commission.

During this inspection we carried out a short observation using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who used the service. We also spoke with the clinical lead, three nurses, a bank nurse, an agency nurse, two senior care staff, four care staff, four agency care staff and the administrator. We observed how staff interacted with people and looked at a range of records which included the care and medicine records for six people. We checked the personnel files for the agency staff and viewed a range of documents related to the management of the home.

Inadequate

Is the service safe?

Our findings

At the last inspection we found a breach of regulation 13 in relation to concerns around how safeguarding matters and concerns were addressed. The manager had carried out a number of investigations into staffing issues during the previous five months. One concerned an allegation a staff member had acted inappropriately with other staff and had spoken to person who used the service in a way which represented a safeguarding concern. The manager told us these concerns had been investigated. However when we viewed records we found they were incomplete. Staff statements were missing, and interview notes were insufficient to provide assurances that the concerns had been fully investigated. The concerns had not been reported to the local authority safeguarding team. The steps taken to protect people whilst the investigation was underway had ceased and the staff member had been cleared to return to work, however the manager was unable to explain how this decision had been made as they were unable to locate records of the allegations or the response from the staff member. We passed over our concerns to the local authority safeguarding team and commissioners for the service.

Following our inspection, the provider sent us regular action plans of how they were addressing these concerns.

Prior to this inspection on 6 August 2017 we were made aware that a person using the service made an allegation that two agency staff members had behaved towards them in an inappropriate manner. The staffing level on night shift, at the time had been one nurse and four care staff (two of which were agency). A nurse on duty had told the permanent staff that they needed to pair up with agency staff members throughout the shift. During the night the person had raised concerns. It was found that the direction given by the nurse had not been followed and the agency staff were working together. The police investigated the allegation and it was expected that the provider would investigate the staff disregard for directions and why they were working together. The provider had stated that one of the actions they would take forward was to ensure that, at all times, agency staff worked with permanent members of staff.

When we visited on 17 and 23 August 2017 none of the staff could provide any evidence to suggest an investigation had taken place. Following the inspection we requested that the regional manager supplied this information but to date this has not been received.

We found that of the eight staff members on duty there was an agency nurse and four agency care staff. On the top floor all bar one staff member was from an agency, which meant the provider was not adhering to their own undertaking.

On 17 and 23 August 2017 when we were looking for information to show an investigation had occurred we found recent complaint letters from a GP and a relative relating to an allegation, which had been reported to the police. We found a partial report called 'safeguarding meeting outcome' in the complaints folder that contained some information about the incident. This suggested the incident occurred early July 2017 but made no reference to police involvement, however as a further action it was stated 'Need to interview all staff to see if they saw/heard anything.'

We have been unable to find out any more information about these two events as no one at the service could detail what had happened or provide investigation reports.

We found that practice overnight was to go into each person's room every two hours to check if they needed assistance to address any continence needs. Only two people in the service had been deemed able to make a decision around this issue and requested not to be disturbed. Rather than completing a visual observation people were routinely woken up every two hours so staff could check they did not need continence aides changed. This type of practice causes sleep deprivation and is not conducive to supporting people maintain their well-being. We found that staff did not recognise this type of practice could be considered as institutional abuse.

This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated activities) regulations.

On 17 August 2017 we started the inspection at 3am and found that of the eight staff on shift five were agency. The staff were deployed via a permanent nurse and senior downstairs with an agency care worker. Upstairs there was an agency nurse, a permanent carer and three agency care staff (two of whom had never worked at the service.) This meant not all of agency staff could not be assigned to work with permanent members of staff, which meant people would not receive consistency of care. We found that the manager and deputy manager had ceased to work at the service. An interim manager had been employed but they were on holiday as was the regional manager. Staff did not know, which senior manager was on call and only when the administrator came on duty at 7.30am could we identify who was providing cover. This was a manager from another service and they had only been to the service once before. Unfortunately they could not assist us locate any of the information we requested because they were unfamiliar with the service.

On 23 August 2017 when we visited the bank nurse was in charge and no manager was on site. The clinical lead was working their third day at the service as the nurse overseeing the upstairs unit. They had not completed the Wellpad training so could not administer medication so the bank nurse was doing this and reported difficulty in ensuring there were sufficient gaps between medicine rounds as they had only been able to finish the lunch medicines at 3pm. The bank nurse had pointed out to the administrator that the clinical lead was working all week as the second nurse so this issue would persist and the clinical lead was supposed to be supernumerary during this induction period. The administrator told us they had contacted the area manager who had authorised the use of agency nurses for this week and next to ensure the medication could be administered safely and in line with the prescription.

On both days we visited we found that the rotas did not include the agency staff who were due to be on shift and this information was on a different sheet. We found that neither document was accurate as different staff were on duty to those on the rota, different agency staff were on duty to those expected and an additional agency care worker was on duty to what the sheet suggested.

Staff reported that this pattern of deployment had been occurring on a regular basis.

The profiles for Standby Healthcare agency indicated the staff had completed all of their mandatory and condition specific training in one day. One of the agency staff had undertaken 14 training courses in one day whilst another member of staff had undertaken 22 courses on one day. We found that no one from the service nor the provider had considered this to be a concern or checked the accuracy of the information.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated activities) regulations.

The staff did not have profiles for all of the agency staff so could not be sure people had the necessary skills to work at the service or had been vetted appropriately. All agency care staff on duty on 17 August 2017 were overseas students and the profiles available suggested they had right to work in the UK. We checked with immigration services and the student visa allows people to work up to 20 hours per week. We found the staff at the home were unaware of this and had engaged these care staff to work at the home for 40 hours per week.

We found the service used agency staff and relied on the agency to tell the manager if a nurse was registered with the Nursing and Midwifery Council (NMC). We found the information supplied by the agency for one nurse said their NMC registration ended in March 2017 but no one from the service had noticed. Staff told us the nurse had recently worked in the service. We asked them to check NMC online records and found the nurse had renewed their registration.

We found that no one checked the rota to confirm which agency staff were due or checked the identity of the agency staff when they came on shift.

This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated activities) regulations.

Staff we spoke with recognised that staffing numbers had depleted. One staff member told us new staff had been recruited and a new clinical lead had commenced employment. We saw they had begun with an induction to the service.

We checked the first aid kit in the clinic and found a number of items which were out of date. We discussed this with the nurse on duty who immediately disposed of the items and ordered replacements items.

Records of the administration of people's medicines were stored electronically. Staff used a hand-held electronic device to monitor all aspects of people's medicines including ordering, administration and disposal. The device showed when people next needed their medicines. The staff on duty were familiar with people's needs and their medicine routines. We found the clinic area of the home to be clean and tidy. Fridge temperatures were taken every day which ensured medicines which were to be stored below room temperature were stored in a safe manner.

We found that following our previous inspection action had been taken to ensure code to the front door was not on display outside of the building. This had previously been the case and meant visitors could gain access to the service without staff attending.

People's records confirmed that consideration had been given to the daily risks which people faced and appropriate risk assessments were put in place. For example, the service had in place a list of people's required fluid intake for each day. One member of staff told us they used the fluid intake chart as a guide and following our last inspection had taken action to ensure they correctly calculated how much fluid each person needed each day.

Handover sheets with pertinent information about each person were used to pass on information between shifts. Nursing staff from each floor gave the information to the new shift coming on duty.

People, and their relatives confirmed, that they felt safe living at the service. Comments included, "I have no concerns and find the staff helpful" and "The staff on the whole are very nice and kind." One person said, "I am well looked after." They told us they were an early riser and staff offered them breakfast each morning.

We observed one member of staff offering the person tea and toast.

During our night time visit we heard one person shouting for help. Staff explained during the night the person needed someone to pop into their room and provide reassurance. We found the person quickly settled.

Inadequate

Is the service well-led?

Our findings

Since our inspection in April 2015 we have found that action needed to be taken to ensure the service was well-led. At the December 2016 inspection we found a continuing breach of regulation 17, good governance and ensuring the audits in place were effective. Following our inspection, the provider sent us action plans detailing how they would address these concerns and gave assurances that they would be compliant with this regulation.

At the last inspection in May 2017 we reviewed audits and checks that the provider and the registered manager completed, for example medicines, care plans, incidents, infection control, the kitchen area and health and safety. Actions plans had been created to address any shortcomings found with dates for completion. We noted improvements had been made, however, from the action plan which had been sent to us, checks were not always being completed as described which may have led to some of the shortfalls we found during the inspection.

We issued a warning requiring the provider to be compliant with regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulation by 25 July 2017.

At this inspection we found a continuing breach of Regulation 17 in relation to good governance and the provider had not met the requirements of the warning notice.

Audit files were stored in the manager's office; however we found the audits were out of date. The last kitchen audit we found on file was dated 6 April 2016, care plan audit was dated 10 March 2017 and the infection control audit was carried out on 3 January 2016. Following our inspection the provider supplied an infection control audits dated 27 January 2017 and further infection control audits for February, April and May 2017. These three audits reported 100% compliance with infection control procedures. The provider also supplied a 'food allergy catering' audit date 6 April 2017, which reported 100% compliance with requirements.

We were aware that a new computerised system [Care Block] had been put in place but neither the visiting manager nor administrator could confirm that this was being used. The manager who was visiting the service at the time of the inspection had only been to the service once before and that was earlier in the week. They were unable to find any further audits. Following the inspection we requested copies of any audits the service had completed. On 29 September 2017 we were sent a range of action plans and apart from the infection control and 'food allergy catering' audits we were sent a medication audit, which was completed in July and showed 45% compliance with requirements. The action plans we received showed that issues were found at the service but the home development plan submitted in October 2017 indicated the majority were expected to be resolved. We could not establish how the concerns had been identified as did not receive corresponding audits highlighting these gaps and other than the medication audit the ones we received showed 100% compliance with requirements.

We found that the home development action plan however did not pick up on issues we found, for example,

that there was a lack of information about of incident and complaint investigations.

We found the provider did not have enough permanent staff employed to cover the service, and was heavily reliant on agency staff. However, they had not put measures in place to ensure agency staff were appropriately vetted. Also no checks were in place to ensure the agency staff that arrived at the service were the ones expected. Nor had measures been put in place to ensure that if a particular agency staff member was no longer to be used from one agency they were not working for another. No action had been taken to ensure that agency staff who were overseas students did not exceed the number of hours they were permitted to work each week or that nurses NMC pin were regularly checked to make sure the agency nurse remained registered and able to work.

Again concerns were found in the way in which investigations had been carried out and information reported to others. Despite asking at every visit and after the inspection for investigation reports relating to any complaints, safeguarding allegations and incidents these were not made available. The information we did see on site was incomplete and did not detail any actions staff had taken to reduce the risk of events re-occurring. The provider had not adhered to their own undertaking to ensure agency staff always worked with a permanent member of staff so people remained at risk of receiving inappropriate care and treatment.

We found systems and processes in the home were not used effectively to monitor the quality of the service.

During the inspection we confirmed that the provider had not sent us all notifications which they are required to do under their registration. We will be looking at this issue outside of the inspection process.
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These issues had either not been found or not been addressed through quality assurance checks completed.

At the time of our inspection there was no registered manager in post. The deputy manager had left the service, although staff told us they were not sure if they had left in the handover meeting. We were told by a manager visiting from another service the regional manager was on holiday. The visiting manager was in the home to check with staff before going on holiday. We found there was no consistent management oversight and accountability in the home.

We spoke with both night and day staff and found that there was a distinct divide between these two teams and from what we heard it appeared that staff worked at odds with each other. Staff values, their motivation, and their personal goals are essential to creating a positive and successful working environment. We felt the staff culture had been damaged due to the underlying atmosphere within the staffing team which had been brought about by a range of issues, including the continuing anonymous concerns we received about staff and care practices. One staff member commented, "I worked in lots of nursing homes and can honestly say this has the poorest working relationship between night and day staff. There is a very evident 'us and them' approach, which really does not help staff give their best." Another staff member told us, "There doesn't seem to be a culture of working together here and it is as if day staff are always looking to find fault. I find this very stressful." Another staff member said, "We do our best to get on with the night staff but they always say we are not being helpful. I don't know what more we could do."