Akari Care Limited

Bridge View

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

This comprehensive inspection took place on 20 December 2016 and was unannounced. Due to receiving concerns after the inspection we made a further visit on 30 December 2016.

At our last inspection in March 2016, we found that the provider had not fully met the regulations and was in breach of Regulation 12, which was in connection with the cleanliness of the kitchen area. At this inspection, we found that improvements had been made.

Bridge View provides accommodation with nursing and personal care for up to 61 adults, including older people with physical and mental health difficulties and those living with dementia. At the time of our inspection there were 56 people living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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 not present on the first day of inspection due to annual leave.

Complaints were now dealt with thoroughly by the registered manager; however we had found that one particular complaint had not been managed well by the provider organisation.

Record keeping within the service was in need of improvement. People who required their food or fluid intake monitored did not have this done in a way which meant staff could be assured that people had received correct levels of nutrition and hydration.

We found that people who were cared for in bed and needed support to move positions, due to their mobility, had not had this information fully recorded in their records. This meant staff could not be certain when the person was last moved or in which position they were previously in.

We found people's drink thickeners where stored in unlocked cabinets within one of the dining room areas. As there is a risk of harm associated with these we asked a staff member to remove these straight away. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties.

The provider had recruitment and induction processes in place although we found the registered manager had not always ensured these processes were followed either before staff began work or once they had started their employment.

Quality monitoring systems were in place at the service and they had helped the registered manager identify areas which needed to be developed. However, they had not been effective enough to identify the concerns

we had found in connection with record keeping for example.

After our inspection we wrote to the provider and asked them to send us an action plan as to how they intended to address our concerns, which they responded to immediately.

We found the service to be clean and tidy, particularly the kitchen area, which was unclean at our last inspection.

People were protected by staff who were aware of their safeguarding responsibilities. Staff had received safeguarding training and policies and procedures were in place detailing the process staff would follow to report any concerns they had. Since our last inspection, two safeguarding concerns had been upheld and one partially.

We received mixed views from people, their relatives and staff about whether they thought there was enough staff working at the service. They told us that at times it was busy. We were also told that call bells took a little longer to answer.

We observed staff carrying out their duties in a timely manner, other than early morning when staff were busy getting people up and ready for breakfast.

The home had implemented an electronic medicines management system since our last inspection. We found that people overall had received their medicines as prescribed as the registered manager monitored medicines closely to ensure they were in stock. However, we found that a small number of people did not have their medicines in stock on the day of the inspection and the regional manager was going to follow this up.

Risks in connection with people had been identified, including those in relation to care and support and the environment in which they lived. However, we found that some risk assessments, including those for bed rails and medicines, had not always been completed accurately or put in place.

Staff had received adequate training and had the knowledge and skills they required to do their job effectively.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. We found the provider was complying with their legal requirements.

People's nutritional needs were assessed and monitored. People were supported with any special dietary requirements, however, we received mixed views on the standard of the food provided.

People were able to see healthcare professionals outside of the home environment if they needed to. People told us that staff were effective in ensuring GP's were called and they received support with hospital appointments.

We saw people being offered support if it was required and care staff did this in a way which retained the dignity of the people they were caring for. Care staff were seen to be kind and considerate. People told us

they had choice and we saw people choosing what meals and drinks they would like.

People and their relatives felt that the staff at the service kept them up to date with information and enabled them to be involved with planning and review of their care needs.

A range of activities were on offer at the service and social isolation was addressed through the individual sessions held with people and via various events held within the service and at outside venues.

The provider continued to ask people and their relatives to complete surveys and attend meetings in order to gain their views on the service and to support them to ensure they delivered a quality service.

People and their relatives were complimentary about the registered manager and felt they could speak with her at any time.

The provider had recently made changes to the senior management team. There were new directors in post and there had been a reorganisation of head office teams dealing with, for example, the quality and governance of the organisation and human resource matters. This meant the provider would no longer use an external healthcare management support company to run the business.

New policies and procedures were being finalised and the provider was planning on rolling these out in the near future. This would provide managers and staff with current guidance in line with recognised best practice.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment, staffing and good governance.

We have also made three recommendations in relation to food and drink and call bell procedures.

You can see what action we told the provider to take at the back of the full version of this report.

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 always safe.

Risk assessments were not always completed fully or in place.

Drink thickeners had been left unsecured in open cabinets and posed a safety risk. A small number of people did not have their medicines in stock to take as prescribed, although the regional manager looked into this issue immediately.

Safe recruitment processes were not always followed.

People had mixed views on staffing levels and call bell procedures.

People felt safe and staff understood their responsibilities with regard to safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

New staff had not always received a full induction, although existing staff had received adequate training.

People's nutritional and hydration needs were assessed but monitoring was not always in place. There were also mixed views on the standard of food and refreshments provided.

The registered manager and staff were aware of the Mental Capacity Act (MCA) 2005 and of the Deprivation of Liberty Safeguards and had applied good practice.

Is the service caring?

Good

The service was caring.

People and their relatives felt staff were caring. We saw people being treated as individuals with respect and dignity.

People and their relatives felt involved in the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff at the service had not maintained people's records or kept them secure.

There was a complaints procedure in place and complaints were dealt with in line with company procedures, although there had been a concern raised that was not dealt with well by the provider.

People and their relatives felt involved regarding people's care needs and said they had choice in their day to day lives.

There was a programme of activities for people to participate in if they wished.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems in place had not identified the concerns we had found during the inspection.

The registered manager was described as being approachable and supportive.

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.

This comprehensive unannounced inspection took place on 20 December. It was followed up with a further visit on 30 December 2016, after we had received a number of concerns via CQC's 'share your experience' web form. We also reviewed all the information held by the provider in relation to one particular complaint from a family whose concern had been investigated by the local authority safeguarding team and had been upheld.

The inspection was conducted by four inspectors, a specialist advisor and an expert by experience. A specialist advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected. This particular specialist advisor had a nurse background and expertise in tissue viability (skin care). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection process we looked at the information that we hold about the service, prior to the visit. This included notifications which the provider is legally obliged to send the Commission. Notifications are information sent to the Commission in relation to any deaths, safeguarding concerns, or incidents and accidents for example.

Prior to the inspection the provider was not asked to complete a Provider Information Return (PIR) on this occasion due to late scheduling of the inspection. 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.

Before the inspection we spoke with the local authority safeguarding and contract commissioning teams at an information sharing meeting and gained their views about the service. We later received an update from the same local authority teams after a recent visit they had undertaken at the service. We contacted Healthwatch, the local 'infection prevention and control practitioner' for the area and also the 'food & health

worker & nursing home training coordinator'; all of whom cover this care home. These views supported the inspection process. During the inspection we spoke with a district nurse and a GP who were visiting the home.

During our inspection, we spoke with 19 people who lived at the service and eight relatives. We also spoke with the registered manager, regional manager, the deputy manager, two nurses, two senior carers, six care staff, an activity co-coordinator, a talk and listen support worker, the maintenance person, the temporary cook and an administrator. We also spoke with another registered manager from one of the providers other services, who was supporting the staff during the first day of inspection.

During the inspection we carried out observations around the service, which included the interactions between care staff and the people who lived there.

We reviewed the care records of 11 people, to see how their care was planned and monitored. We looked at how medicines were managed, including observations when medicines were administered. We looked at personnel records for three staff, which included recruitment, training and support information. We reviewed how the provider monitored the quality and management of the service, including medicine audits, health and safety checks, accidents and incident reporting and checked compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that the kitchen area was unclean, posed a risk to food hygiene and did not meet regulation 12. When we visited the kitchen area, we found that improvements had been made. All areas were found to be clean, including fridges and freezers, store rooms, cookers and general kitchen equipment. A new hood had been installed over the whole of the cooking area and we were told this was to protect the area and promote a better working environment for kitchen staff. One member of kitchen staff said, "We never want for anything.....if something is not right [in working order], the manager will replace it for us." This meant that people had their meals prepared in suitable kitchen facilities.

Risk assessments were in place to ensure that people were as safe as possible during their regular day to day activities. This included people being assessed for risk in connection with falls, being transferred or risk due to their weight or hydration levels. We found some risk assessments were either not in place or not fully completed or reviewed. For example, one person had no bed rail risk assessment in place and their moving and handling risk assessment was not fully completed, with missing height, weight and date of assessment. Another person had a risk assessment in place for choking; however, this did not match with the care plan in place as they were on a normal diet. Medicines risk assessments had been completed but the ones we saw had not been done correctly and staff had finalised the whole form when only the first section required completion. Although we found no impact on the people where records were not in place, this still meant that there was potential for harm because staff had not followed the provider's procedures and did not have full and accurate information in place.

Part of the inspection team consisted of a specialist whose core role was the provision of expert advice in the prevention and the treatment of wounds.

Staff were aware of the need to assess people to help prevent pressure ulcers. Pressure ulcers are skin injuries which can be caused by, for example, friction, humidity, temperature, continence, medication, shearing forces, age and unrelieved pressure. They were also aware of the need to trigger further intervention when a person's waterlow score was higher than normal. A waterlow score estimates the risk of a person developing pressure ulcers. One nurse told us that a nurse colleague oversees people's mattresses to ensure they are suitable as they have an interest in this area of care (pressure ulcers). One nurse explained that people who were at risk of developing this type of wound or who already had one; were turned by staff every few hours to support the healing process and prevent further damage. One person told us about a wound that staff had supported them with and said, "I had a nasty foot wound. I would not be alive today without the great care the staff gave me. They pushed the doctors in hospital to do something for me when they had already written me off."

However, we found one person who was at risk of developing pressure ulcers used a special mattress which needed the weight of the individual input to ensure it worked correctly. We found the incorrect weight had been input and when we advised nursing staff of this at 11.00, we confirmed after checking a number of times that this had not been updated until we finally asked them again at 4pm. This showed that no regular mattress checks were completed during the day by staff at the home to monitor the settings of specialist

mattresses.

In 2015 NHS England issued an alert which was disseminated to all care homes in the local area. It was made to make providers, managers and staff aware that a person had died in a care home following the accidental ingestion of the thickening powder that had been left within their reach. During the inspection we found containers of prescribed thickeners in an unlocked cupboard within the dining area of one part of the home where people who were living with dementia were accommodated. We watched one person opening cupboards within this area. We kept them under close observations and informed a member of care staff who removed the containers to a safe location. Although no person came to any harm, this meant that staff had not followed safe working practices to protect people as well as they should have.

These are a breach of Regulation 12 in relation to safe care and treatment.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

People and their relatives told us that medicines were administered to them safely and when they required them, although two people told us that sometimes they received them later than they should. We checked this on their medicines administration records and confirmed they had been administered in suitable timescales. One person said, "The girls [care staff] bring them to me when they are due. Not sure what I would do without them, because I would probably forget." One relative commented, "At her other care home she was very agitated and refused to take her medication, here she is taking them."

We observed two different staff members administering people their medicines. Medicines were administered with dignity and respect and people were spoken with throughout.

The registered manager had implemented an electronic medicines management system since our last inspection and we found staff had received training to support them in its use. We asked one nurse if there were any medicines which were out of stock. They gave us a list of a small number of people throughout the home and the items of medicines which they were short of. We asked if this was a regular occurrence and they told us it was not. We checked the registered manager's daily error reports, which list which medicines (if any) were not available. We saw that the registered manager monitored these very closely and had recorded the reason and the action they had taken on any particular day in which this had occurred. For example, one person's medicines had not been delivered by accident. These were available later in the day as a member of staff had been sent to collect a new prescription from the GP and then to collect the medicines from the pharmacist. The registered manager confirmed that they would look into this and find out what had occurred.

We checked the controlled drugs at the service and these were stored securely and were administered and recorded appropriately. Controlled drugs are prescribed medicines used to treat severe pain for example, and they are subject to stricter controls. Room temperatures were checked to ensure that medicines were stored at levels to maintain their effectiveness; and storage facilities for all medicines were secure. This meant that medicines were kept in suitable and safe storage facilities.

At the last inspection we found the provider had followed safe recruitment procedures, however at this inspection, we found areas for improvement. We had been told prior to the inspection that two staff had been started with a Disclosure and Barring Service (DBS) Adult First checks. Formerly known as 'ISA Adult First' and 'POVA Check', the DBS Adult First allows an individual to be checked against the DBS Adults' Barred List. Dependent on the result of the check, this service allows the individual to start work under

supervision while waiting for their full DBS check results. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

The registered manager said there had been a rise in numbers of people using the service so they needed staff to start as soon as possible but confirmed that staff were fully supervised where this was the case. We asked for a list of all staff with start dates and DBS status and there were six staff without full DBS working under supervision, including one nurse and five care staff. One member of new care staff that we spoke with confirmed that they were being fully supervised as they waited for the DBS full check to come back and showed an understanding of the reason for this. They explained, "I would not provide care to anyone on my own, I need to protect myself as well as the people we look after."

One new member of nursing staff had begun work without full pre-employment checks being completed, including checks on their competencies and training records and PIN. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN. We also found one staff member without references in place. However, when the registered manager returned from annual leave she sent us copies of verbal references received from their previous employers which were positive. The registered manager told us she had simply forgot to file them as they awaited the full written reference to arrive. The registered manager also admitted that she had forgotten to follow up the PIN number.

We received mixed views from people and their relatives as to whether they thought there was enough staff on duty and that call bells were answered in a timely manner. One relative positively commented that there was now less agency staff working at the service. They told us that at times it was very busy and sometimes had to wait longer to gain a response.

Comments from people and their relatives included, "I think they could do with some extra staff"; "I have never had any concerns with that [staffing]"; "Could do with more carers"; "The carers are really pushed sometimes. Sometimes I have to wait and wait for bed pans if I need the toilet. They need more staff it is not their fault"; "Staff are busy, particularly in the morning but I have never been left without being seen to for too long"; "They do well with the limited staff"; "There are not as many agency staff as there used to be"; "Sometimes you have to wait [when buzzer pressed], and other days they all come together"; "Not quick enough.. I had to wait a long time for water"; "Buzzer…. they don't always come very quickly or as soon as they used to, the care home is full now" and "The odd time when they buzz it takes ten minutes."

During the visit, we noticed that on occasions call bells were ringing for an extended period of time before being answered. We noted two people who had pulled their call bell for assistance and staff had immediately answered, although the bells carried on ringing as the staff had not deactivated them. When we first arrived at the service it was early morning and staff were busy assisting people to rise. A number of people were asking for support at the same time and although staff were extremely busy they addressed every person's needs.

The registered manager used a dependency tool to check on the levels of staff within the service to ensure they were maintained in order to meet the needs of the people who lived there. We observed that the numbers calculated were just within the limits identified by the tool. We spoke with the regional manager about the issues that had been raised and they told us they would review staff levels with the registered manager. The registered manager later contacted us to confirm that staffing levels were over the required amount but that they would keep this under close review.

We recommend that the provider review staff deployment to ensure all call bells are answered in a timely

manner.

People we spoke with considered the care provided and environment to be safe. One person said, "Yes [confirming they felt safe]." Another person described how they had lived at the home a number of years and said, "Yes, I feel safe living here dear, I have no reason not to. The staff are very kind and look after me very well." Relatives told us they thought their family members were safe and comments included, "Yes, there is always a nurse on duty and the girls [carer staff]. I have no complaint about them"; "Yes it's safe and they [person] get the care that they need" and "I go out of here with ease, when I go home I know she is alright."

Staff knew what procedures to follow if they suspected any type of abuse. Training records confirmed staff had received safeguarding training and there were policies and procedures in place related to safeguarding and whistleblowing to support staff. One care worker told us, "If I thought something funny was going on, I would report it, these people are like our family." When we asked people what they would do if they saw or experienced anything they thought was not right, they all told us they would tell a member of staff.

The registered manager kept a safeguarding alert log which recorded any alerts made to the local authority safeguarding team, either by the service or by others. Safeguarding alerts are made to the safeguarding team at the local authority in order to make them aware of alleged concerns within a service. It is then their decision to take matters further and investigate if they think that is required. We found where alerts had been made, details were stored and actions taken with lessons learnt noted. However, from one complaint which led to a safeguarding concern being upheld by the local authority safeguarding team, we found the service had not learnt lessons and similar issues were found during this inspection. This is described in other elements of the report, including the responsive and well led areas.

The registered manager and staff undertook regular checks within the service to ensure the environment was safe. Key codes were used to stop unauthorised entry or exit via main entrances. We observed reception and care staff telling visitors they were not allowed to give out the code. One member of staff told us that the codes were regularly changed. This meant that people were living in a home where staff took their security seriously to keep them safe.

We checked maintenance records at the last inspection and safety equipment, including people's personal evacuation plans and emergency contingency plans. We found that nothing had changed and they remained in good order.

We had no concerns with the cleanliness and hygiene standards of the service. Soap dispensers were filled and hand towels were available. Waste bins were clean and not overflowing and there were no unpleasant smells. People told us, "The staff keep the place clean and tidy"; "The cleaners come and clean every day" and "No problems with cleanliness." We did note that during lunchtime observations in the upper levels of the home, the dining area benches were messy and after lunch some of this 'clutter' remained.

Accidents and incidents were recorded and monitored. Analysis was completed for each person and both the manager and the provider monitored this information and reacted to any concerns. We noted one person had been referred to the falls team after they had fallen a number of times. This meant the provider protected people's safety and their exposure to further risk by robust monitoring of accidents and incidents.

Requires Improvement

Is the service effective?

Our findings

We found concerns with how some new staff were inducted into the service. Registered providers are expected to implement a robust induction programme called the 'Care Certificate' for new staff employed after 1st April 2015. Whilst the Care Certificate is not mandatory, providers should be able to demonstrate that staff are competent in 15 minimum standards such as duty of care, dignity, person-centred care and communication. The Care Certificate assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. Of the two new care staff who worked on the night shift, one had not completed any induction, the other had a company induction form initialled by the staff member and signed by the registered manager but not dated. A nurse had not undergone their full induction and had been working for ten days. The basic company induction record which included being shown fire exits and general procedures had not been completed. However, we observed staff taking them through part of this induction on the first day of the inspection. The registered manager said this was because she had been on annual leave. However, there were other staff in charge during this time. The registered manager is to address this.

This is a breach of regulation 18 in relation to staffing.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

Notices on walls within the service indicated that tea trolleys were available during the morning and afternoon. We saw no tea trolley was offered during the morning period of our inspection, although there were social activities taking place in the 'talk and listen' café on the ground floor. However, not everyone was able to attend the café as some people, for example, were nursed in bed. One person told us, "There is normally no tea at 11am, none today, none yesterday or the day before…….the excuse the staff give me is "we are short staffed."

We brought this to the attention of the regional manager who said trolleys should be available in the morning and in the afternoon. We found that the tea trolley was available in the afternoon. We noted that during lunch time people on the ground floor waited for their meal to be brought to them but no refreshments were offered until after the meal was served. This meant that staff missed opportunities to offer drinks to some people, which was particularly important for those at risk of dehydration or those who required additional fluids.

A number of people commented how breakfast drinks were not warm enough for them. Comments included, "The tea is always cold at breakfast"; "We are offered tea, coffee, water and juice. The drinks [coffee/tea] are not hot" and "The first cup of tea is at 9.30 and it is not hot." We checked this later in the day and at that time, the temperature was correct.

We recommend the provider review their procedures for providing suitable refreshments to people.

We found people's fluid charts were either not fully completed or not completed at all. Although we found no evidence to suggest people were suffering from dehydration. We checked one person's chart at 11.00am and saw it had been completed at 02.25am with 200mls of fluid as having been taken. We checked again at 14.20pm and no further entries had been made. We spoke with the person and asked them if they were thirsty, which they replied they weren't. In addition, they showed no physical signs of dehydration. There were no individual target fluid levels recorded on the forms which monitored how much fluid people had received. When we mentioned this to one nurse, they were aware that staff had not always completed records fully. This meant that even when there was a recorded intake, there was no system to ensure whether the person had reached the required levels of fluid or not. People were then placed at risk of dehydration because complete records were not maintained.

This is a breach of Regulation 17 in relation to good governance.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

People thought that the service was effective in providing them with care and support and their relatives thought the same. Comments included, "Everything they can do, they do well"; "Doing all they can under the circumstances [family member very unwell]"; "She is more settled, which makes us more settled."

People's needs and preferences were met by staff who were supported to carry out their role effectively. Staff told us they received training such as dementia awareness and equality and diversity which enabled them to be more aware of each person's individual needs. A member of staff we spoke with told us, "I feel really supported in my role. I have had lots of training including dementia awareness." Staff received a range of training which included what the provider classed as mandatory subjects, such as fire safety, food hygiene, moving and handling and first aid. One nurse told us that staff had received a range of training on wound care and we saw this on the training matrix.

Regular supervision and yearly appraisal of staff's work was undertaken by the management team and any concerns with staff performance were either discussed on an individual basis, or where the issues were uniform across the staff team, during staff meetings. Minutes of staff meetings were recorded and evidenced that staff were encouraged to contribute to the discussions.

We sat in on a morning shift handover in part of the home and observed how staff passed information from one staff shift to another. This meant staff coming on duty were fully updated with any issues before they started work. One healthcare professional that we spoke with told us they thought the staff team were good at passing on information to one another.

We asked people if they had consented before tasks were carried out and they responded with, "Yes, they always ask if it okay before they start a job" and "Oh yes dear, the girls [care staff] always check with me first."

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 is 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 and found they had been. There were 35 people where an application to the local authority had been made to deprive them of their liberties and two had been granted to date.

Staff demonstrated an understanding of the principles of mental capacity, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). A member of care staff said that staff had received training and we confirmed this via the providers training matrix.

One of the concerns that we had received after our first day of inspection was that people were being given fluids without thickener's when this was required as part of their care. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. We checked people's records and found that this was not the case. Staff were using thickeners appropriately.

Staff had received the providers training in food and nutrition and had also received further training from the CHANT team. The CHANT team is the Care Home and Nutrition Training provided by staff at Northumbria Healthcare NHS Foundation Trust. MUST was being recorded correctly with weights up to date. MUST is a five-step screening tool to identify adults, who were malnourished, at risk of malnutrition or who were obese. This meant that people who required additional nutrition had this written in their care plans and staff followed this guidance and when concerns were identified about a person's weight, this was monitored by senior staff at the service.

We observed the lunch time experience on both floors of the home. Menus on display indicted foods that were available to people, however we saw no menu for the day displayed and not all staff were aware of what meals were on offer. We were aware that menu boards were available; however these had not been used. One person could not remember what they had ordered and staff were not able to help them until the food arrived.

People's nutritional needs were met. We saw a variety of foods served to people during the inspection, including chicken curry and rice, sausage and a selection of vegetables, sandwiches, and a choice of desserts. We looked at a range of menus in the kitchen which had been devised by the provider and was on a rolling four weekly system. This meant that thought had been given to the type of food to be made available and we saw there was a variety of nutritious food which was to be made available. We checked the menu matched what was on offer on the day of the inspection and it did. We looked in freezers and fridges and found a range of fresh and frozen foods which matched what would have been required to cook the menus listed. However, one person told us they preferred brown bread and All bran but these weren't available. This had affected their physical health. We brought this to the attention of the registered manager who said they would look into it.

People had received support with their nutritional needs when special diets were required, for example, those who had diabetes or those on a pureed diet. Relatives told us that their family members had put weight on since they had lived at the service. One relative said, "She [person] is eating better now, she has enough to eat and drink and has put weight on since she has arrived here. Another relative confirmed that staff supported their family member with eating food and said, "The staff are around to give food" One person explained that staff had built them up physically, from not being fit for surgery, to being able to undergo a procedure. They said staff had saved their life. They were very grateful.

However, we had received mixed views about the food prepared and how it was served to people at the

home. Comments included, "Food is not hot"; "The meals could be better"; "We come here [dining room] at 12.30pm…. it sometimes doesn't come until 1pm"; "Yes we get enough food"; "The food is not always warm"; "We had crumble last week as well, I think they forgot to put the pears in"; "If you don't like what they [kitchen staff] bring, you can send it back…they do anything I say." One relative told us, "The food is not great, beef burger and hot dogs. There seems to be beans, beans and beans at tea time."

We recommend the provider review their daily menus with people and their relatives.

People were provided with information about their day to day health needs. All of the people we spoke with told us they had access to health care professionals, such as, opticians, dentists, GP's and podiatrists. They told us the service organised transport for hospital appointments. The deputy manager told us when people required an appointment externally, a member of staff would go with them to support and offer advice or guidance when it was needed or if a family member was unable to attend.

Bedroom doors had names, door numbers and photographs identifying individual people's rooms. Signage was in place on toilet and bathroom doors. Corridors were well lit with walls and banisters being of a contrasting colour to aid people who were living with dementia to move around the building safely. There were suitable sitting areas to support and provide comfort to people and we saw tactile items, including dolls, cushions and other items of interest for people who were living with dementia to use. The building was wheelchair accessible and people had the use of a small secure outdoor area.

Good

Is the service caring?

Our findings

People were complimentary about the staff team. Comments included, "I am really happy here"; "They work hard, all nice ladies [care staff]"; "They [care staff] are kind" and "All of the staff are kind and try their best to look after us all." Relative's comments included, "The carers are kind and caring"; "Everyone here seems to want to help and nothing seems to be too much for them"; "They [care staff] interact and give her anything she wants, they love her and talk to her on the same level"; "She gets on well with the staff"; "It's not bad, the staff treat me well" and "I feel like part of the family."

One person said, "I feel comfortable coming back here, when I have been out." Another person told us that when they had been feeling a little down; staff had all came into their room to try and lift their mood.

However, we were told by one person living in the home about an incident with one member staff. The member of staff had not showed a caring approach when the person had asked them for Horlicks one night. The person told us the staff member had said it was upstairs, but never offered to go and get any.

Relatives told us they felt welcome while visiting the home. We observed three relatives being offered refreshments and cakes as they sat and chatted to their family member. One relative commented, "Oh, you do get looked after here!" Another relative told us they had been made welcome to stay for Sunday lunch.

There was evidence in people's rooms that they had the opportunity to have individual personal effects around them, including pictures and some items of furniture. One person told us, "I have brought my armchair from home." A number of people commented they were supported by the maintenance person, for example to hang pictures. A relative told us "The handy man comes and checks everything." Another relative said, "The maintenance man is going to put photographs on her wall."

One relative told us that they could contact the home at any time of the day or night for information on the wellbeing of their family member. They said, "If I am worried I can ring the care home at any time to see how he is and get feedback. I have rung at 11.30pm and I could ring at 3am if I wanted to." Notice boards were placed throughout the building providing information including typed menus, activities, information on how to safeguard people, what services were available in the local area and the complaints procedure.

People told us that 'residents and relatives' meetings took place regularly, but most people had chosen not to attend. A number of people said they planned to go to the next meeting. Relatives told us they knew about meetings that had taken place and were aware of surveys. One relative said, "I know about the resident's and relatives meetings….not been to one yet. I have been asked to complete a questionnaire." Another relative said, "Not been to a relatives meeting yet, know about them and will go to the next one." We saw minutes of recorded meetings which showed that a range of items had been discussed, including the Christmas festivities, people's birthdays, complaints, cleanliness of the home and food. We noted that staff had encouraged people at the service to become chairperson of the meetings, but people had declined and preferred staff to continue with this role.

Staff told us that no one at the service was currently receiving support from an advocacy service because they used their family members or friends to support them. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

We observed staff respecting people's dignity and privacy by knocking on bedrooms doors and requesting access before entering. One member of care staff was overheard calling through one person's door, "Hello [person's name]…..are you decent? Can I come in? Its [staff name]." We then heard the person call back, "Come in dear."

A GP had been called to support someone with their end of life needs and to prescribe anticipatory medicines. Anticipatory medicines are medicines prescribed when a symptom or pain is expected. The GP told us they were happy that the person was very comfortable and with the forward planning by staff in anticipation and advance of the bank holiday weekend. End of life care was detailed with the necessary information recorded. During our inspection, one person sadly passed away. Staff handled the passing very well; immediately calling family and relevant healthcare professionals to arrange the final care with the person in a dignified and sensitive way.

Requires Improvement

Is the service responsive?

Our findings

Prior to the inspection, we had received information from one family about the level of care provided to their relative whilst they resided at Bridge View. We reviewed the information they sent to us as well as care records from the service and investigations and outcomes of strategy meetings held with the local authority safeguarding team and the CCG. The family were not satisfied with the complaints process and information provided.

At the inspection we thoroughly reviewed the complaints procedure. Improvements had been made by the current registered manager and we saw that all complaints had been formally acknowledged. Outcomes were stored with the complaint information and we could see that the registered manager had responded to the complainant with explanations, actions taken and apologies. Where actions were required, for example, one complaint had led to a meeting with a dietician being organised and another had resulted in the purchase of a door alarm. Where staff were involved in a complaint, initial written statements had been gathered and interviews had taken place. Where complaints had occurred, staff were reminded in handovers, had received additional training or support and in some cases disciplinary action. We concluded that the registered manager had improved the way that complaints were dealt with, although improvements were required within the provider organisation.

We saw the complaints policy was in need of review as it was dated 2012 and was the most up to date version at the service. We saw this policy explained the use of the 'complaint form' and a 'complaint' register and we found the registered manager had followed this process. It was noted that a new management team were now in positions within the provider organisation and new policies and procedures were about to be rolled out across all of their services.

People considered the registered manager to be approachable and listened to them. They said they would feel comfortable to raise any concerns if necessary.

We found people who were receiving regular support to reposition in bed, had not had their charts completed fully to indicate which position they had been placed in or moved from. For example, one person's record stated 'moved', but did not indicate if the person had moved from their right to left side or from their back to their front. We found one person's records which should have showed them being repositioned every hour; had no recordings for a period of eight hours during the night.

Another person had a thorough care plan in place in relation to their skin which was written on the 9 December 2016. The person had suffered some skin damage on 18 December 2016 and this care plan should have subsequently been reviewed and updated with this information, but we found it had not been.

Staff had placed a dressing on one person's leg after they had knocked it and sustained a small wound. There was no note of it in their records and it wasn't recorded on a body map.

On the first day of the inspection people told us staff responded well to their personal care needs. They told

us they felt well groomed and were kept clean and tidy. Comments included, "The girls make sure I am kept clean. I am not able to do that very well myself nowadays"; "I have a shower, that's what I prefer"; "I get my hair cut and washed at the hairdresser regularly"; "I pay extra to have my hair trimmed"; "I have a bed wash, I am happy with this." One relative told us, "I asked them to give him a bath everyday as he is prone to infections…. they do this every day unless he says he doesn't want one." We saw some people had long nails, some of whom had chosen this, but this wasn't always the case and we suggested that attention to nail care could be improved. The registered manager said they would address this.

On our second day of inspection, a number of people said it had been some time since they had been assisted to bathe or shower. When we looked at their records it was difficult to evidence that they had been receiving regular baths and showers as personal care records lacked detail and often simply had recorded, 'independent', 'refused' or assisted.

These issues are a breach of Regulation 17 in relation to records.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

People and their relatives felt the service was responsive to their needs and requests. Comments from people included, "If I am not happy in this room, I can change to another room, I can't say better than that"; "Everyone got a new mattress… I said I didn't like it, so they changed it"; "She [Registered manager] gave me a carer so I could attend a wedding."

One healthcare professional we spoke with told us they had a relative who lived at the service. They said, "[Person] lives here as a resident. I wouldn't have [person] here if I had any worries about the care."

Relatives told us, "She [registered manager] implements things, she got a sensor alarm put at the door and toilet seat with rail fitted." Another relative told us, "Whatever I request it is granted, I asked to change rooms and change the mattress…. this was done." A third relative told us, "He has had two falls recently, the manager put a sensor alarm on the door so we know when he is going to the toilet or out of the room as he tends to wander."

People had been assessed when they first moved into the service and details were collected about their health and personal history, including information about their families. People's needs had been identified, including mobility, personal care, communication and medicines.

People told us they were involved with the process of setting up their care plans and where appropriate relatives or other appropriate representatives were consulted. A relative said, "I am always involved with the decisions about my [family member's] care." Another relative told us he believed his wife had been involved in her mother's care plan. A further relative said, "He has a care plan and I did sign it when we first came in." Care records showed people contributed to regular reviews and assessments of their care and support. For example, we saw a person had attended a review about how they could maintain as much of their independence as possible when mobilising around the home. We observed staff supported this person when they moved around the home in line with instructions in their care plan. They were encouraging and supportive and ensured the person was in control of what they wanted to do.

When people first came to the service their personal interests, preferences and hobbies were discussed with them by staff. However, the provider had recently employed a 'talk and listen' support worker whose role it was to support people new to the home and help them settle in. We spoke with the activities coordinator

who told us they had been appointed to this position six months ago after working previously as a member of care staff. They showed us a plan of activities for each week which they had devised with the help of people and staff at the service. The activity plan for part of December included bingo, sherry and mince pies and carols. They confirmed it was important to get people involved in as much as possible at the service. People told us they enjoyed activities and said, "We have made pompoms for the Christmas tree, it is in the local paper. This has kept us going and kept us busy"; "We have played bingo, baking, 3D vision, there was a good singer last week and dancing" and "They [care staff] get disappointed when I don't go to all the things that are on. I go if it is something that suits me." Relatives told us, "There is a movie theatre downstairs"; "I have been to a coffee morning" and "She's joined in with the dancing and a sing along…. she did not do this in her previous care home."

People who were cared for in bed or who were reluctant to join in with activity sessions told us they had opportunities to speak with staff on a one to one basis. One person told us, "She [activity coordinator] has come to talk to me." A relative told us, "She ['talk and listen' support worker] had a chat with [person] and came to talk to me."

We found that people were supported to maintain personal relationships and social contact with their relatives and friends. The provider had set up a 'talk and listen' café on the ground floor which took place regularly and was a chance for people to gather in a social setting and reminisce and catch up with general gossip. People told us, "The café just started in July"; "The café is on from time to time, I have been and it's good" and "There is a café on this morning, but it is not on every morning."

People were able to participate in activities away from the home, or go for a walk with a member of staff to get some fresh air. We were told by the activity coordinator that they had taken people out by taxi and this was supported by staff who were usually on their day off. One person remembered going out with others when the weather was warmer. One person told us they had a walk around the block one Sunday with staff when the weather was better.

People told us they had choice. One person stated, "I am the queen, I am still the one who makes decisions." Relatives confirmed that choice was given to their family member. One relative said, "She is happier here….she is given choices." We found that people were able to make their own decisions about the time they got up and the time they went to bed. They had the opportunity to choose what meal they had and if they wanted to receive assistance or not from staff.

Requires Improvement

Is the service well-led?

Our findings

We found a range of audits were carried out at the service by the registered manager, deputy manager and other senior staff. These included, for example, audits and checks on infection control procedures, kitchen practices, accidents and incident detailed analysis, complaints, medicine procedures and safeguarding concerns. Daily manager's reports included information on a range of areas, including hospital admissions, deaths, wounds, infections, professional visits and any enquiries. Falls were monitored and analysis completed to identify any potential trends which, if noted, were addressed. Prior to the issues we had found, we concluded that the audits were thorough and included evidence of good monitoring, analysis and actions taken with lessons learnt. However, after further review, the audits had not identified the issues we had found, particularly in connection with record keeping.

During the inspection we found one person's records had been left in the kitchen area on one level of the service. We spoke with a member of care staff and they removed these. However, we noted that they had passed them and left them prior to being asked to secure them by ourselves. We also found a second person's records had been left unattended in one of the lounge areas. We saw no unauthorised individual viewing these documents. This meant that although records were unsecured, people's confidential information had not been compromised.

The deputy manager told us when mistakes were identified they ensured the staff member was made aware of the mistake and how they could improve. They told us that if required, they addressed the mistakes with all of the staff during team meetings in order to ensure people's safety was not placed at risk by staff committing the same mistake again.

A recent safeguarding investigation concluded that record keeping required improvement within the service. However, we found records were not all accurate or completed correctly. This meant that the provider had not fully actioned the recommendations from the investigation and did not have robust procedures in place to fully monitor the quality of the service provided to people who lived at the home.

The management team had not always checked to ensure that staff inductions were robust.

These were a breach of regulation 17 in connection with good governance.

The registered manager sent us an email on her return from annual leave to apologise for the issues we had found during the inspection. She said that they would be addressed immediately. We also wrote to the provider asking them to provide and action plan of how they intended to address the concerns we had found during the inspection. They responded with a detailed action plan and dates by which all areas of concern would be fully addressed.

The service had a registered manager in post. They had worked for the provider for a number of years and had been running this service for just under two years. They were not available during the first day of inspection due to planned annual leave, but were available on the second day. The regional manager and a

further registered manager from another of the provider's services were present to support us on the first day.

We found the registered manager and provider had complied with their legal requirements under their registration, to send the Care Quality Commission (CQC), notification of relevant incidents, safeguarding concerns or other changes to the service.

The provider had used a management support organisation until recently, but had now appointed a number of new directors and had made changes to the structure of their central departments.

Notice boards stated the home operated an open door policy to encourage contact with the friends and family. This was confirmed by the people and families we spoke with. People and relatives consulted during the inspection thought the service was well led. Comments included, "You can go anytime and speak with [registered manager or deputy manager name] and it's never a problem to do that"; "It is properly run"; "She [registered manager] is an excellent manager, she is for the people in here"; "It is well managed, I am quite happy"; "It is managed well and she [registered manager] does try to accommodate when she can"; "She [registered manager] is excellent." One person told us, "I know the under manager….my relative has had a word with her."

Records showed staff meetings were held regularly within the home. Notes from meetings showed issues such as staff vacancies, admissions and training were all discussed. There were separate meetings with nurses and senior management where clinical issues were more thoroughly discussed. We also saw separate meeting minutes for kitchen and domestic staff where a focus could be made on issues that were pertinent to them, for example, ordering food and use of frozen food or in the case of the domestic staff, deep cleans of carpet areas and laundry facilities. When speaking with staff it was clear they understood their roles and the level of care they were expected to provide. Staff told us they worked together as a team and were committed to provide good quality care.

Surveys continued to be issued to people and their families who used the service, analysed and used as a tool to gauge the impact the service was having on people and to identify any issues arising from the quality of 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided by staff in the safest way. Risks were not always identified and assessed in a timely way. Checks on mattresses was not always completed. People were not always protected from unnecessary harm as prescribed thickeners had not been secured. Regulation 12 (1) (2) (a)(b)(c)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits and checks had been carried out but failed to find the concerns we found during the inspection. Not all risks to service users had been mitigated against. The provider had not maintained secure, accurate, complete and contemporaneous records for people who lived at the service. Regulation 17 (1) (2) (a)(b)(c)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate induction. Regulation 18 (1)(2)(a)