Akari Care Limited

Bridge View

Inspection report

Ashington Drive
Choppington
Northumberland
NE62 5JF

Tel: 01670811891

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 29 and 31 January 2018. This meant staff and the provider were unaware of our visit.

The service had been previously inspected in August 2017, where we found continued breaches of good governance, safeguarding service users from abuse and improper treatment, staffing and recruitment. We also issued a fixed penalty notice to the provider for failure to send notifications as legally required to the Care Quality Commission (CQC). The service at that time was rated overall as inadequate, placed in special measures and closely monitored.

We are currently conducting an investigation within our regulatory powers in connection with a death at the service in 2017. This continued at the time of the inspection.

Bridge View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bridge View accommodates up to 61 people over two floors, each of which had separate adapted facilities. People had a range of support and care requirements, including those who needed nursing care and people living with dementia. At the time of the inspection there were 40 people living at the service, 23 of which were classed as 'nursing residents'.

A new manager was in post who had applied to become registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We checked the procedures in connection with diabetes management and found that not all care plans had been followed as they should have been. This put people at potential risk of harm. We have made a recommendation about this.

Medicines management was suitable, with trained and competent staff administering medicines to people. The provider rectified a couple of issues we found during the inspection.

Safeguarding processes had been reviewed and staff were knowledgeable about what to do should they suspect or have any concerns about harm being caused to people. People told us they felt safe.

Accidents and incidents were recorded and monitored. Risks to people were identified and assessed to ensure that risk was minimised as much as possible. Fire safety and other building related checks were carried out to ensure the service was safe for people to live in. People's emergency evacuation plans were in place to support an evacuation from the service should the need arise.

The service was clean and tidy and staff followed infection control procedures. The service was generally well decorated, and had a programme of continuous improvement.

There were enough staff in place and less agency staff used than in previous inspections. The manager ensured that agency usage was at a minimum. Staff felt well supported now and morale was much better than previous. The providers training programme was in need of review to ensure that staff had suitable and effective training in place. We have made a recommendation about this.

Recruitment was effective with safe working practices being followed, including receiving suitable references and obtaining Disclosure and Barring Service checks (DBS).

Food and refreshments at the service was good with positive feedback from people and their families. Special diets were catered for and support to people who needed it was given at the right times. Records in connection with this had been completed fully and in detail.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Applications had been made for Deprivation of Liberty Safeguards (DoLS), where it was considered that people would be unable to keep themselves safe if they were to leave the home unaccompanied. We noted that some improvements were required in the recording of best interest decisions and the copies of lasting power of attorney details held. We have made a recommendation about this.

Healthcare professionals were fully involved with people at the service to maintain their health and wellbeing and this information was recorded. Referrals and appointments had been made with, for example, GPs, specialist nurses and occupational therapists. Any advice was used to support people's care plans.

People told us that staff were kind and caring and knew them well. People were treated with dignity and respect. Independence was maintained. During observations we saw positive interactions between staff and people and their relatives. Care plans were person-centred, regularly reviewed and tailored around the individual needs of people and included information about people's personal backgrounds.

People enjoyed the activities provided. There were stimulating activities for those wishing to participate and further new ideas planned for the future, particularly for those people who were living with dementia.

Complaints procedures were in place and people and their relatives knew how to complain and would not hesitate if they felt they needed to. They felt the new manager would respond positively to any issues raised.

Governance system were in place and evidence confirmed that the provider had identified concerns through these processes. However, we noticed that some issues found were still on going, for example recording of 'as required' medicines. We have made a recommendation regarding this. We also found that archived records were not always locked away securely. We have also made a recommendation about this.

People and relatives were very positive about the new manager and recent changes within the service.

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.

People at risk of particular health conditions had not received proper monitoring, which posed potential risk to their health.

People felt safe and had been safeguarded against any potential abuse. Risks had been monitored and accidents had been recorded and checked.

There were enough staff and recruitment was done safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider training programme needed to be reviewed to ensure it was robust.

The provider needed to ensure that the principles of the Mental Capacity Act 2005 were followed, including recording of best interest decisions.

Communication had improved. Good nutrition and hydration was in place for people.

Is the service caring?

Good

The service was caring.

People were cared for by respectful and kind staff. Privacy and independence was maintained.

Staff knew people well and observations confirmed this.

People had information about advocacy services but most used their families to support them.

Is the service responsive?

Good

The service was responsive.

Call bells were answered in a timely manner and care was person centred. Activities for people continued to be improved upon.

Staff handover information between shifts had been improved and people and relatives were aware of the complaints system.

People received appropriate end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

A manager was now in post and had applied to register with the Commission. Some of the issues we found during the inspection had not been addressed fully.

People and relatives were complimentary about the new manager and felt included in the service and how it operated.

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.

Following the last inspection which was rated as inadequate overall; the provider sent us an action plan to show what they would do and by when, to improve. At this inspection we found that improvements had been made in all areas and the service was no longer inadequate and was no longer in special measures.

We are currently conducting an investigation within our regulatory powers in connection with a death at the service in 2017. This continued at the time of the inspection.

The inspection visit commenced on 29 January 2018 and ended on 31 January 2018. The inspection was unannounced. Two inspectors', two specialist nurse advisors, and one expert by experience conducted the inspection. A specialist advisor is a member of the team with specialist knowledge in a particular area. In this case the advisors had specialisms in tissue viability and nutrition. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We contacted the local authority contract monitoring and safeguarding teams, the Clinical Commissioning Group (CCG) and the local Healthwatch to obtain their views about the service before our visit. Healthwatch is the local consumer champion for health and social care services. We also contacted infection control lead for care homes in the area, care managers and district nurses involved with the people who received care from the provider. We contacted the local fire authority to see if they could offer any feedback. All of this information helped to inform our planning of the inspection.

We spoke with 18 people and seven relatives to gather their views about the service. We also spoke with the manager, the regional manager, the deputy manager, the chef, the administrator, the 'talk and listen' staff member, the activities coordinator, the maintenance supervisor, one of the domestic team, two nurses, two senior care staff and seven care staff.

During this inspection we carried out observations 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 reviewed a range of 12 people's care records, including medicines records. We looked at seven staff personnel records. We also checked records relating to the management and governance of the service.

We placed a sign at in the reception area to alert visitors to the service that an inspection was under way if they wanted to speak with one of the team and give feedback.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found a continued breach of Regulation 13 in connection with safeguarding people from abuse. We also found a breach of Regulation 18 because poor staffing arrangements were in place and a breach of Regulation 19 as fit and proper staff had not been employed. The 'safe' domain was previously rated as inadequate.

During this inspection we found improvements had been made and the service was no longer inadequate. However, further measures were required to improve 'is the service safe' to good.

We checked the support regimes of three insulin dependent diabetic people who lived at the service. Insulin was dated and stored correctly. We were shown how the insulin was prescribed and administered and this was completed appropriately. Each resident had a blood sugar monitoring chart which recorded the blood sugars prior to the giving of insulin. We saw evidence that one nurse had queried the insulin regime for one person and this had been discussed with the person's GP and subsequently changed.

One person was at risk of ketoacidosis. Ketoacidosis is a serious complication of diabetes that occurs when the body produces high levels of blood acids called ketones and is potentially life threatening if left untreated. The person's emergency health care plan stated that staff should check their ketones if their blood sugar levels went over 25mmol/L (mmol/L is millimoles per litre and is the internationally used measurement for checking blood sugar levels). The service had recently purchased a new ketone monitoring device. Care staff knew where the machine was and how to use it. We checked monitoring records from September. Ketone checks had not always been completed when the person's blood sugar levels went over 25mmol/L. We discussed this with the manager who assured us that they would fully review the procedures straight away.

We were aware of previous issues with lack of ketone testing at the service. We had been assured by the provider that these procedures had been reviewed, however, we found this was not the case.

We recommend the provider review their procedures in connection with diabetes management and ketone testing.

All of the people we spoke with reported that they received their medicines on time. The provider told us they were experiencing some issues with the electronic medicines administration system they used. The manager told us they were considering changing back to paper based medicine administration records (MARs) and that some of the providers other services had already done this. Issues included people's medicines being reversed on the system after they had been updated or changed.

Time specific medicines had been administered as they should have. All other medicines were available, other than one which was on order and expected to arrive from the pharmacy. We found one person had not been administered their Alendronic acid. The nurse in charge explained that night shift normally administered this medicine due to timescales. They were aware it had not been administered and had

raised this with the manager and had contacted GP to confirm new arrangements for administration.

'As required' medicines were not always fully recorded either on the electronic system or in people's records. 'As required' medicines are those which are administered from time to time, for example for pain relief. We observed two medicine administration 'rounds' with senior care staff and nursing staff and found they knew people well and appeared to know the medicine requirements of each person, including their 'as required' medicines. However, any newer member of staff may not have that knowledge and it would be difficult for staff to know how and when to administer any 'as required' medicines for those people with missing information. We found no evidence to suggest people had not received any 'as required' medicines. We spoke with the manager about this and they said they would look into it and have this addressed.

We found that there was some discrepancy between information recorded. For example, one person's emergency health care plan listed medicines which did not correlate with the medicines listed in their care plan and risk assessment information. We mentioned this to staff who updated the information straight away.

Staff trained to administer medicines were required to complete three consecutive competency checks conducted by a senior member of the team. We looked at two examples of these and saw they included a check of knowledge of documentation and medicines safety. The manager was currently in the process of updating competencies, although all staff had already received electronic MAR competency assessments.

At the last inspection we found issues with incorrect settings on people's special pressure relieving mattresses. At this inspection we checked 17 mattresses and those which required a particular setting were all correct. One person told us, "I know my mattress is set correctly as I know what number it needs to be on, the staff tell me. I know it's to stop bed sores but I don't have any. I've never had one yet. The staff keep checking my mattress is ok, and they turn me overnight, every four hours or so." Records confirmed that people at risk of pressure damage (to skin) had been moved and repositioned as they should have been. A person at risk of pressure damage told us, "I get repositioned every two-three hours overnight, during the day the staff move me too."

One mattress we checked had some unseen damage and an odour. We reported this to the manager who arranged for it to be addressed immediately and later confirmed that this had been actioned.

The manager had taken steps to ensure all members of staff understood the whistleblowing policy. This included discussing the differences between safeguarding and whistleblowing and when they should escalate concerns about unsafe practice. All of the staff we spoke with demonstrated understanding of the whistleblowing procedure and said they would not hesitate to raise concerns.

When we asked people and their relatives if it was safe to live at the service they told us, "Oh yes I am quite comfortable here"; "Yes quite safe. I have been here for one and a half years"; "Yes, they look after him very well. He is shaved and dressed every day. He has his hair washed every day"; "Yes. We did have a few problems last year but it is all sorted out now" and "I feel very safe, the staff are very good."

The maintenance supervisor led fire safety in the service and had carried out practical fire drill simulations to ensure each member of staff understood their responsibilities. We asked four members of staff about this who all told us correctly what their responsibilities were in an emergency. We found fire exits were clear of clutter. People's emergency evacuation plans were in place which illustrated what support each person would need from emergency services should there be an evacuation situation arise, for example, from a fire or flood. Fire equipment had been routinely checked and a fire risk assessment was in place to help

minimise any identified risk with all actions identified confirmed as completed. The provider also had an up to date contingency plan in place which would be activated should an emergency situation arise, for example poor weather conditions. This all meant the provider had considered risks and monitored safety to ensure people remained as safe as possible. Routine checks and monitoring had taken place, including those in connection with, for example, lifts, hoists, water temperatures and mains electric checks. PAT (portable appliance testing) had been completed annually; however, we found a number of items which had not been tested within best practice guidance, including a radio in the main reception, two extension leads, a lamp and a reclining chair.

Risks had been assessed for a range of identified vulnerabilities relating to people in their everyday lives. For example a specific risk assessment had been completed for one person at risk of choking following concern from staff that the person was 'pouching' their food. 'Pouching' food is when people store food in their cheeks for example and refuse to swallow. We did find one risk assessment which has not been completed for one particular person at risk from depression. We spoke with the manager about this and the assessment was immediately completed and implemented. Accidents and incidents were recorded appropriately and monitored by the provider.

The service was clean and tidy. One relative said, "I worked in care homes and this is one of the best. Clean and spotless." One member of the housekeeping team said there was a renewed focus on good cleanliness standards in the service. Housekeeping staff had undertaken updates in infection control training and had recently improved the cleaning system for carpets and curtains. This included steam cleaning rather than only the use of chemicals. In addition, the team had secured approval from the provider to replace flooring in the stairwells and obtain new linen and bedding. Staff were wearing appropriate and clean uniforms, were all well-presented and all bare below the elbow, which followed best practice in infection control procedures.

People who lived at the service and their relatives generally thought that there was enough staff on duty to meet people's needs. Although we also received some negative comments. Comments included, "Yes, there seems to be (enough staff)"; "Always seem plenty of staff, sometimes if busy it might take a bit longer for someone to come, but it's not always like that"; "Generally speaking yes. Occasionally they are a bit short"; "Some people expect the staff to be at their beck and call. I can honestly say that I feel there is enough to see to everyone. Sometimes when it's busy, they may have to wait a little longer than usual, but not massively. I think there is enough, yes" and "I think they are very short staffed. The staff that are here are very good but sometimes there are four or five people in the lounge and there are no staff available. They don't seem as if they have time to pop in every 20 minutes to see if a person is alright."

Staff said staffing levels felt stable, including night shift. For example, staff said when they arrived for a day shift, the service felt safe, clean and tidy. If people wanted to be up and ready they were and those who wished to stay in bed could do so. Agency usage was at a minimum. We completed three observations over the inspection and found that people were not left unattended for any extended period of time. One person called for assistance and staff responded quickly. We sat in three different locations without staff knowing initially. Within minutes care staff were checking the people we sat with.

The manager used a dependency tool to plan staffing levels. The tool assessed people against levels of dependency on a scale between low and very high and included people who needed one-to-one care. We looked at the dependency tools used in November 2017 and December 2017 and found in both months the level of staff cover was significantly more than the minimum needed to keep people safe. For example the manager identified a need for a minimum of 2738 hours of care staff cover between the two months and provided 468 hours of cover in addition to this.

We viewed interview records for seven staff. There was documented evidence of a competency-based interview that assessed staff against standards in education and experience and attributes relating to their personality. Although senior staff had assessed each applicant there was inconsistent use of narrative, which meant it was not always clear what each individual's specific skills had been assessed. Staff records we looked at included at least two professional references and background checks by DBS (Disclosure and Barring Service).

Requires Improvement

Is the service effective?

Our findings

Each member of staff completed a standard induction based around the Care Certificate, before they were able to work unsupervised in the service. We spoke with two members of staff who had recently completed their induction period. Both individuals spoke positively of this and said they had received mentoring from senior staff and been given enough time working supervised before they worked by themselves.

We looked at the training certificates for seven members of staff. We saw there had been a significant drive in 2017 to update the training of the whole staff team with training relevant to their role. This included advanced 'train the trainer' instruction for moving and handling, which enabled staff to help people to mobilise safely. Staff had also undertaken safety-related training in the use of bedrails, national control of substances hazardous to health standards, fire safety awareness, nutrition and hydration and safeguarding of vulnerable adults.

One staff member confirmed they were taking 'CHAPS' training. CHAP (care home assistant practitioner training) training involves staff expanding their clinical skills knowledge, for example, minor wound care. The manager confirmed two staff were in the process of completing this.

Some members of care staff had developed their own strategies to safely protect themselves and others when people presented with people's behaviours which challenged. This included moving away from the person and using a calm voice to deescalate the situation. However other staff said they did not know what to do in situations like this. For example one member of staff said, "One person often digs their nails into my arm, it really hurts but there's not much you can do, I just have to deal with it." Although all care staff had completed dementia awareness training, it was not evident this was always effective. For example one member of staff said, "I think I've done it. I can't remember much about it." We also found that care staff had not received diabetes training, although the manager told us that this was planned to take place in the near future.

We recommend that the provider reviews their training programme to ensure effective training is delivered to meet the needs of people at the service and keep them and staff safe.

We looked at 13 supervision records. We found each member of staff had a monthly supervision, which rotated between a whole-team agenda that covered issues in the service and an individual supervision. For example, in one month supervisions focused on medicines management following errors in administration. Where staff had not been on shift when an incident or feedback occurred, we saw they signed the supervision to note they understood the key messages. Individualised supervisions took place according to each member of staff's role and responsibilities. For example a member of the kitchen team was supported to complete a diploma in hospitality and catering and identified improving meal presentation as future learning.

All members of staff we checked had completed an appraisal within the previous 12 months. We looked at five examples of these. We saw the manager or a senior care worker encouraged each member of staff to

identify their achievements and what they hoped to work towards in the coming months. For example one member of staff said they were proud of becoming a moving and handling trainer and another said they felt they could provide better care if they completed diabetes training. Another member of staff noted they had encouraged a number of people to eat more regularly and more healthily after they moved into the service and refused to eat.

Communication between staff at the service had improved. One example was regarding wound care. Care staff knew which people had wounds. A nurse advised us that all people's acute health needs were documented in an "Acute Care file" which was looked at daily by the nurse on duty. All of the details in the file had been evaluated daily. Care staff knew which people had wounds and which people needed to be repositioned and at what frequency. The manager knew which people had wounds as all information on new wounds was relayed to them on a daily manager's report.

Continence checks were done frequently during the day and night, every two to four hours for some people. Although the checks could have disturbed people, frequently the documentation reflected that the incontinence products were wet or soiled. Wet or soiled incontinence products can lead to skin inflammation and incontinence associated dermatitis (IAD). The care staff knew which people were likely to be wet or soiled and checked these people at an appropriate time interval. Our specialist advisor [tissue viability nurse specialist] confirmed that prevention of incontinence associated dermatitis or "moisture lesions" is much preferable to treating damage once it is has occurred. As the service did not have a problem with IAD and no person complained about the frequency of checks, the checking and actions were considered appropriate.

Where people were on pressure relieving mattresses every one of these mattresses had been checked as functioning and this check had been signed and dated by staff. Although regular checking of devices is not a requirement within the National Institute of Health and Care Excellence (NICE) guidance, it is considered good practice and effective to ensure that when residents are using this type of mattresses they are functioning and set correctly.

People who lived at the service and their relatives thought that care staff were effective in meeting people's needs. Comments included, "Oh yes and they know now when she is not very good and when to leave her and come back. She has dementia and sometimes she gets so annoyed but the staff know how to deal with her"; "The staff [upstairs] are extremely conscientious about everything. They do look after my partner. I have been to other care homes but this care home is home from home"; "I have no doubt that the staff are very well trained. Nothing has happened to contradict this"; "Staff have helped [person] put weight on, very good really" and "Oh, they are a good bunch, they'll do me. Good at what they have to do."

However, one relative thought that staff were not always effective. They said, "I wouldn't say all of them (have the right skills). It's just that sometimes they will let my mum sit in her room day after day, whereas with a little bit of coaxing she will come out for her dinner, but they don't seem to have the time". We looked into this comment and observed people being encouraged to come out of their rooms by staff where possible. We found no evidence to suggest staff deliberately left people isolated because of lack of skills or due to lack of staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where a DoLS application had been made for some people who required restrictions for their own safety, these had been made appropriately to the local authority and authorisations had been obtained. No person had restrictions placed upon them without the correct processes being followed.

People were encouraged to make day to day decisions around what they wanted to eat, wear or the time they wanted to get up and we observed this taking place. We saw that capacity assessments had been completed. Discussions regarding any best interest decisions required had been recorded. However, we found some decisions had been made for people but not always recorded, for example, changing pads during the night for some people. We also noticed that for one particular person best interest decisions had been made by one particular staff member and no record was made of any other relative or healthcare professional involvement.

Copies of lasting power of attorney (LPA) arrangements were not always kept by the provider. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. We spoke to the manager about this and they said they would ensure they asked and kept copies for everyone who had an LPA.

We recommend the provider review their processes to ensure they follow the principles of the MCA fully.

Care records confirmed that consent had been recorded, for example in connection with taking photographs and using them in a number of ways. The provider had recently reviewed this process in light of some concerns raised by a relative in connection with the use of a photograph of their family member on the provider's website. We saw letters of apology sent to the family and confirmation that lessons were learnt. We queried with people if they were asked for their consent. We posed the question to people but few grasped the concept. However, after further questioning, it was clear that staff do routinely ask for consent before carrying out personal care or support. We observed people being asked for their consent during medicine administration and before staff performed personal care tasks.

We observed the lunchtime experience throughout the service. The atmosphere was calm and pleasant and staff worked hard to make lunch time enjoyable despite being very busy. The tables were set out in a restaurant style which we considered made people feel special and not institutionalised. The room was decorated to a high standard and had scenic views from large windows. Drinks were offered to people, most of whom chose juice but one lady requested a cup of tea, which was made for her individually. We observed what happened when one person, who was agitated, refused their meal at lunch time. A different member of staff returned 10 minutes later to offer the meal again and this time the person ate it all.

The service's chef helped to feed one person. They told us, "I like to spend time with my residents. I like to know who I am cooking for. I was a carer for years and although I'm the chef now I still care. My residents love my roast dinners, that's what they tell me anyway. I love my job, I love mixing with people." The food looked appetising and we noted that the Chef had payed particular attention to the presentation of the soft food diet, which avoided drawing attention to its texture, which people might have found embarrassing. The kitchen area had a range of foods to enable staff to fortify meals, including double cream, full fat milk, cheese and milk powder. Fortified milk shakes were made available to people during the day on request from staff, however our specialist nutrition advisor discussed this with the Chef and agreed it would be

better if they were available on tea trolleys during the day as standard.

People were complimentary about kitchen staff and thought that there was enough suitable food and refreshments available to them and relatives confirmed this. Comments included, "Oh yes, when mum came in here she was only six stone and she is nearly nine stone now. Sometimes she won't eat, but they just keep trying her"; "The meals are quite good, the majority of the time. If we don't fancy what's on the menu they will always cook you something you want"; "You cannot fault the meals here but you don't get a lot of variation"; "Yes I am diabetic so I have to drink a lot of water"; "They vary. I have had a few choking episodes so I am on a soft diet and everything is puréed. If you have any special requirements they will get them for you, like when I requested sardines. There is quite a decent choice and there is always a choice of two meals"; "Mum is always given a choice of a hot meal or a cold meal. The puddings are nice" and "If they haven't eaten at dinner time, they will make a special meal that they like for tea time".

Staff had a list of which meals people had ordered but still asked them to reaffirm their choice. This is good practice as some people living with dementia had forgot what they had ordered and some people had changed their minds. One person asked for food which was not on the menu. Staff went to the kitchen and the alternative meal asked for was brought within a few minutes.

People and relatives confirmed that a range of healthcare professionals were involved where needed. One person told us, "They get the doctor or the out of hour's doctor during the night." Another person said, "They do what they can for me. They get the nurse to come along and check me out. If they feel there is anything seriously wrong, they will get in touch with the surgery." A further person said, "They are very good. They give you a general check over. I have had the doctor in here." The manager told us, "When patients have wounds, nursing patients are seen by the tissue viability nurse and dressings are ordered by staff. We keep a basic stock of dressings in case residents need something, and we never have problems getting any dressings we need."

We found staff had made significant improvements to the environment at the service. This included refurbishing one lounge as a reminiscence room, including the purchase of an old gramophone and other antique items. Pictures of past times had been hung on walls to trigger recollections of earlier life or childhood memories. Staff took photographs during activities and printed these out so people could decorate their bedrooms and bedroom doors. One relative said, "The manager has had all the doors painted different colours so that residents with dementia can identify their room. There are new carpets and new furniture with different colours to make the rooms look different." As part of the work towards reminiscence, the chef had prepared meals that people were used to from their childhood, which staff said made people feel more at home. Staff told us and the manager was able to confirm, that memory boxes had been ordered for the people who were living with dementia. Memory boxes are aids which help people recall and support them in a number of ways, including to support them in recognising their own room.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the staff and their kind and caring attitude. One person said, "Yes they are [caring]. They get me dressed in the morning. They have to hoist me into the chair, which they are very careful in doing. I must admit that when I came in here I was quite ill and I don't think I would be here now if it wasn't for the care here." Other comments included, "There is nobody who is not nice. They help you if you need it"; "The staff are extremely conscientious about everything. They do look after my partner. My partner gets cuddles and hugs"; "I have never come across a member of staff who doesn't put themselves out"; "Yes the staff are caring" and "The staff are all lovely, and [deputy manager name] is a star." One person was keen to tell us, "The staff are lovely" and "they always have time for me."

We observed caring interactions between people and staff. During one observation a person was telling a care worker they were worried about their medical condition. The care worker sat with them on their bed, held their hand and explained why there was less to worry about than they thought. In another observation, a person told staff they felt "helpless" because they couldn't change their own bed linen anymore. The care worker demonstrated kindness and said they understood but that it was also nice to be looked after sometimes.

One person told us how caring the management team were. They said, "The home manager came in on Christmas day, and New Year's day to check everything was okay, and she spoke to as many of the residents as she could. I thought that was excellent of her." We were also told that the deputy manager of the service attended on Christmas day, dressed as a Christmas Elf, to cheer up people. This was despite it being a very difficult time for personal reasons.

Observations confirmed that staff knew each person's personality and what they liked to do. For example, we saw care staff made a particular effort to gently engage a person who was sleeping when an activity was about to start. We saw this had a positive impact on the person, who enjoyed joining the social activity. During another observation a person asked a care worker for a cup of coffee. The member of staff said, "I'll make it the special way you like it, I know how you like your milk frothy!" We spoke with staff about this. One staff member said, "People don't see us as 'staff', they see us as family. We eat together, they like to sit and hold our hands; I think we have very good relationships with everyone." Another person told us, "It's better here than last year. There are much fewer agency staff here, that means the staff know us better, and look after us better."

Relatives were actively involved. One relative told us, "The nursing staff that are regular staff know my mum well. She often needs to go to hospital and they are good at liaising with me over when she needs to go into hospital."

All members of staff in the service had developed relationships with people. For example, the maintenance supervisor demonstrated how well they knew people and told us they spent time talking with them, including when they had a low mood and needed cheering up. In addition, one person became happier when they were engaged with practical tasks. As a result the maintenance supervisor helped the person to

paint part of the service and to paint the garden fence. This was carried out with appropriate risk assessments and safety measures in place.

We observed staff adapted their communication to each person they were speaking with, which demonstrated their knowledge of each individual. For example care workers spoke with one person in an informal style and with others very formally. We spoke with staff about this. One staff member said, "I talk to some people as if they're my mates. They respond really well to this and it makes them feel like they're at home. Others prefer you to be very polite and well-spoken and of course that's fine too."

Privacy and dignity were maintained. One relative told us, "Yes, they always shut the door and draw the curtains when they are getting her out of bed." Another relative said, "Yes, the door is always closed and staff always knock on the door before they come in." There was evidence in staff supervisions that the senior team maintained a focus on ensuring people were cared for with privacy and dignity. For example, the manager had used feedback from the relatives of a person and an ambulance crew to discuss improvements in care. This included remaining with relatives while waiting for paramedics so they felt supported. Staff demonstrated consistent awareness of privacy and dignity during our inspection. This included knocking on bedroom doors before they entered and asking people before carrying out a care task. For example a housekeeper asked a person if they could clean their room and offered to take them to the lounge while they did this.

People were encouraged to remain independent. One person told us, "The staff are firm but nice." We observed people being encouraged to mobilise independently, to support themselves with meals and to put pieces of clothing on without help. For example, one person was asked if they were cold and asked if they wanted to put a cardigan on. The staff member then encouraged them while allowing the person to remain independent as they put the cardigan on slowly themselves.

Staff used a 'resident of the day' system to focus extra time and attention on one person. This meant staff deep-cleaned the person's room and offered 'pampering' activities depending on the person's wishes.

People had a choice of what they wanted to do or how they wished to participate in everyday matters. One person told us, "Yes they usually come and ask. I think if I said I don't want this done or I wanted that, they would do as I asked." Relatives said, "The staff always give my mum a choice. So, it's like they are always asking for her opinion. At least you know they [mum] have the choice to say no" and "Yes they will say to a person, 'what do you want for your breakfast'. Sometimes she likes a lie in in the morning and they will let her."

At the time of our inspection we were not made aware of anyone who accessed the services of an advocate, but we saw more informal means of advocacy through regular contact with families. This meant that people were invited to be supported by those who knew them best. Advocates help to represent the views and wishes of people who are not able to express their wishes. Information was available regarding advocacy services if this was required.

Good

Is the service responsive?

Our findings

Call bells were answered quickly during the day. In the morning there were lots of call bells activated, though they were answered within two to three minutes. We tested the call bells twice in the afternoon in two different areas of the service and both were answered within 20 seconds.

Pre-assessments were completed with people before they were moved into the service. This was completed to ensure that the person's needs could be met by the provider. After people moved into the service a range of care planning documentation and risk assessments were put in place to ensure that their needs continued to be met. Care plans were generally detailed and person centred, although two which we viewed were in need of further development. Records we viewed showed that a range of care needs had been planned, including those in connection with continence, moving and handling, nutrition and hydration and the care of skin.

One person had a particular PEG fitted. A PEG is a medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Records in connection with the PEG, included how to use it appropriately and its maintenance, including who to get in touch with for further advice were all appropriate and in place. There was a PEG regime from the dietitian that was seen to be followed, by the recordings on the PEG fluid chart. The previous seven days of charts, showed that the target amount of food and fluid had been reached each day.

Care staff had undertaken person-centred care planning training. The care team had also completed training in meeting the needs of people with complex behaviour and demonstrated how they put this into practice. For example, one member of staff found they could calm a person who regularly became upset by talking about football and their loyalties to different teams. They said, "We have a good natured discussion about whose team is the best and this always helps to calm them down from whatever was upsetting them."

Staff were more responsive to people's needs by ensuring a good handover system was in place. The manager had implemented mandatory handovers at each change of shift. This was led by the senior person on duty and included a review of each person who lived at the service whose needs had changed or whose medical needs had increased. Handovers also included a discussion of incidents and complaints that had happened on the previous shift. We asked staff about the new procedure and each individual spoke positively about this. One member of staff said, "It's a great initiative. I think it's helped us to communicate much more clearly." Another member of staff said, "I know there is no one with wounds at the moment on my unit. We have a handover every morning for 15-20 minutes and anything like that we know about. We discuss how the residents have been during the night and the previous day." They continued, "I know which residents need to be repositioned as it's in the handovers and the paperwork. We know that if a resident gets poorly we have to reposition them more often so their skin doesn't get sore – this is usually two hourly. I look for any redness on the skin - mainly on the resident's bottoms but anywhere really."

One relative told us, "She's [person] been here for five years now, I'm happy with everything. The new

manager has not been here long but I know she has been active in the short time she has been here. The staff treat [person] well, she's just been bought a new chair. When she is well enough the staff get her up and about…she's well looked after."

The service provided end of life care and care to people with terminal and life limiting illnesses. We saw words of thank you received from relatives who had lost a loved one at the service. We had no concerns shared about the end of life care people had received. People and their relatives had been asked to consider sharing their end of life wishes, this meant information was available to inform staff of the person's wishes at this important time when people may no longer be able to communicate those wishes themselves. Not all care staff had completed end of life care training. However care staff told us they had been given structured guidance on providing care such as mouth care and how to make people comfortable.

There were two staff employed with keeping people entertained and socially involved. One individual focused on talking and listening and one individual focused on practical activities. This team had planned and designed a new reminiscence room and were awaiting a quote to install a mining mural. This reflected the background of many of the people who lived at the service who were from the local area and would provide new opportunities for positive discussions of their past. The team had also trialled cheese and wine afternoons and changed this to include juice after feedback from people who lived there. Activities staff had also supported people with home baking sessions, which helped stimulate them and give them a sense of contribution to the running of the service. The team had started a large family tree, which included handprints from the people who lived there. This helped to establish a sense of community.

The service provided seasonal activities for people, including festivities at Halloween, Christmas and New Year's Eve. Staff dressed up in costumes to help provide fun and light-hearted events. During warmer weather, activities staff led weekly trips out including to the beach. People told us that there were a range of activities to choose from. One person told us, "We had baking last Friday and usually they have an entertainer comes in once a month and bingo. They do try to get people interested. If you ask them, they will take you out. They try and give everybody a turn." Other comments from people and relatives included, "Cooking scones and chocolate cake. Yes, we have entertainers. You can go out once a week and they will take you to the shops in the car"; "They do bingo and they have people coming in to do exercises for them. I like to come and have a meal with my mum and they are going to invite relatives for a meal on Valentine's Day and Mother's Day" and "They have special events from time to time and entertainers visit."

Activities staff recognised the improvement in mood in people living with dementia when they played music to them. As a result they arranged for a local school choir to visit as a pilot to see if people would enjoy this. The pilot was successful and the service reached an agreement with the school's leadership team to arrange the choir on a rolling monthly basis.

During the first day of inspection, activities were noted to be taking place in one lounge. People were playing a game with a ball and seen to be happy, smiling and laughing throughout the activity. The manager had ideas to continue to further develop meaningful activities for those people who were living with dementia, including the use of 'Apps', for example the Liverpool museum award winning dementia app called 'House of Memories'. Apps are programs designed to run on devices such as a mobile telephones or tablets.

People and their relatives told us they would have no hesitation to raise any concerns and confirmed they knew how to complain. Comments included, "No problem at all. I have just got to mention something to the carers [staff] and they sort it out. They are very good"; "Yes. We usually have a meeting about once a month for residents and we can put forward any concerns to the management"; "I had one concern a while back but the new manager sorted it out"; "Yes you can talk to the manager, she comes upstairs"; "I would have no

hesitation speaking to any of the staff. There has been so many changes in the last year; but things are definitely getting better now. I would complain if I needed to without concern about repercussions" and "I would go to the manageress and I wouldn't be frightened to go."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found a continued breach of Regulation 17, Good governance and there was no registered manager in place. We found further breaches of three other regulations in relation to safeguarding people from abuse, staffing and failure to ensure suitable skilled staff were in place. The 'Is the service well-led' area was rated as inadequate. We also issued the provider with a fixed penalty notice for failure to send CQC notifications which they are legally obliged to. The provider was placed in special measures.

During this inspection we found the provider had improved and was no longer inadequate, however, some areas required further improvement and monitoring.

At this inspection there was a manager in place who started working at the service in November 2017. They had applied to register with the Commission and were awaiting the outcome. One of the permanent nurses had also been promoted to deputy manager just prior to Christmas. The deputy manager was also the clinical lead for day shift with a separate clinical lead at night. All staff knew their responsibilities. The provider's practice improvement manager had provided regular support in the service since the previous registered manager had left. Staff told us this individual had been helpful in implementing improvements and changes.

People were complimentary about the new manager. One person told us, "I keep on top of the CQC reports. The new manager has put the staff into the right place and things have improved since she has come. The new manager speaks to us all, the last one did not." Another person said, "I am happy here. We have a residents meeting here once a month and the new manager [referred to by their name] is very nice. She listens to us."

Current care records were stored within office locations and kept confidential, however, we found some older archived records stored in an unlocked equipment storage cupboard. One the second day of the inspection, the cupboard was locked.

We recommend the provider reviews its procedures in connection with confidentiality of information.

A range of audits were undertaken within the service. Kitchen audits were performed monthly with action seen to be completed on the following month. Other audits included those in connection with health and safety, medicines and infection control. The provider had a home improvement plan in place and this document was now live on their new IT system. This was updated regularly with actions taken. For example, when boards had been put in place with information for people and their relatives. Also, notifications had been monitored to ensure they were being sent to the Commission. We were able to confirm from the records we checked that this was the case. We noted a number of points on the plan which had a completion date but then had ongoing in the date completed column well past the date planned for completion. For example, the provider had recognised that people's 'as required' medicines needed to be checked to ensure that details were available to staff. There was an action recorded as 'All PRN (as required)

medication protocols are to be updated to reflect all PRN medications and clear directions for use'. The target date was the end of August 2017 but this had not been completed as we had found during our inspection. We did, however see that many actions had been identified and completed by the provider, including review of handover documentation and process and review of service cleaning procedures.

The provider visited the service regularly to provide support and monitoring. However, these visits had not always ensured that dates for action had been met, for example, in connection with 'as required' medicines.

We recommend the provider further reviews their governance procedures to ensure dates set for compliance are fully monitored.

People thought the atmosphere within the service was now better. One person said, "I think it's pretty good. Speaking personally, I think the new manager is much more accessible. She helps to generate a community spirit and her admin support staff are very helpful." Another person said, "The atmosphere is very nice." Relative's told us, "It's friendly. It's comfortable to come in to"; "It's a friendly atmosphere. They are quite caring. I have never heard anybody shout or raise their voice"; "It's nice and friendly. Everybody talks to you and you can talk to the other people who have family members here"; "The manager makes them feel like her own family" and "It's alright, it's happy, it seems relaxed and quiet."

Three members of the inspection team had been to the service on previous occasions and noted a much more positive attitude amongst the whole staff team.

Staff spoke positively about changes in the service with the introduction of a new manager, and told us now they felt empowered and valued. For example one member of staff said, "Since [the new manager] joined it's been 100% better. I was job-hunting last year but I stopped it when I saw how great the new manager was. It's a totally different place to work and a totally different place for [people]." Another member of staff said, "Everyone seems happier, there's a better atmosphere and we all enjoy coming to work. We didn't have that before." We spoke with staff who had recently joined the service, including one person who was new to adult social care. They said they had been welcomed into the service and felt the training and support they had received helped them to provide good standards of care. A further member of staff said, "The manager does a floor walk every day and checks in on us and each resident." Staff also told us the manager provided emotional support whenever they needed it. They said they found the manager approachable and ready to listen whenever they wanted some time to talk. One member of staff said, "Nothing is a bother to her. Morale is much better and she thanks everyone at the end of each shift. It's made us feel valued again."

The manager told us they wanted all staff to work together as a family and look after each other. We overheard them a number of times speaking to staff and referring to them as part of a family.

People who lived at the service and their relatives found the new manager open, transparent and responsive. Comments included, "Well I speak to the manager, the lady who has taken over. She is very approachable"; "Yes I have seen her come round. If we have any issues we can raise them with any member of staff or the manager"; "You can go and knock on her door and she will see you" and "Yes it seems to have improved here and the manager has improved if there are any issues or anything, which is good. The previous manager I found was pretty unapproachable."

The senior team demonstrated an open and honest approach to communication with staff, which helped to facilitate a respectful and positive working culture. For example one care worker said the manager had discussed the service's previous CQC inspection rating with them and asked if they understood the work that would be needed to improve this. The member of staff told us they found the honest discussion "very

refreshing" and had contributed to their decision to accept a job offer as they wanted to be part of a team that was improving. Regular staff meetings had taken place which showed all staff had the opportunity to discuss issues important to them and management had the opportunity to raise items important to the safe running of the service, including safeguarding, incidents and health and safety.

The senior care team acted as mentors to new staff. One new care worker said, "There's always someone to talk to or ask. The seniors and managers are very approachable and I've never felt out of my depth." Staff told us they felt able to raise concerns about a person's medical condition to the senior on shift and they would be listened to and taken seriously. They said this had improved recently and meant they had become more involved and acted better as a team.

We asked people and relatives, "How does the service ask your opinion?" One person said, "We have a couple of residents meetings organised by the residents. Staff attend, but it's led by the residents. I raised the question of agency staff, particularly during the night times. The manager said that they were taking steps to improve it and in the last few months there have been many fewer agency staff than last year."

Relatives confirmed, "They [people] have meetings quite regularly. The residents have a chairman for the residents meetings and he speaks for them"; "I came to the first meeting the new manager had and I was very impressed with her"; "Yes they have regular meetings. I have been to past Residents Meetings" and "There is a relatives meeting about every six weeks and there are always notices put up. If you can't attend, you can always get the minutes of the meeting". The Chef told us that they attended regular 'resident and relative' meetings to gain feedback on the quality of food and gain any suggestions for improvement.

The last inspection rating was displayed as legally required, both on the provider's website and in reception. Although we also saw older reports in reception too. The manager told us they would ensure this was rectified, including ensuring that when the new manager's registration came through their certificate was placed in reception too.