Akari Care Limited

Bridge View

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 March 2016 and was unannounced.

At our last inspection in April 2015, the safe, effective and well led areas required improvement, which meant the service, was overall rated as requiring improvement. At this inspection, we found that improvements had been made in all those areas, although we found additional issues that needed to be addressed in the 'safe' area.

Bridge View provides accommodation, nursing and personal care for up to 61 older adults. At the time of our inspection there were 40 people living at the service and made up of a mix of people, including those with more complex nursing care needs and those with a dementia related condition.

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 kitchen area of the service was found to be in a dirty condition, and although the rest of the service was clean and tidy we considered this to be a breach of the regulations.

People were protected from the risk of abuse because staff were aware of the processes they needed to follow and we were confident they would have no hesitation in reporting any concerns.

The provider ensured that there were adequate numbers of staff available to meet people's needs at all times by the use of a dependency tool and by close monitoring. Agency staff were currently being used, but the provider was in the process of recruiting to all vacant posts.

People received their prescribed medicines as required and the provider followed safe management practices. Although the medicines rooms were untidy this was in readiness for a new electronic system coming into use in the near future.

Staff had received adequate training (or were booked to receive) and had the knowledge and skills they required to do their job effectively. The provider had recruitment processes in place and practised these safely, although we have made a recommendation in this area.

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 to identify any risks associated with nutrition and hydration and had food they enjoyed.

People were supported to maintain good health because staff worked with other health and social care professionals when necessary.

Staff were kind and caring and knew people well. People were complimentary about the staff team and said they looked after them well. Relatives that we spoke with confirmed this.

People were cared for by staff who protected their privacy and dignity and who were encouraged to be as independent as possible.

The service was responsive because people and their relatives felt involved in the planning and review of their care and documentation had been put in place to support the recording of this action.

People had the opportunity to engage in group and individual social activities that they enjoyed and were supported to maintain relationships with their friends and relatives.

People were encouraged to offer feedback on the quality of the service and knew how to complain. The registered manager had dealt with the small number of complaints appropriately. We are currently reviewing information of concern which we have received about the location and are considering our enforcement options.

The provider had a wide-range of systems in place to assess and monitor the quality of the service and these worked well to identify shortfalls. The registered manager addressed any shortfalls found quickly.

Staff felt supported in their work and reported Bridge View to have an open and honest leadership culture at the service now.

People and their relatives knew the registered manager and thought she was 'nice'. Staff reported the registered manager to be approachable and responsive to their requests.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment. You can see what action we told the provider to take at the back of the full version of this report.

We also made two recommendation to the provider in relation to recruitment and staff induction.

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.

The kitchen area was found to be dirty, although other areas were clean and tidy.

People felt safe and were protected from the risk of abuse because staff were aware of the processes they needed to follow.

People were supported by enough members of staff to meet people's needs.

People received their prescribed medicines as required.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had received adequate training and had the knowledge and skills they required to do their job effectively. When a referral was needed to other healthcare professionals this was made.

The manager and staff were aware of the Mental Capacity Act (MCA) 2005 and of the Deprivation of Liberty Safeguards and they worked within legal guidelines.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration and they told us they enjoyed the food served.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and caring and comments made were all positive in relation to this.

People rights for privacy and dignity were protected and they were encouraged to be independent.

Is the service responsive?

Good

The service was responsive.

People and their relatives felt involved in the planning and review of their care, although records did not always confirm this.

People had the opportunity to engage in social activities that they enjoyed and maintained contact with friends and relatives.

People knew how to complain and any complaints made to the registered manager had been dealt with effectively. However, there is information of concern that we are looking into outside of the inspection process and will deal with this separately.

Is the service well-led?

Good

The service was well led.

People, relatives and staff reported the registered manager to be approachable.

The management team had suitable systems in place to assess and monitor the quality and safety of the service.

Staff felt supported in their work and reported Bridge View to now have an open and honest leadership culture.

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 unannounced inspection took place on 2 and 3 March 2016. The inspection was conducted by three adult social care inspectors and a Specialist Advisor. 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 clinical governance.

As part of the inspection process and before we visited the service, we looked at the information that we hold about the service. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We contacted the clinical commissioning group (CCG) and received positive feedback about a recent visit they had conducted. We contacted the local authority safeguarding and contract teams and asked their views about the service provided to people at Bridge View. We also contacted Healthwatch, and the local fire authority to gain their views. Contact was made with Northumbria Healthcare NHS Foundation Trust, infection prevention and control practitioner and also the food & health worker & nursing home training co-ordinator; both of whom cover this care home. All of their views supported the inspection process. On the day of the inspection we spoke with a continuing health nurse assessor from the Funded Care Nursing Team.

During our inspection, we had conversations with 12 people who lived at the service and spoke with another 12. We spoke with 14 relatives and 14 members of staff. Staff spoken with included, the registered manager, two nurses, the regional manager, two senior carers, the deputy manager, six care staff, an activity co-coordinator, one maintenance person, the cook and an administrator.

Some of the people who lived at the service had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called the Short Observational Framework for Inspection

(SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of nine people, to see how their care was planned. We looked at the medicine administration records as well as observing a medicine administration round. We looked at training records for staff and at eight staff files to look at recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, medicine administration audits, accidents and incident records and compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

Areas that required improvement at the last inspection were in connection with the management of medicines. We found that the new registered manager had acted upon these recommendations and addressed areas that required improvement.

When we visited the kitchen area in the early part of the morning, we found it to be unclean and not well organised. The stainless steel units and surrounding areas were all marked and looked as though they have been washed with a dirty cloth. The cookers were in need of cleaning as there was dried food and dirt underneath them. We looked in the storage areas. There was, what looked like, flour spilled on the floor of one pantry area. One pantry had a freezer which was dirty on the outside and when we opened the freezer we found that food was not stored carefully in any particular order and looked like packets had been 'piled in' on top of each other in an adhoc manner. When we returned in the afternoon, there was little evidence of change despite the fact that staff in charge were aware of our concerns. We spoke with the registered manager about this and she told us that she would look into the matter.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and their relatives confirmed these views. One person said, "I am as safe as houses." Another person said, "I feel totally safe here. The staff look after me well." One relative said, "Can I just say everything is the same today as it is any day. They haven't done anything different because you are here."

Staff had been trained in safeguarding procedures. Staff were able to explain how their safeguarding training would help them to identify any concerns over a person's safety and explained to us how they would report any concerns if the need ever arose in the future. Staff were able to tell us about the provider's whistleblowing policy and how they would use it. One member of care staff said, "Without a doubt I would use it if I needed to; I know it very well and it's always on display in the staffroom in case we need it." Another member of care staff said, "The new manager has really pushed the whistleblowing policy – we've all had to read it then sign to prove it. I know this manager wouldn't just ignore any such problems."

The registered manager and staff undertook regular checks within the service to ensure the environment was safe. A maintenance record was kept and we observed that the building, apart from the kitchen area, was clean and tidy and well maintained. We saw records that confirmed equipment checks were undertaken regularly, for example, wheelchairs and bedrails. We also noted that safety equipment within the service, such as fire extinguishers, were also checked regularly. Fire safety procedures were followed, including the completion of personal evacuations plans (PEEPs) and the use of an emergency bag in the reception area, which included devices (e.g.. torch) and information to support an evacuation of the building. PEEPs are documents which contain detailed personal information about each individual in the service and how they would need support in the event of an evacuation. For example, people who use wheelchairs.

We asked seven members of staff about the emergency procedures within the service. We found they had a consistent and detailed understanding. The registered manager had recently appointed two members of existing staff as fire wardens and staff had received a range of fire related training, including fire extinguisher training and training in the use of evacuation equipment. The local fire authority confirmed that at the last fire safety inspection the visit had been recorded as satisfactory. This all meant that the provider had put in place measures to protect people should an emergency occur and had contingency plans in place should people need to be evacuated.

Following a query raised about how often staff checked air mattresses, we asked four members of care staff about this. Air mattresses are more specialised mattresses to help people who are at risk of developing damage to the skin. We found a lack of consistency in staff responses, which meant we were not confident the provider had a robust procedure in place for the mattress checks. One member of care staff told us, "The previous team leader used to check them [air mattresses] but I'm not sure who does it now, maybe the maintenance manager when they do room checks." Another member of staff said, "I don't think anyone does it at the moment, I think they're getting someone new in to do the checks." We noted in the registered manager's 'to do' list that she provided us with, there was an entry indicating they were aware of mattress checks outstanding and that a staff member had been tasked to complete this from December 2015. Senior staff assured us that checks on air mattresses had been completed and that they would make sure all staff were aware of this.

During our general observations around the service, we saw that wardrobes were secured to the wall. This meant that people were protected from the risk of pulling the wardrobes over and hurting themselves.

Staff told us there was an open culture of incident reporting, which meant they could report accidents and incidents and be confident they would be investigated and acted upon. A member of care staff told us there was a particular focus on learning from falls and mobility-related accidents. We checked accident and incident records and found that were an accident had occurred; it had been recorded correctly and checked by the registered manager.

Records we looked at showed that people had risk assessments in their care files. These included moving and handling, falls, pressure care, medicines and nutritional risks. The risk assessments generally detailed what actions staff were to take to reduce any risks, for example, what equipment was to be used to help move people safely. We saw staff using moving and handling equipment safely and effectively during the inspection. Risk assessments were evaluated monthly and changes were made as necessary. The provider also had in place environmental risk assessments, which included risks around farm animals, which visited as part of activities for the service, moving and handling inanimate objects and workstations. This meant that the provider had considered risk and put measures in place to protect the people who lived at the service.

People we spoke with told us there was enough staff available to meet their needs. One person told us, "They are very helpful and usually quick to help." Another person said, "If I press my buzzer they usually come quite quickly." A third person told us, "I don't have to wait for help." Care staff thought there was normally enough staff to manage people's needs well, although one said, It can sometimes get busy, but its peaks and troughs. Overall, we have enough staff in my opinion." We noted that the service had relied on agency nurses for an extended period of time due to staff shortages. Care staff we spoke with told us agency nurses were "a part of the team" and said the registered manager had achieved consistency, with the same agency nurses working the same shifts regularly. We were able to confirm this from the staff rotas we checked. This meant care staff got to know them and the nurses built good relationships with people. The registered manager used a dependency tool to monitor the staffing levels at the service. During the

inspection we looked at staffing rota's for a period of four weeks and found suitable levels of staff on duty. During the inspection there were consistently suitable levels of staff on duty with a mix of skills. This meant people had enough support to meet their needs.

People we spoke with told us they received their medicines when they required it. We were told that all of the people who lived at the service required support to take their medicines.

We observed three medicines administration 'rounds' at the service. One completed by the nurse on duty and the other by a senior member of trained care staff. We found that correct procedures were followed, for example, staff checked the details of the medicines to ensure they were correct as prescribed; they checked the correct person was receiving them and also asked the person's permission to administer their medicines. Staff had received training in the administration of medicines and had also their competency checked by more senior staff. This meant that staff were trained and followed appropriate procedures and ensured people received the correct medicines at the right time.

When we visited the medicines rooms with nursing and senior staff, we found the rooms to be a little untidy. We noted that medicines awaiting disposal were not in a tamper proof box and were not locked within a cupboard within the medicines room. We spoke with staff about this and they told us they were busy sorting the room out for a new electronic system that was going to be used in the near future. Room temperatures were checked and storage facilities for all medicines were secure.

We saw the provider had a recruitment policy in place and staff had been recruited via a formal interview. We found each member of staff had an up to date Disclosure and Barring Service (DBS) check and at least two professional references. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). In most cases, staff had a third character reference and the provider had verified the identity of each member of staff using appropriate photo documentation. We noted, however, that not all of the interview records we checked had documentation recorded to show evidence that knowledge or competency had been checked. For example, one interview with a nurse had no record of how the interviewer had tested the clinical and leadership skills of the nurse, yet another nurse interview record showed that they had detailed checks of their competency and training, including their ability to provide catheter care, management of percutaneous endoscopic gastronomy (PEG) tubes and their phlebotomy skills.

- A catheter is a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid.
- 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.
- Phlebotomy is the practice of drawing blood from patients and taking the blood specimens to the laboratory to prepare for testing.

We recommend that the provider maintains consistency and follows best practice while conducting interviews with all staff.

The service was trialling a 'clean air' system. At various points throughout the service a device was placed which gave off a lemon grass smell. We were told it helped to neutralise odours and helped kill bacteria. A number of people thought it was a pleasant smell, but not everyone was in favour. One person told us, "It's too strong – it catches my throat." A staff member also commented that the odour it gave off was strong, particularly when the device had been refilled. We spoke with the manager about this device and asked if a risk assessment had been completed. She told us that they had not completed one, but would do one

straight away as this was fairly new.

Good

Is the service effective?

Our findings

Areas that required improvement at the last inspection were in connection with supervision of staff and particular elements of training. We found that the new registered manager had acted upon these recommendations and addressed areas that required improvement.

One relative told us that they were very happy with the care provided to their family member. They explained that since their relative moved into the service, they had put weight on and staff, with the help of other health care professionals had helped to heal an old wound until it disappeared.

Each member of staff had a recorded initial induction and probationary period, which had been signed off by a manager before they were able to work unsupervised. We saw the induction process included an introduction to basic rights, such as the right of people to privacy, dignity, choice and independence. Staff who had joined the service in the previous 12 months had been given an induction workbook. This was a detailed self-directed learning pack, which included the principles of care such as effective risk assessments and person-centred care. However, we found that this was not routinely checked by any line manager's.

We recommend that the provider follow best practice guidance in regard to staff induction and probationary processes.

Staff had received a range of training, both mandatory and specific, including dementia awareness, infection control, moving and handling, confidentiality, data protection and equality and diversity. One senior member of care staff told us, "The dementia training is great. It gives a bit more insight into the condition and it was really specific. We learnt about vascular dementia and Alzheimer's as well." All staff at the service, including those not in a care role, had undertaken dementia awareness training. This meant staff were skilled to support and communicate with people regardless of their main role and responsibilities.

Staff had been offered the opportunity to achieve higher qualifications, for example, housekeeping staff were encouraged to complete Level 3 diploma in housekeeping. This showed us there was a consistent and robust focus on ensuring staff had the support, training and tools they needed to provide an effective service.

We looked at clinical supervision for nurses and senior staff. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work, particularly with regard to nursing staff. We saw this included a number of performance-related checks. For example, during an observed medicines administration round; staff had been observed with regard to infection prevention and control procedures, correct use of Medicine Administration Records (MARs), the reporting of stock discrepancies, obtaining consent and providing support to people. Management explained that this process would be completed for all permanent nursing staff once they started work at the service.

Supervision and yearly appraisals were being completed with all staff. Where a change in policy had been

made or the registered manager wanted to alert all staff to an issue, supervisions included some general topics. Past topics had included the provider's code of conduct and instructions on how to accurately complete diet fortification charts. The new registered manager had begun a new system of scheduling and tracking supervisions and appraisals, with new rounds of appraisals beginning in April 2016. This ensured that all staff received support and developmental opportunities regularly.

Members of care staff had additional responsibilities to help meet the individual needs of people. For example, one member of care staff was the designated continence lead. This meant they were responsible for assessing people for incontinence pads, ordering stock and ensuring pads were used appropriately. We saw from looking at this individual's supervision record they had been supported to work effectively in this role.

We sat in on a well communicated morning shift handover and observed how staff passed information from one staff shift to another. All senior staff were present, including the registered manager. This meant staff coming on duty were fully updated with any pertinent issues before they started work and were aware of any concerns that they may have needed to address. A nurse assessor who was visiting the service told us "It's one of the better homes for information." They continued, "You get the same treatment whether you come announced or unannounced and staff are helpful."

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 were. There were 15 people where an application to the local authority had been made to deprive them of their liberty.

Staff we spoke with demonstrated a good knowledge 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 nurses conducted mental capacity assessments with care staff involved. They said this ensured that staff with good knowledge of each person was involved.

People were positive about the food that was prepared for them at the service. Comments included, "The food is beautiful, I enjoy it, probably too much"; "The food is quite good" and "The food is good, we enjoy it."

We observed positive interactions between people who lived at the service and the care staff during the lunch period. One member of care staff said, "Do you want more juice or do you want a cup of tea instead." Another member of staff said, "Can I cut your 'Yorkshire' up for you? Do you want to put the salt on yourself?" Another member of care staff supported one person who required help. To do so, they pulled up a chair and while holding the person's hand they gently assisted them to eat. People were not hurried and there were quiet conversations taking place.

Staff had undertaken nutrition and dietary training and understood how to provide additional support for people when they needed it. For example, we saw care records that instructed staff to fortify food using

honey, thickeners and supplements and this had been approved by a dietician. We saw this action being taken during our inspection with one person who needed to have thickeners added to their meals. One staff member helped a person who was on a pureed diet, to eat their meal. The weights of people were recorded. A total of 15 people had their weight monitored on a weekly basis and we noted both loss and gains were recorded. Full nutritional assessments were in the process of being updated after staff had received recent 'CHANT' training (Care Home and Nutrition Training) from staff at Northumbria Healthcare NHS Foundation Trust. The trainer said, "[Registered manager name] showed me the full nutritional assessments; I was very pleased as this was a vast improvement. Patient likes & dislikes were detailed, very extensive detailed action plans for patients. 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.

Relatives confirmed that their family members received cooked breakfasts if they so wished. One relative told us, "[Person's name] often has a cooked breakfast. They love it, but not always. If they want something different, it's never a problem." No menus were displayed in dining rooms, although there were facilities to do this. We spoke with the registered manager and she said that was not acceptable and would speak to the kitchen staff about this.

There was good evidence for the recording of fluid intake. This information was recorded on the fluid balance charts within the person's bedroom. Running totals of fluid intake was recorded in all records we reviewed, which meant that staff would be easily able to identify if people had not drunk the recommended daily amounts they needed as per their care plans and individual needs.

We looked at the records of people who were at significant risk of developing pressure areas and those that had current skin wounds. Pressure areas are skin injuries which can be caused by friction, humidity, temperature, continence, medication, age and unrelieved pressure. We also spoke with staff and to the people themselves where possible. Staff told us they checked for evidence of changes in people's skin when they supported people with routine turns in bed. We saw appropriate wound dressings were used as recommended by the tissue viability nurse and community matron and records confirmed this. The tissue viability nurse is a nurse from the NHS trust and the main role is the provision of expert advice in the prevention and the treatment of wounds. We did, however, find gaps in the wound dressing records of one person and we were therefore unclear whether their wound had been dressed as it should have been; although care staff assured us it had. We brought this to the attention of senior staff on duty, who said they would look into it.

People we spoke with told us they had access to doctors and other health and social care professionals. One person said, "I see the doctor regularly." A relative we spoke with told us, "[Person's name] often has a visit from the chiropodist and sometimes from their GP." Records we looked at confirmed that healthcare professionals were regular visitors to the service, including, GP's, occupational therapists, dieticians and community nurses.

The service had been adapted to suit the needs of people who lived there. This included adequate signage to support people living with dementia, wide doors for people who needed the use of a wheelchair and easy access into the garden area. This meant that the provider was responsive to the changing needs of individuals and made suitable changes to the building as necessary.

Good

Is the service caring?

Our findings

Everyone we spoke with was complimentary about the staff team. We saw two care staff waving to people who were looking out of their windows at the time, as they came to work for the morning shift. Comments from people who lived at the service included, "Staff do anything for you and they are very kind"; "There are some lovely people working in here. Very kind" and "I wouldn't live here if they [staff] didn't care – it would be horrible." Comments from relatives included, "They are always clean and happy. The lasses are lovely. They treat [person] well, they are very kind. There are all sorts going on. We have never found any faults or needed to complain. Everything is spotless"; "I ask every day if things are okay. [Person] always says yes"; "[care staff name] thinks the world of my [relative]" and "Carers are canny [nice], really nice staff." A visitor told us, "The staff are really nice with the clients."

We asked care staff about the care they provided. One said, "I'm most proud of how people look at us and recognise us. We're not strangers to them, they trust us and love living here. It is very clearly their home and we do everything we can to make sure this is always the case." Another staff member told us they got to know people by chatting with them whenever they could, such as during mobility support and during meals.

People told us that the staff made sure they were comfortable and not hungry. During our observations we saw a care assistant had brought one person a meal for lunch. The person said, "I don't want it." The staff member said, "Let's try it, I don't want you to go hungry. I'll leave it to see if you fancy it. If you don't I'll get you something different." The person still refused and did not want anything different. The staff member then said (in a caring and friendly manner), "Do you want some cake and custard. Will I give you a double helping?" This resulted in the person eating all of the dessert. We saw staff demonstrated kindness and familiarity to people, such as holding the hand of an anxious person until they were settled in a seat they liked during lunch time.

Kitchen staff visited the dining area after lunch and asked people if they had enjoyed their food. They knew people by their names and it appeared to be a normal occurrence. We saw staff were able to successfully comfort a person who had become agitated and seemed to understand each person's personality which made it easier for them to support people with their individual needs.

We saw staff had built positive, caring and compassionate relationships with people based on their likes and interests. For example, the maintenance person recognised one person liked to be involved in the day-to-day upkeep of the service to keep them busy and feel useful. As a result the person was able to be involved by carrying log books, checking tasks were signed off correctly and helping to check the standard of equipment cleaning.

One relative explained that their family member had been unwell in recent months and said that when they asked staff if they should bring in additional clothing items because of this, they were told that they did not need to as laundry staff would take care of any additional cleaning required.

There was not always the evidence in place to demonstrate that people and their relatives had been actively

involved in the development and evaluation of care plans. There were 'resident monthly involvement' sheets on people's care records which were new and had started in January 2016, but we saw no evidence of these being used. When we spoke with people and their families, they confirmed that they felt they had been involved. One person said, "They [staff] asked loads of questions when I moved in. I think my son helped with some things I had forgotten."

Information on a range of subjects was available in the reception area and throughout the service to help people. There was guidance on safeguarding, advocacy information, a service guide, dementia support and contact numbers for a range of support agencies and health care professionals. Staff told us that no one at the service was currently receiving support from an advocacy service, and one said, "If someone needed help, we would make sure they got it. Like anything else they needed." An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

People we spoke with told us that the staff promoted their independence. One person told us they went out every day to the local shops. They told us that when they returned they went into one of the dining rooms and made their own lunch. We observed this in action and noticed that staff observed at a distance and supported the person discreetly so as not to interfere with their independence.

People we spoke with said that the staff treated them with dignity and respect. One person said, "They [staff] always knock. It's good that." A relative told us, "They look after [person's name] well; always clean and tidy. They used to be a stickler for that, so I am sure it pleases them to be looked after the same here." Staff we spoke with were mindful of people's rights to have their privacy and dignity respected and we also saw that privacy and dignity care plans were in place for people. We, however, found one person who was overlooked by private houses on a nearby estate and on one occasion we saw their dignity was at risk. We spoke with the registered manager about this and they said they would look into this and discussed possibly getting some netting or other window cover for the person's room if they wanted it, and would speak with the family too.

End of life care was detailed with the necessary information recorded in a document entitled, "My end of life wishes." This document was well completed for those people we checked. One person passed away during the night. The staff did all they could to ensure that this person had a dignified death and was pain-free. There was good coordination with the person's GP, and the family were kept fully informed. One of the care staff supported the family with arrangements from a funeral director and this was done with respect, consideration and dignity. At all times, staff kept, not only the families feelings, but those of other people living at the service in mind; and tried to minimise any distress by whatever means they could. We noted that although staff had not all received end of life training, this was planned to take place in the next few months.

Good

Is the service responsive?

Our findings

One relative said that they often cleaned their family member's nails for them when they visited and continued, "But I know someone has done them in between." One person told us, "Nothing is any trouble to them [staff]. If I ask for something, they will do their best to get it. Cannot grumble at that can you?"

When a person came to live at the service, people and their families confirmed that staff spent time with them to discuss their needs and how they would like to be cared for. We asked a member of care staff about this. They said, "It works really well. We sit down with the person and their family and have a chat about what good care will look like for them. Then we start the process of getting to know them better." A person confirmed that they had been involved in their care planning process. A relative we spoke with confirmed that they were involved in the initial assessment and contributed to the care plans. They said, "When [person] first moved in, they asked us all about everything." These arrangements ensured people's individual needs were included in the care plans. People's care plans were tailored around their individual needs, including personal care, nutritional, wound care and medicines and included clear details for staff to follow. We also saw that care plans were regularly reviewed. This meant that people received personalised care that was responsive to their needs.

A number of people had complex needs and occasionally demonstrated this with behaviour which challenged staff. Staff knew how to respond well and were able to describe what they would do. For example, if a person was aggressive and it was not obvious why, staff would complete hourly checks of the person's mood and social interactions. Staff used this to try and identify triggers or causes of the aggression so they could prevent it in future. We saw this worked well in practice. For instance, staff had found they could calm one person if they sat and chatted with them about their family life whereas another person would become calm if staff withdrew and gave them some time alone. A member of care staff said, "I worked out one person in particular gets agitated if they feel disorientated or unsafe. I've had great results in calming them down and helping them relax, by reminding them where they are and reassuring them about how safe they are here." One of the nursing staff also confirmed that the service had very good links with the challenging behaviour service and often contacted them if they needed additional advice.

On the day of our inspection we saw the activity co-ordinator interacting with people throughout the day. There was an activity plan on notice boards and throughout the service, including in lifts (at wheelchair height) which listed a variety of events taking place.

We saw people reading, chatting in small groups in lounge areas, chatting with staff, watching television and listening to music. Two people were also singing along to karaoke type music and thoroughly enjoying themselves. One person told us the garden was 'nice' and they went out when the weather was good. Two people told us they used taxis to visit the local shopping centre. One person said they enjoyed the "Singers and baking sessions" held at the service. The relative of one person confirmed that people attended 'tea dances' away from the home regularly. Relatives told us that the activity coordinator was very good. One relative said, "She's amazing."

However, during the inspection, the majority of the activities took place on the ground floor and there was limited stimulation on the upper floor levels. We spoke with the registered manager about our findings and they said that this would be fully addressed when a new member of staff started soon, who would be working with the activity coordinator to provide a full programme of activities tailored to people who were living with dementia.

We found that people were supported to maintain personal relationships and social contact with their relatives and friends. Staff promoted lunch as a social occasion and asked each person where they wanted to sit, reminding them where they usually sat with their friends. We found staff were skilled in understanding when people would benefit from making new friends during, for example, lunch. We saw one person who had recently moved into the service and was confused. Staff supported their family to accompany them to the dining room at the start of the lunch service and then introduced them to people who would make them feel welcome. Relatives told us they were able to participate in the service's activities and felt included. One relative told us that they had a family Christmas lunch at the service which was "Lovely."

People had choice. One relative confirmed that their family member sometimes preferred not to join in activities and chose instead, to read the newspaper in their room. Another relative confirmed that their family member would stay in their room if they wanted to and at other times enjoyed sitting in the lounge watching out of the window. People had a choice of the gender of staff members who supported them with personal care, although we noted that male care staff were limited in numbers. The registered manager had organised shifts so that a male member of staff was normally on duty, however, this sometimes was not possible. One staff member said, "If there was a problem with a female doing personal care, we could always get someone from one of our other services – but we have always managed."

People we spoke with told us they knew how to complain. One relative said, "We've been very satisfied and have no complaints. There were a few little niggles at first but they were put right straight away." Care staff said they were able to resolve minor complaints or issues from people and visitors at the time they were made but these would always also be escalated to the manager as a matter of course. There had been a small number of written complaints and we saw that the registered manager had acted upon these appropriately and quickly and used the complaint as an opportunity to learn and improve the service. However, the provider overall had not acted in accordance with the complaints procedure fully and we are dealing with this matter separately.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. They had worked for the provider for a number of years and had originally been sent to the service as a temporary manager after the previous registered manager left. They told us during the inspection that it was their hope to stay on at the service for a long time.

Areas that required improvement at the last inspection were in connection with visibility of registered manager, audits and actions taken. We found that the registered manager had acted upon these recommendations and addressed areas that required improvement.

The new registered manager kept logs of all work outstanding and this was regularly updated, with any outstanding actions noted. We saw evidence of meetings that had taken place and actions were followed through. One healthcare professional told us, "I was impressed with [registered manager's name] attitude on what she would like to achieve with this home and what I had seen so far."

People and their relatives thought that the registered manager was approachable and likeable. One person said, "She does not just sit in there all day (as they pointed to the registered managers office), she comes out and speaks to us. She's nice." Another person told us, "(Registered manager's name) pop's in from time to time to check I am ok. If I wanted to see her, I just have to ask." Relatives we spoke with were complimentary about the registered manager. One said, "Canny [nice] lass. Always has a hello for you."

People we spoke with and records showed that the provider often asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One relative said that the registered manager was approachable and, "Held meetings every month and her door was always open." Another relative said there had been improvements since the new registered manager came to work at the service and said staff seemed more settled.

When we asked staff about the registered manager their responses were all positive. One staff member said, "There was a period of transition as we got used to a new manager. She's very fair but firm and has really improved the work that goes on here. Any of us can speak to her anytime, her door is always open." Another staff member said, "Our staff meetings are much more constructive with the new manager, I feel we get something out of them now." A third member of staff said, "[registered manager name] is lovely, open, always got time for us."

Staff told us they felt supported and were asked for their input as well as given constructive feedback on their work. For example, a senior care worker said, "We get asked if we're happy, if there's anything we'd like to change and if we'd like to arrange any extra training." This showed that the provider listened to staff and gave opportunities for them to support change within the service.

We found that there was a clear leadership structure in place within the service. Staff knew who to contact if they needed support and when the registered manager was not available (holiday etc.), staff knew who they should contact in an emergency.

We found the work culture fostered by the registered manager meant staff were supported to work towards professional development and promotion. For example, we spoke with a senior member of care staff who had recently been promoted. We found this member of staff had been provided with additional training, including medicine administration, to support them with their additional responsibilities. In another instance, we found a nurse who had been assigned shifts from an agency had worked very well with people and staff and had recently been employed as a permanent member of staff.

The provider had recently funded a new post at the service; that of a 'talk and listen support team' member. The registered manager confirmed that this person was going to work alongside the activity coordinator and their role was to establish a relationship with people who lived at the service and encourage them to talk about any issues that were important to them individually. The activity coordinator planned to swap their current role with the new post, which meant that during the recruitment period they would work at both roles and share their hours over the two. We spoke with the registered manager about this and they told us that this would not impact on activities because other staff would support in the short term.

During our inspection we looked at the systems and checks that the provider had in place to monitor the service. The medicine audits we checked had found errors which staff had made. For example; one staff member had not signed the medicine administration record of one person. Senior staff had investigated any issues and actions had taken place including retraining when needed and staff competency checks.

We looked at other audits in place, including those in connection with care plans, health and safety and finances. We found that any issues found had been dealt with. For example, in the care plan audits (which checked all sections) for one person; we found actions in connection with having the medicines risk assessment signed by the family, as it had not been. We noted that this action had been completed and the action marked to confirm this. In the hand hygiene audit we noted that staff had not all completed infection control training, but also noted the action that the training had been booked to take place. This was confirmed in the training plan for the service. This meant that the provider had systems and checks in place and they were used to help monitor the quality of the service and quickly address any issues found.

We looked at how accidents were monitored and analysed. The registered manager summarised these every month onto the provider's operational IT system. We saw that in December 2015, for example, there had been 14 accidents. These had been broken down into types, dates and times. There was evidence, that when an accident had occurred, learning had taken place and all actions that should have been taken, were. For example, one person had fallen. Observations had been put in place and from their records we saw that these had been completed, with notes of the person's improving health after the fall.

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.

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 did not take formal enforcement action at this stage. 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 The provider had risked the health of people who lived at the service by not ensuring the kitchen area was clean. Regulation 12 (2) (h)