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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The unannounced inspection took place on the evening 16 of May and carried on to 17 May 2017. We completed the inspection on 19 May which was announced. We last inspected Bridge view December 2016 and at that time found the provider was breaching regulations 12, 17 and 18 in relation to safe care and treatment, staffing and good governance.

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

Bridge View is spread over three floors, the ground and first floor providing nursing and residential care for up to 61 people, some of whom are living with dementia. At the time of our inspection there were 57 people living at the service.

The service had 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.

Staff knew how to report safeguarding concerns. However, we found that safeguarding systems and processes were not effectively followed by the registered manager and provider. Where staff disciplinary investigations had been undertaken, not all were robust enough to protect people fully.

People received a range of food and refreshments to choose from. We received mixed views on the quality. We found staff did not always follow people's dietary needs as they should have been, for example, for those who were diabetic or on soft diets. Information which had been provided to kitchen staff and care staff was at times contradictory. This meant people were at risk of receiving inappropriate food to meet their needs.

We found a number of places within the service which were malodourous, although the service was clean and tidy in other areas.

Medicines were available as prescribed and were stored, administered, recorded and disposed of in line with best practice.

Accidents and incidents were acted upon, recorded and monitored appropriately.

People felt safe and their relatives confirmed they thought their family member lived in a safe environment and had no concerns with this aspect of care.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). Staff followed the requirements

of the Mental Capacity Act 2005 (MCA) and DoLS.

People confirmed staff asked for their consent before embarking on any personal care and we heard examples of this during the inspection.

There were not enough staff in some parts of the service and the registered manager agreed and confirmed after the inspection that this had been immediately rectified.

The registered manager had procedures in place to ensure any staff recruited were suitable to work within the service. There was a training programme in place and staff development was monitored by the registered manager to ensure they had up to date knowledge and any training needs were met. The registered manager had procedures in place to ensure staff felt supported.

People told us they had access to health care professionals if they needed additional support. For example, GPs or community nurses.

During the inspection we heard positive interactions taking place between staff and people. However we did note two members of staff did not treat people in this way and this was dealt with promptly by the registered manager. We also considered practices we had found, including not following correct procedures was not conducive of a good caring service.

Care records were completed individually and regularly reviewed to ensure they met the person's individual needs. Although there had been improvements in record keeping, we found some shortfalls which needed to be addressed and have made a recommendation to the provider.

People were not always given suitable opportunities to participate in activities tailored to their individual needs, particularly those people who were living with dementia.

People had choice to decide what they wanted to do on a daily basis.

People and their relatives knew how to complain. They told us they were able to meet with the registered manager and staff at any time and were able to give feedback about the service.

The registered manager held meetings for people and their relatives and surveys were sent out which meant feedback could be given in a supportive environment.

The provider had systems in place to monitor the quality of the service provided and improvements had been made, but staff had not always followed procedures in line with the action plans they had sent us. We considered quality assurance systems were not robust as they had not found the issues we had during the inspection.

We found three breaches in relation to Regulation 13, 14 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safeguarding service users from abuse and improper treatment, meeting the nutritional and hydration needs of people and good governance.

We made two recommendations in connection with activities, particularly for those living with dementia and checks on mattresses.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Steps had been taken to protect people from the risk of abuse, however the registered manager had not followed their own processes fully.

Some parts of the service did not have enough staff to support people with their needs.

There were odours found in places within the service.

Medicines were being appropriately managed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always adequately supported to eat and drink.

Staff were trained to deliver safe and effective care at the service.

The provider met the requirements of the Mental Capacity Act 2005 to ensure that decisions about people's care and support were made in their best interests.

Is the service caring?

Requires Improvement

The service was not always caring.

People were consulted in relation to the delivery of their care but this was not always delivered to meet their needs in a caring way.

Staff treated people with kindness and compassion and encouraged them to maintain their independence wherever possible, although we observed this was not the case with two staff members.

People's privacy was respected at the service. Staff treated people with respect and understood people's individual needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans generally contained the detail required to ensure people's individual needs would be met, although we found some shortfalls.

An activities co-ordinator and 'talk and listen' staff member worked at the service to ensure people had access to a range of activities, although some improvements were required.

There were opportunities for people to express their views about how the service was run and there was a system in place to manage complaints.

Is the service well-led?

Inadequate

The service was not always well led.

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

The provider had a quality assurance programme in place and had put actions in place to address concerns identified, however staff had not always maintained the actions they should have followed.

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 inspection took place on 16, 17 and 19 May 2017. The first two days were unannounced. The inspection was carried out by two inspectors, two specialist advisors and two experts by experience. A specialist advisor is a person who specialises in a particular area of health and social care, for example medicines, moving and handling or quality assurance. One specialist advisor was a tissue viability nurse and the other was a nurse who specialised in nutrition. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Both of the experts had backgrounds of caring for older people.

We did not request a Provider Information Return (PIR) prior to the inspection, due to the prompt scheduling of the visit. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including all of the concerns we had received over the period of time since the last inspection. We checked the notifications we had received, including those for serious injuries, deaths and safeguarding incidents. Notifications are incidents or events which the provider is legally obliged to send the Commission.

We contacted the local authority contracts and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used any comments to support our planning of the inspection.

On the day of our inspection we spoke with a community nurse who was visiting the service.

During this inspection we carried out two lengthy 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 spoke with 29 people who used the service and 15 family members or friends. We also spoke with the registered manager, deputy manager, four nurses, the administrator, two bank nurses, three senior care staff, the 'talk and listen' staff member, the activities coordinator, eight care staff, the housekeeper, one domestic, the chef, a kitchen assistant and the regional manager who called in. We observed how staff interacted with people and looked at a range of records which included the care and medicine records for 15 people. We checked six staff personnel files and viewed a range of documents related to the management of the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found a breach of regulation 12 in relation to concerns with incomplete or missing risk assessments, thickeners were not always stored appropriately and mattress checks were not completed. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. Following our inspection, the provider sent us regular action plans of how they were addressing these concerns.

At this inspection we found improvements had been made. Thickeners were in the control of the nurses or senior staff in charge and no containers were left unsecured as we had found at the last inspection. We saw that once staff had used them they were taken back to the medicines rooms and stored securely. Mattress were checked on a daily basis, although we found a number were the settings were not correct. Risk assessments were completed and in place on people's records.

We did, however, find further areas which needed to be addressed.

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

This was a breach of Regulation 13 Relating to safeguarding service users from abuse and improper treatment.

Staff had an understanding of safeguarding procedures, including how to protect people from harm and assured us they knew what to do if they suspected any harm was occurring and how to report it. We confirmed training was up to date. The provider had safeguarding and whistleblowing policies and procedures in place for staff to use should the need arise. The registered manager had dealt with safeguarding concerns, although evidence to support actions taken was not always in place, including investigatory records.

People's records confirmed that consideration had been given to the daily risks which people faced and appropriate risk assessments were put in place. For example, people who were at risk of falls had detailed risk assessments on record and overall staff knew what actions to take to follow these, although we found some areas where risk assessments were not followed.

Staff were aware of the need to assess people to help prevent pressure ulcers. Pressure ulcers are skin injuries which can be caused by, for example, friction, humidity, temperature, continence, medication, shearing forces, age and unrelieved pressure. We checked 19 mattresses and records were in place to show that regular daily checks were now being completed and signed off by senior staff at the end of their shift. However, we found four mattresses where the settings were not as recommended in line with the person's weight and two people who had no mattress recording sheets in place in their rooms. We raised this with staff and this was immediately addressed. Following our feedback the registered manager told us they had reinforced with staff the need to check mattresses on a daily basis.

We recommend that the provider review procedures in connection with mattress checks.

We found that a code to the front door was on display outside of the building, which meant visitors could gain access to the service without staff attending. This was particularly unsafe between the hours of 8pm and 9pm when less staff were present. Staff told us the main door was locked at 9pm so no one could gain access to the building without permission of staff. We confirmed there had been no incidents in connection with this. We raised this issue with the registered manager and with the regional manager. The code to the outer door was removed immediately and we were told the code was changed.

People, and their relatives confirmed, that they felt safe living at the service. Comments included, "I have no concerns, in fact it's just the opposite" and "Everything is fine here, the ladies [care staff] on the whole are very nice." One visitor stated, "I think he is quite happy."

At the previous inspection we had not found any issues with odours within the service. However, at this inspection we found the first floor was malodourous in places. For example, we found the lounge carpet to be stained and a number of carpets within people's bedrooms to be stained too. Other areas in the service were clean and tidy. We spoke with the housekeeper about deep cleaning and she explained how this process occurred and showed us how it was documented. We noted that due to sickness and staffing issues that some of the work that would have been normally carried out had not been. We discussed this with the housekeeper and the registered manager who told us that this would be addressed.

All of the communal shower rooms and toilets were clean, well-stocked with hand gel and hand towels and in a good state of repair. Waste bins in these areas were clean with bin liners were in place. We saw staff following appropriate hand hygiene procedures throughout the inspection. Although the areas were clean, we noted that some people's ensuites were cluttered with piles of sealed incontinence pads and toiletries, making it difficult for staff to keep clean. During the inspection we brought this to the attention of the registered manager, who said they would look at storage.

People's medicines were in stock as prescribed and any issues arising from non-delivery was addressed by senior staff at the service and monitored by the registered manager. We found the storage, administration; disposal and management of medicines were all in line with best practice. One person told us, "I get my water tablets at 7am, I like to do this, I go a lot to the toilet in the morning and it is sorted by dinner time. They bring my tablet at 7am the right time." Another person said, "I get my medicine on time. The staff are very good." Prior to the inspection we had received concerns that medicines were left unattended. We found no evidence to suggest this was the case.

People told us they felt safe living at Bridge View. They told us not only did they feel safe but felt their personal belongings were safe too.

The service continued to have emergency evacuation plans in place and to monitor accidents and incidents.

On the first day of inspection we visited the service during the night shift. We found that on the first floor of the service there were not enough staff to meet the needs of the people living at the service fully. During the night shift, we found staff were extremely busy at particular times and the following day we saw people still in night ware as lunch time approached. Mixed comments from people included, "Staff come in (to see person) all the time, I don't need to use my buzzer"; "No, it takes a bit of time (for staff to come)"; "Sometimes they take ages and ages"; "You have to wait a while about ten minutes in a morning. It is alright at night time" and "Not always quick, if they are doing dinners, they come as soon as they can." One person told us, "Last night they [care staff] wouldn't let me get out of bed. This morning I wanted to get up. In the morning I banged on the table and the window, nobody came so I went back to sleep. I have not got my clothes on (yet)." This was at 10.26am.

Relatives told us, "I don't know why she is still in bed, she is normally sitting in the chair, and dressed"; "There always seem to be carers around"; "I have had to go and find someone when she [person] wanted the toilet"; "I think there are enough staff around"; "I think she has to wait quite a bit. I have been here at lunch time when she has asked to go to the toilet and I have seen her wait twenty minutes." One relative told us, "You can sit here and not see one staff member for some time. Don't think it's their [staff] fault…just don't think there is enough." They also said, "We have pulled the buzzer before to get [person] sorted out for bed…and waited longer than we should really."

Staff confirmed that they felt there was not enough staff. Comments included, "It's really busy at times…we do our best, but it can be too much sometimes."; "The staffing isn't adequate. [We] Can't talk to anyone. Buzzers are going off all the time. Trying to do personal care, but that takes two of us, which means there is no one around for anyone else" and "It feels understaffed at the moment. It's stressful." We completed an observation for over an hour during the day and watched as one person who was sitting in the upper level lounge area was not approached by any members of staff to check their wellbeing.

The registered manager told us staffing levels were based on people's changing needs and that a dependency tool was used to calculate staffing levels. We were made aware that changes to the layout of the upper levels, including the move of one person to a different room had just taken place and this had caused some additional work to the staff team and had clearly impacted on overall capacity. After we had completed the inspection, the registered manager told us that the provider had confirmed staffing levels were to be increased to suitable levels, and said additional staff were to be deployed immediately. We concluded that concerns raised regarding staffing levels should have been found by the provider during quality assurance checks and that tools used to monitor staffing levels had not verified sufficient staff were on duty. This is being dealt with in the well led domain.

As we found with our previous inspection, the provider continued to operate safe recruitment processes including checking nursing PIN's regularly. All nurses who practice in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identification number called a PIN. The provider had recently reviewed the way that new staff were recruited which meant tighter control measures were in place to improve the whole process, including much of the information being dealt with centrally at the providers head office.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found a breach of regulation 18 in relation to concerns with the induction of new staff.

Following our inspection, the provider sent us regular action plans of how they were addressing these concerns. Improvements had been made and staff now received appropriate induction.

We did, however, find further areas which needed to be addressed.

During lunch time we observed staff on the ground floor were attentive, patient and offered appropriate support to people. We overhead comments such as, "Do you need some help cutting your meat up?"; "Do you want some more to drink…To wash your food down?" and "Can you try to eat a little more for us, you have not eaten much yet."

Food at lunch time looked and smelled appetising in the downstairs dining room. Staff were aware of the dietary needs and personal preferences of people. For example, those who were diabetic and ensuring their meals were appropriate to them. Kitchen staff came into the dining rooms to check the food was adequate and sufficient.

However, the upstairs meal time was a different experience. We saw that one dining area on the first floor was used for people to sit and have their meals served, with the other used to provide a base for supporting people with meals in their own bedrooms. Staff were not organised and it felt chaotic, with staff giving us three explanations about which people were having meals in their room and which were having meals in the dining area. We saw a member of domestic staff had been asked to support one person in their bedroom. This person was on a special diet. The staff member had not received training in how to safely support the person and could have put the person at risk of choking. There were no menus or juice available at the tables, with refreshments served later. We saw a member of care staff served a person a slice of meat with their fingers without wearing gloves. One member of care staff was unable to identify the diabetic custard on the food trolley when we asked them.

In some cases people's records did not have up to date information on their dietary needs, for example, one person who was diagnosed as diabetic had no mention of this in their care records, although nursing staff knew they were diabetic and completed blood sugar checks regularly. However, the nurse had to contact the GP to confirm this diagnosis was correct, which it was. The nurse could not understand why there was no information on their care records.

At the last inspection the four weekly menus were in the kitchen but not displayed in the dining rooms for people, staff and relatives to see, this continued. When we visited the kitchen area we found that the records held were not up to date, with people who were diabetic not being included on their lists. The information in the dining areas did not correlate with that held in the kitchen.

Prior to the inspection, concerns had been raised with us which stated people were being provided with inappropriate food. On our first day of inspection we arrived in time to see supper preparations. We observed snacks being distributed to people on the upper levels of the service. The snacks included a selection of freshly made sandwiches, cakes, scones, crackers and cheese with some people preferring toast and or cereal. As we observed we saw one member of care staff ask one person whom we had confirmed was on a special diet, what they wanted. We heard the staff member confirm that they wanted a selection. We then witnessed the staff member preparing crackers and cheese and other items. We stopped them and said this person was at risk of choking and on a special diet. The person then received the correct items of food choice. Correct information about this person was on the dining room notice board so this incident should not have occurred.

Food and fluids were monitored to check the intake of those people at risk of malnutrition or dehydration. The monitoring tools used, meant staff could closely observe and quickly identify any changes in nutritional or hydration needs or in a person's condition. However, we noted that fluid target levels were not based on people's individual needs, but were the same for all people using fluid charts. This meant those people with a larger body mass may be at risk of dehydration as they had the same set of targets as someone of a smaller frame.

We raised these issues with the registered manager who confirmed they would look into the issues regarding food and fluids.

This is a breach of Regulation 14 which is in relation to meeting nutritional and hydration needs.

Prior to the inspection we received concerns that people were losing weight unnecessarily. We checked people's weight records and found this not to be the case. All the relatives we spoke with confirmed this not to be true and one said, "If anything, they have put weight on." Other relatives said, "She has put weight on since she has been here"; "She has put a little bit of weight on. They are checking her hydration levels and try and encourage her to drink juice rather than pop." We observed a jug with juice and a glass on this person's table.

We observed tea trolleys both in the morning and the afternoon. There was a wide selection of drinks and snacks including, juice, tea, coffee and water and a variety of biscuits, sliced fruit and crisps. We received mixed views on the food made by staff at the service. Comments included, "The choice of food is good, I get enough"; The food is reasonable, you get choices"; "They know that they need to check (if the food is ok for the person as they require a special diet)"; "Its (food) alright, very nice meals and I have a choice"; "It is very basic they ask what we want, sometimes they ask what you want but it's not always on board (trolley to choose)"; "Some is alright, but it is the quality of the food. We get sausage roll or a thin burger, I don't like the mince and in the roast dinner the meat is tough. I don't eat the meat, We get a lot of mince"; "It is not up to scratch, the quality of the food" and "It's not bad, I like Shreddies and I get them, I have mashed banana." We brought these comments to the attention of the registered manager who said they would discuss with kitchen staff.

People told us they felt staff were well trained to support their needs. One person told us, "Staff know exactly what they are doing; they are very good." One relative told us, "She used to be upstairs now she has moved downstairs as she has improved (health)."

Relatives felt that communication was good between them and the staff team. One relative told us, "They are good at contacting one of us if they have any issues, and they keep us informed when we visit." Another relative told us, "Anything at all and they [care staff] are on the phone." A community nurse thought that

communication was also good and said, "I am not in here very often, though it is pretty good. Sometimes the staff seem a bit thin on the ground, but the staff are good and instructions from the community nurse teams are well taken be the staff."

We watched one nurse as she explained to a newly appointed staff member, how to support someone appropriately with mobility needs. Induction had been planned and was in line with the Care Certificate. One recently appointed member of care staff told us, "My moving and handling training is scheduled for some time this month. But [registered manager's name] sent me to another home where a trainer showed me how to do it. I don't do it by myself. I'm always part of a double up." Another staff member told us, "I sat down with [registered manager], and went through the induction book and read the policies and procedures." Training was either up to date or had been planned for the coming weeks.

Staff told us they felt supported and had received regular supervision and appraisal from their line managers. Supervision is where a meeting occurs between a staff member and their supervisor and is an opportunity to discuss, for example, any day to day issues arising or look at areas of support required by the staff member. Yearly appraisals form another part of a staff members work performance and give both parties (employer and employee) a chance to sum up the work year, set goals and review staff development opportunities.

We looked at the care records of one particular person who had several skin wounds. The records were well written, comprehensive and had been regularly reviewed at appropriate intervals. The dressings were suitable and there was evidence in their healthcare record that the Community Matron had also reviewed their wounds.

We heard consent being requested before particular actions were undertaken, for example, personal care or supporting people with moving and handling.

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. They continued to work within the framework and had applied for DoLS authorisations appropriately.

People we spoke with told us they had access to health care professionals, such as, opticians, dentists, GP's and chiropodists. There was evidence of people being reviewed by the community matron when their input was needed and reviews of care by GP's had been completed. One nurse told us, "The community matron comes once weekly at least and we ask her advice if we need it to help manage the residents' health needs." People's health and wellbeing was monitored and staff responded when their needs changed. For example, we observed staff making telephone calls to people's GP's and in connection with hospital appointments to ensure they were informed of changes to people's health and to gain advice on how best to meet people's needs when appointments needed to be altered.

Handovers were completed when staff shift changes occurred to ensure that all staff were aware of people's current care needs and had up to date information of any issues which needed to be addressed. One bank

nurse told us, "I get a handover when I come in, as sometimes I don't start at the same time as others, the carers are fabulous." This meant staff coming on duty were updated with any issues before they started their shift.

The service had a small outdoor area which was well maintained and fully accessible with paved areas, seating, tables, bird feeders, and raised flower containers. People's bedrooms were light and airy. There were quiet rooms available for people to go into when they wanted. The provider was in the process of changing the layout of the first floor and adopting one section to be for people who were living with dementia. The activities coordinator who was responsible for the first floor in the home told us that they needed to make modifications to this area to make it more "dementia friendly". They gave us some ideas they had and said that this would happen once the full changes to the layout had been completed. Bedroom doors displayed the names of the person who lived there and their photograph and door number. Signage was also apparent on toilet and bathroom doors to help people orientate around the building.

Requires Improvement

Is the service caring?

Our findings

One person's care plan advised a slide sheet must be used when the staff moved them. Sliding sheets are designed for sliding transfers and repositioning. They are made of very low friction material, which when placed on top of one another become very slippery. Placed underneath a person they enable staff to move and reposition people easily. Moving people without the use of a slide sheet puts that person at risk of shear forces on the skin that could contribute towards skin damage. We asked the person if a slide sheet was always used to reposition them. They told us, "They use it occasionally, if they can find it. Usually they just use my sheet to move me on". We saw there was a slide sheet available in the person's room. We found no evidence that staff had caused any skin damage to this person.

We recommend the provider ensures that staff follow agreed procedures and follow best practice guidelines.

During part of our inspection we witnessed inappropriate behaviours taking place between two members of care staff and two people who lived at the service. We brought this to the attention of the registered manager and were told on the second day of inspection that one particular member of care staff no longer worked at the service and the other was being monitored.

Other interactions with people by care staff proved to be positive and caring. Staff, including management, nurses, care staff, and other personnel within the home showed kindness and compassion to the people they looked after. People told us, "I moved here from a different care home, around Christmas time. This is a much better home than the last one I was at"; "The staff here are nice"; "There is nothing I don't like. All the staff are nice"; "I find the staff very friendly. I can have banter with them. I feel free to have conversations, I can be jokey with them" and "Yes they are nice and we have a bit of a laugh."

A number of staff indicated that people were woken around 5am and washed and clothed ready for day shift to arrive. One member of care staff told us about one person, "We will get her up early. Our last round of checks are at 5am and after that we'll start getting people washed, dressed and up, or washed, dressed and back to bed depending on what they want. We try and do as many as we can before the day shift start." When we asked "Do day staff expect people to be woken at 5am", Another member of care staff told us, "Definitely…there would be hell on if people weren't dressed when they started. I don't think we should be doing it, would you like a flannel in your face at that time of the morning." Other staff spoken with denied that people were woken at 5am. When we spoke with the registered manager and deputy manager about this they both said, "That should not happen." We spoke with the local authority commissioners for the service. They told us that they had completed an early morning call at the service recently and found no evidence to suggest people were woken up earlier than they liked or earlier than was indicated in their care plans. The registered manager said she was going to speak with night staff and discuss this concern in the daily handover. We also discussed this with the registered provider who gave us their assurances that this would be addressed to ensure if it was happening it would be stopped immediately. Before the report was finalised, the registered provider confirmed that they had visited the service early morning and found people still asleep and only those awake who wanted to be.

Relatives told us, "They [care staff] seem very good. They are good with [person]. The staff keep me informed; told me when they called the out of hours doctor and the nurses get in touch"; "I feel calm when I leave here because I know she is looked after"; "Staff deal with issues affecting person], and always inform me when I visit" and "He came here 18 months ago and he has been looked after. They gave him a lovely party last year for his birthday. The staff have made an effort to get to know him."

People's privacy and dignity was maintained. Comments from people and their relatives included, "Definitely no concerns (with dignity)"; "No worries on that score" and "I have never seen anything but (dignity and privacy given)." We observed staff knocking on people's doors before entering and when staff were about to provide personal care to people, we saw doors being closed to ensure people's privacy was maintained. People were well groomed, for example, dressed with clean clothes, shaved and with clean and cut nails. One staff member said, "Their [person] family told us they always like to look smart, so we make sure they are…it's important we do that." We observed at meal times that people were given the option whether they would like to wear a clothes protector placed on them to help keep them clean.

Staff were knowledgeable about the people in their care and appreciated the needs of people were different. One staff member described how one person enjoyed reading while another enjoyed music. They said, "Some people like to sit quietly and just watch TV in their rooms, while others like company and enjoy a chat with us."

One person who lived at the service required staff to turn them in their bed as they were unable to perform this task fully. We saw that staff had respected the person's wishes. There was evidence of the person refusing to be turned on some occasions, indicating staff involving the person in their care and respecting their wishes. At these times we saw recorded that staff had encouraged the person to move themselves where possible.

People told us that their relatives could visit at any time and their relatives confirmed this. One person told us, "My son comes from time to time and has to come when he arrives as he lives away…they have never been stopped from coming even when it has been a bit later." A relative told us, "I come sometimes at night… it's never been a problem. I can make a cup of tea if I want…yes, its fine."

We were not made aware of any person currently using the services of an advocate. Most people had relatives who could support them with decisions, however, staff were aware, and information was available to people who may have needed additional support from this type of service. An advocacy service ensures that vulnerable people have their views and wishes considered when decisions were being made about their lives.

One person was at the end of their life. All relevant documentation was up to date and accurate and the person looked comfortable. End of life care training had been undertaken by some staff and understanding was evident with senior staff we spoke with. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and Emergency Health Care Plan (EHCP) with family and GP input were evident and available input from palliative care team was seen. A DNACPR is a decision made to not perform resuscitation on a person should their heart stop beating and is signed off by a suitably qualified healthcare professional. An EHCP is a document that is planned and completed in collaboration with people and their GP to anticipate any emergency health problems, including with possible admission to hospital.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found a breach of regulation 17 in relation to concerns with records.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns. Improvements had been made, however, further areas needed to be addressed and we found continuing breaches of regulation 17 which will be dealt with in the well led domain.

An activities coordinator was in post and also a 'talk and listen' staff member. A talk and listen staff member was a new post brought in by the registered provider on a trial basis. The role was to welcome people who were new to the service and help them to resolve any issues on admission. Their role at Bridge View also included involvement with activities. On the morning of the inspection there was a Dementia Café taking place in one of the downstairs dining rooms. We observed a member of care staff approach one person and invite them to the event. Later we saw the event was well attended.

One relative told us that the activities coordinator had installed a colour changing table lamp to try and stimulate one person. Another relative said, "The two girls [activity staff] try to keep everyone entertained. It's a hard job, but they try their best."

During this inspection we found limited activities taking place on the first floor, particularly for those people living with dementia.

During the inspection we found a number of people of people living with dementia sitting unattended for long periods of time without any form of interaction, including one person who was left sitting in a lounge area with no contact for over an hour. There were some board games and magazines which had been left out for people to look at but we saw no staff member utilising these with individuals in a meaningful way. For example, using the pictures to discuss past holidays etc. We spoke with the activity coordinator and although they had some ideas, we felt that these needed to be expanded on. We discussed this issue with the registered manager and asked that she address the shortfall.

We recommend the provider review their activities programme for the first floor, particularly in relation to people who are living with dementia.

A nurse told us detailed assessments were completed prior to admission, to confirm the service could meet the needs of the person and ensure that the care provided for others was not compromised, through an inappropriate admission.

Care plans were in place which aimed to meet people's health, emotional, social and physical needs. They gave staff specific information about how people's care needs were to be met, instructions for the frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. Care plans were regularly reviewed and relevant changes added where it was identified a change in need had occurred.

Pressure ulcers heal only if appropriate care is given and we saw that pressure ulcer care was good. Pressure ulcers are skin injuries which can be caused by unrelieved pressure or shearing forces. Factors which are considered contributory to an individual developing a pressure ulcer include friction, humidity, temperature, incontinence, medication, age, and malnourishment. One person was at very high risk of developing pressure ulcers and we found they had no wounds. Their Waterlow score was completed and reviewed appropriately and correctly. This type of risk assessment gives a Waterlow score which estimates the risk of a person developing a pressure sore. The person had specific risk assessment in place for pressure ulceration which had been regularly and recently evaluated and a comprehensive person centred care plan was available to support staff.

We found on occasions people had not always been repositioned as often as their records stated, for example, two hourly. This is particularly important for people at high risk of skin damage. However we found no evidence to suggest that this had been detrimental to people who lived at the service. We saw that one person's care plan indicated they needed to be repositioned every two hours when in fact this was not the case as they could move themselves. When we asked the nurse in charge why they did not have a positional chart in their bedroom, the nurse said they could turn themselves. The nurse in charge was very knowledgeable about the 'reposition' requirements of the people they cared for. We raised this issue with the registered manager who said that the care records would be updated to reflect the person's needs.

A wound assessment record should be completed for each separate wound and updated at each dressing change for people, as this record includes the size of the wound. Tracking the wound size allows staff to determine improvements or deterioration. Not completing this record makes it more difficult to assess. One person did not have a wound assessment and dressing record sheet for a particular wound, however there was evidence of their wounds being reviewed and dressed by the community matron. We spoke with senior staff on duty and they told us they would update this person's record.

Although considerable improvements had been made since the last inspection these issues had not been uncovered through the providers quality monitoring checks and we will deal with this in the well led domain.

Body mapping was used extensively on people who had wounds. Body maps are pictorial documents used in conjunction with written information to record the location, size and number of injuries which may have occurred. Body maps allow accurate 'at-a-glance' documentation of skin damage. It is considered good practice to document wounds on admission or discharge and having body maps in people's care records allowed care staff to identify which residents had wounds.

Concerns received indicated that people were not able to have baths or showers. People we spoke with told us, "I have a wash in the toilet (en-suite) every morning, they [care staff] give me a wash"; "Yes, a regular bath twice a week, I choose to have a bath"; "I have a bath once a week, this is plenty for me" and "I have one when I want one, twice a week." One person told us, "I wash myself every day. At home I had one (bath/shower) every day, they don't have time here. I would like one more often. I need someone there to keep me safe." When we asked the person if they had raised this issue with staff they said they had not. We brought this to the attention of senior staff. One relative told us, "I am quite happy with the care, she is fed and bathed regularly even though she can be difficult."

People and relatives told us they were involved in the care planning process. Information was used by staff to finalise care plans to enable them to meet people's individual needs appropriately.

People had choice in how they had their bedrooms and what they wanted to do on a day to day basis.

People told us their bedrooms were decorated how they liked. One person told us, "It's my home now and I wanted to have pictures and things around me." The hair dressing salon in the service was open during the inspection and we saw it was in use. We observed two people using the facility. We complimented one person who had had their hair cut and they said, "Thank you, it's nice having your hair done…makes you feel better."

There was a complaints procedures in place with four complaints having been received since the last inspection. Complaints had been handled well with immediate responses and evidence of investigations, witness statements and letters to complainants showing empathy in place. We were satisfied that all complaints were taken seriously and dealt with effectively.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found a breach of regulation 17, good governance and in relation to audits in place and record keeping. Following our inspection, the provider sent us regular action plans of how they were addressing these concerns.

At this inspection we found a continuing breach of Regulation 17 in relation to good governance.

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

We found the provider did not have enough staff on duty on the first floor of the service, despite completing regular staffing level tools used to calculate the number of staff required. Sporadic night checks had been completed but had not found the concerns we found during the inspection.

Concerns were found in the way in which investigations had been carried out and the lack of care taken with storage of pertinent records. Not all checks which were meant to be carried out had been, including mattress checks and repositioning checks. Although improvement had been made in record keeping we continued to find missing information, including for example food and fluid charts and repositioning records.

People may not have received the correct food and hydration because information available to staff was not always up to date. At the previous inspection we had received mixed views on the quality of the food made available with no menus displayed at times, and this continued to be the case. We also found people who lived on the first floor received a poor meal time experience at times.

We found a code to gain entry to the service had been placed on the outer of the building and although there had been no issues in connection with this, the provider and registered manager had allowed this to carry on without recognising the potential risks to people at particular times of day, especially between the hours of 8pm until 9pm when a reduced night shift were on duty.

During the inspection we confirmed that the provider had sent us notifications which they are required to do under their registration, although a small number had been sent late. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

These issues had either not been found or not been addressed through quality assurance checks completed.

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

At the time of the inspection there was a registered manager in post with a background in nursing and social care. They had worked for the provider for a number of years and been at this particular service for two years. During the inspection the registered manager was available throughout and supported the process as much as possible.

The registered manager knew which people had wounds as all information on new wounds was related to her on a daily manager's report and via morning handovers, which she attended. This meant that close monitoring of wounds, including pressure damage was monitored for fluctuations and increasing numbers.

People and relatives that knew the registered manager spoke positively about her and said she had aimed to get to know people and be available when needed. We were present when a conversation took place between the registered manager and a relative, and it was clear that the registered manager knew the family and the person living at the service well.

All the people and relatives spoken with considered the managers approachable, told us she listened to them and would feel comfortable to raise any concerns if necessary. People told us, "The manager is approachable. The deputy manager is always in the office (meaning available)"; "I know the deputy manager she is really nice"; "I have not had a need to speak to them, but I would if necessary"; "I am happy go to her [registered manager], She says 'good morning' to me when she passes" and "Yes I had a word with her [registered manager] this morning, and [deputy manager's name] is fine too."

Relatives told us, "Yes the deputy manager talks to me"; "No I don't know them but my other family members may know them" ;"I speak to them both [registered and deputy managers] they are very nice. I feel I can approach them" ;"I think she is a good manager [registered manager], she is very supportive"; "I have sat in her [registered manager] office and cried and she took time to explain things to me"; "She [registered manager] is approachable, pleasant and kind, if I ask for anything she always writes it down and deals with it" and "She [registered manager] has told me how to deal with the problems of dementia." One bank nurse told us, "I do a few shifts a week here, I have had good support from the manager, and I have no issues with any of the staff."

We spoke with a large number of staff. There was a split between the staff team when we asked them their views on the registered manager at the service. The majority said she was approachable, kind and caring while a small number of others said she was "abrupt", "shouted" and talked down to staff and "made them feel like a child". One staff member said, "The manager is very unapproachable, I'd go as far as to say I am scared of her." While another staff member told us, "[Registered manager's name] is fine…I don't know what all this is about, but I can honestly say that she has been very good to me and I have only seen her a bit upset when others are slacking." Within minutes of a staff meeting, which was labelled a group supervision it stated, "Stop talking over people, stop calling people 'doubles' or 'singles' on the basis of how much support they need. Stop back answering senior staff if asked to do anything." And then "You will be told if you do wrong and I expect you to put it right and not do it again. I will shout if you continue not to listen." We spoke with the registered manager about some of the comments and she acknowledged that she had, at times, raised her voice to some staff. She recognised that was not appropriate, but said she had been frustrated at staff not following instructions when caring for people.

Staff values, their motivation, and their personal goals are essential to creating a positive and successful working environment. We felt the staff culture had been damaged due to the underlying atmosphere within the staffing team which had been brought about by a range of issues, but mostly due to continuing anonymous concerns received which staff were aware of. One staff member commented, "Don't get why people work in care if they don't care. It's not abusive, but you can just tell they don't really care." We had

received a large number of anonymous concerns from alleged staff members and we noted that much of the content was identical in nature.

Prior to the inspection we received a number of concerns. We investigated all of the concerns we had received and could not find any evidence in some cases. We were already aware of some issues due to safeguarding concerns having already been raised by the registered manager.

The registered provider's representatives gave us assurances that all issues we have found will be dealt with quickly and they aimed to improve staff morale across the service. There was a new regional manager who had been recently appointed.

Meetings for people and their relatives took place. The registered manager confirmed that communication was maintained with relatives on a regular basis via the talk and listen staff member. The last meeting in April was attended by two relatives with no concerns raised. Surveys continued to be sent out to people and their relatives with action being taken where appropriate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding systems and processes were not effectively operated. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always being effectively met. Regulation 14 (1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had quality assurances in place but these were not operated effectively. There was a lack of management oversight and the areas we found of concern had not been found by the provider or the registered manager. Risk assessments were not always followed, records were not always complete or communicated effectively to other departments within the service and staff records were not maintained effectively in relation to performance concerns. Regulation 17 (1)(2)(a)(b)(c)(d)(f)

The enforcement action we took:

We issued a warning notice.