Bridge House Holdings Limited

Bridge House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

The inspection took place on 7 and 8 June 2017 and was unannounced on the first day and announced on the second.

Bridge House Nursing Home is a care home with nursing. It is comprised of two units, one known as Bridge House and the other as Bridge Court. It is registered to accommodate 54 people across both units. At the time of the inspection 20 people were resident in Bridge House and 13 in Bridge Court. Some of the people living at the service may require either nursing or specialist care associated with dementia and other conditions.

At our last inspection in November 2016 the provider was not meeting four Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was rated requires improvement. Requirement notices were issued with respect to the breaches of Regulation 12 (safe care and treatment), Regulation 9 (Person centred care), 17 (Good governance) and 19 (Fit and proper persons employed).

The provider sent us an action plan in January 2017 outlining the improvements they were going to make in order to meet the requirements of the regulations.

This inspection was a comprehensive inspection to follow up and ensure the requirements of the previously identified breaches of regulations had been met and to make a judgement about the overall compliance of the service. At this inspection we found significant improvements had been made and there were plans in place to maintain and further improve the quality of the service. The requirements of the regulations had been met.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the time of the inspection there was no registered manager. Two managers had been appointed since the previous registered manager deregistered. Both had submitted applications to become registered with the care quality commission to manage the service however, both left the service prior to the registration process being completed. Following discussions with the provider the operations manager who had worked with and supported the service for a significant amount of time had begun the process to become the registered manager.

People were safe and told us they felt so. Risk assessments had been completed and plans were in place to manage and limit any identified risks. Incidents and accidents were reviewed, investigated and monitored to identify emerging trends and enable action to be taken to reduce their occurrence. Recruitment procedures

were thorough and established so far as possible the suitability of staff to work with people. There were sufficient numbers of staff to care and support people safely. Staffing levels were calculated according to the needs of people using the service and were reviewed regularly. People were protected from abuse by staff who had been trained in safeguarding people and understood how to report concerns. Medicines were ordered, stored and administered safely. The provider had a business continuity plan which provided guidance for staff on the actions to take in a foreseeable emergency.

People were supported by staff who had received training to perform their role effectively. Induction was provided to new staff who also shadowed experienced staff until they were confident and competent to work unsupervised. Staff were supported by the manager and other senior staff who we were told listened and took action when necessary. Further support was provided through one to one meetings, staff meetings and annual appraisals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems supported this practice. People were given encouragement to eat and drink sufficient quantities. They told us they enjoyed their meals and there was plenty to eat. Menu choices were presented to people and alternatives were available if people preferred something different. When concerns arose with a person's nutrition or weight, referrals were made to relevant health professionals. People's health and well-being were monitored and they were able to access a range of professionals to support them with new or on-going health matters.

People told us the staff were kind, compassionate and caring. We observed positive interactions between people and staff and noted people appeared comfortable with the staff team. People were calm when approached by staff and enjoyed chatting and making jokes with them. People's privacy was respected and staff supported them to maintain their dignity. Staff knew people well and understood their needs. People were made to feel special and valued, they were supported to celebrate significant occasions in their lives. Visitors to the service were encouraged. Relatives told us they visited at various times and were always made to feel welcome. Meetings for residents and relatives encouraged people to share their views on the service. Whenever possible suggestions were acted on to improve things for people. People were provided with the opportunity to discuss and plan the care they would like to receive at the end of their lives.

Care plans were individualised and reflected the needs and wishes of each person. Good and sufficient detail was included to ensure staff knew how to provide responsive, person-centred care to people. Evidence based practice was used to ensure care plans directed staff to follow national guidance when appropriate. A varied and full programme of activities was planned to include people's personal hobbies and interests. People chose if they wished to join in activities or not. People's right to spend time alone or to do things of their choice was fully respected. People knew how to make a complaint or raise a concern.

Systems were in place and used effectively to monitor and improve the quality of the service. Deficits were identified and measures taken to address them. The service sought the views of people and their relatives. They used the responses to look for areas of improvement. Records relating to people's care were accurate and completed in a timely manner. We found an honest and open culture in the service. Staff spoke positively about the leadership they received and how they worked well together for the benefit of the people they care for.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks that may affect people's health and well-being were assessed and plans to mitigate those risks were in place.

Recruitment procedures were effective and the required checks were completed to help ensure suitable staff were employed to work with people.

Medicines were managed safely.

People were protected by staff who understood their responsibilities to safeguard people and report any concerns.

Is the service effective?

Good

The service was effective.

The service worked in line with the principles of the Mental Capacity Act 2005.

Staff felt they received good support from the manager and senior staff.

Staff were trained in their job role and received refresher training to keep their knowledge and skills up to date.

People were offered a choice of meals and drinks that met their dietary needs. When necessary people were supported to eat and drink.

People received support from appropriate health care professionals to maintain their well-being.

Is the service caring?

Good

The service was caring.

People received kind and compassionate care from a staff team who knew them well.

Staff interacted with people in a positive manner. People were seen to be relaxed and calm in the presence of staff.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

Care plans had been reviewed and now contained sufficient detail to reflect people's individual preferences and routines. Staff knew people well and provided support in a person-centred manner.

There was a system to manage complaints and people told us they knew how to raise a concern if necessary.

A programme of activities was provided to suit a range of interests. People chose what activities they wanted to take part in.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality and safety of the service which were used effectively.

Staff were positive about the leadership and support they received from the manager and other senior staff.

There was an open, calm and friendly culture in the service.

Bridge House Nursing Home

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.

The inspection was carried out by one inspector on 7 and 8 June 2017. The inspection was unannounced on the first day and announced on the second. This was a comprehensive inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we had received about the service and reviewed the latest Quality Assurance report from the local authority. We also looked at previous inspection reports for the service and checked notifications we had received. Notifications are sent to the Care Quality Commission to inform us of events relating to the service which they must tell us about by law. We requested feedback from five health and social care professionals but did not receive any replies.

During the inspection we spoke with a healthcare professional and 13 members of staff, including the manager, matron, four registered nurses, one administrator, two housekeeping staff, three care staff and an activity co-ordinator. We also spoke with seven people who live at the service and four relatives or visitors. We used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care plans and associated records for eleven people. We examined a sample of other records relating to the management of the service including six staff files which contained recruitment and training records, the complaints log, quality assurance surveys and analysis, maintenance records and various monitoring and audit tools.

Good

Is the service safe?

Our findings

At the inspection of 25, 28 & 29 November 2016 the provider was not meeting the requirements of Regulations 12 (Safe care and treatment) and 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was failing to assess risks to the health and safety of service users and failing to do all that was reasonably practical to mitigate those risks. The provider did not operate effective recruitment procedures.

Requirement notices were issued with respect to the breaches of Regulations 12 and 19. The provider sent us an action plan in January 2017 describing the actions they were going to take to meet the requirements of the regulations. At this inspection on 7 and 8 June 2017 we found the provider had taken action to address the concerns identified and improvements had been made. This meant the service now met the Regulations.

Risk assessments were carried out and identified areas where action was needed in order to reduce or manage risks. Examples included risks associated with falls, skin integrity and malnutrition. Management plans were drawn up to limit the identified risks and they now provided detailed guidance for staff to follow. During the inspection we observed staff followed these management plans. For example, staff used the equipment detailed in a person's care plan to assist them with moving from one area to another. Staff told us the care plans had been improved and felt they now provided much clearer information. Those we reviewed gave detail of how a person should be assisted, stated their preferences and provided guidance on such things as the type of equipment that may be required. Important information was not only available in the care plans but was also readily available for quick reference in a one page profile found in each person's room. We reviewed these profiles and found the information both accessible and easy to use.

Where tools were used to assess risk such as the Waterlow assessment (a tool to determine a person's risk of developing pressure sores) these were completed accurately and used to inform the care plan. For example, some people were identified as requiring pressure relieving mattresses to protect their skin. Where they were used they had been set correctly for the individual and were checked twice daily. This was to ensure the setting remained correct and no faults had occurred. Risk assessments were reviewed monthly or sooner if a change in a person became apparent. When changes occurred the care plan was updated accordingly.

Risks associated with the building and the environment were also assessed. They included those related to fire, the use and maintenance of equipment, food hygiene and infection control. Maintenance staff were employed by the provider to monitor the risks associated with the environment and carry out routine remedial work in the service. Staff told us this was done promptly and records indicated most jobs were completed in one or two days. Where a specialist was required to inspect and maintain the safety of equipment such as the passenger lift or fire safety equipment, contracts were in place. This routine checking had been carried out in line with guidance and legislation.

Incidents and accidents were recorded and details of actions taken were documented. Body maps were completed for each incident and where appropriate and permission had been granted photographs were

also taken. Incidents and accidents were audited each month and an analysis completed to identify any emerging trends. All incidents and accidents were discussed at the monthly clinical governance meeting to explore themes and identify areas of learning. Nurses reported these meetings were very useful.

The provider had reviewed their recruitment procedures. A Disclosure and Barring Service (DBS) check was conducted for all employees. A DBS check allows employers to ensure an applicant has no criminal convictions which may prevent them from working with vulnerable people. Two references were sought for each prospective employee with regard to their behaviour in previous employment. References had been verified whenever possible by requesting a company stamp or contact was made with the referee. A full employment history was obtained for each employee and gaps in employment were discussed and documented in staff files. Health questionnaires were completed to help ensure prospective employees were fit enough to carry out their role. Where necessary an employee's right to work in the United Kingdom had been established. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

People told us they felt safe at Bridge House Nursing Home. Comments people made when we asked if they felt safe included, "Good Lord yes." "Absolutely safe." and "Very safe thank you." The relatives we spoke with also thought their family members were safe. One said they felt reassured about their family member's safety each time they visited and saw how staff cared for them. Training in safeguarding people was provided for all staff and was refreshed annually in accordance with the provider's policy. Staff were able to describe signs that may indicate a person had been abused and knew their responsibilities to report any concerns immediately. They also demonstrated this knowledge during the staff meeting which took place during the inspection. They responded promptly and with confidence to questions asked by the manager in relation to keeping people safe. The provider's whistleblowing policy was available for staff to refer to and they told us they would be happy to use it if the need arose. Staff were clear that they could go to outside agencies such as the local authority or the Care Quality Commission if necessary.

Staffing levels were determined based on the needs of people living at the service. A dependency tool was used to help establish the amount of time and input a person required from staff. This was reviewed each month by the manager and senior staff with adjustments being made to staffing numbers when necessary. We reviewed the dependency tool in seven people's care plans and found they had been completed fully and reflected the care required by the individual. Staff told us they felt they had sufficient time to care for people safely and effectively. They said they did not have to rush people and were able to meet people's needs in a person centred way. During the inspection we observed call bells were responded to promptly.

The manager informed us that there were two nurses on duty during the day and seven care workers. They were supported by the home manager and matron (a senior and experienced registered nurse) who were both supernumerary and could step in to help on the floor if necessary. In addition, another of the registered nurses worked some supernumerary hours to provide support in introducing evidence based practice and up-skilling the registered nurses. The nursing and care team were further supported by administration, housekeeping, laundry, maintenance, catering and activity staff. We reviewed the staff rotas and found these staffing levels were maintained and in addition there were some twilight hours worked to provide additional support. Some agency staff helped to cover staff leave and sickness. The manager explained they used a regular agency and requested the same staff to help ensure consistency. However, when it was possible the extra work was offered to and covered by their own team of staff.

The manager told us there had been a review of how staff retention could be improved following a number of staff resignations and the consequent exit interviews. The provider had taken steps to make

improvements by instigating a significant pay increase and offering other incentives. This had resulted in some staff withdrawing their resignations and others who had left retuning. One person commented to us that they had been concerned when staff left and told us, "I was concerned when staff left, you know when you've built relationships it's difficult. But it's been fine all the staff are very good."

Medicines were supplied and delivered by a community based pharmacy. They were stored safely in locked trollies in a dedicated medicine room which had been newly refurbished. Matron and three nurses all commented that the improvements to this room had had a significant and positive impact on their work in relation to medicines. It provided a safe storage facility where they were able to maintain safe temperatures for medicines. In addition, the airy and light environment made the ordering, checking and auditing tasks associated with medicines much more pleasant.

Medicines were ordered and managed by one of the registered nurses. Regular audits were carried out so as to ensure the safe management of medicines. In addition, support was available from the community pharmacist on any issues as or when they arose. Matron advised us and records showed that all medicines had recently been reviewed by the community pharmacist and the GP to ensure they remained appropriate and necessary. Additionally, as a result of these reviews and in line with best practice a number of blood tests were being conducted for some people. This was to ensure they were receiving appropriate medicines and doses. Some people were prescribed medicines to be taken when necessary. We found guidance was provided for nurses regarding these medicines. This included symptoms to check for before administration, how people may indicate they require the medicine and when a doctor should be contacted. Staff ensured that any medicinal allergies were recorded and highlighted appropriately.

The provider had a business continuity plan and an emergency plan. These plans outlined the actions to be taken to ensure the safety of people using the service in an emergency situation. An emergency 'grab bag' was available in each unit and staff were aware of the location of these bags. The bags contained information such as how to assist people to leave the building in personal evacuation plans as well as important contact numbers. A torch, batteries and warm socks also formed part of the kit. Staff were familiar with and had practiced emergency drills.

Good

Is the service effective?

Our findings

People received effective support from staff who were trained and felt confident in their role. Staff received an induction when they began working at the service. In addition to this they also spent time working alongside more experienced members of staff for a minimum of two weeks. This period was extended if necessary to ensure the new member of staff felt confident and performed to a satisfactory standard. During the inspection two new members of staff were going through the induction process. One told us they were experienced in care and commented, "It's so good that although I am experienced I have been given the time to shadow and get to know people. I've been told I can't do things like moving and handling until I have completed my training here which is really good."

The care certificate had been introduced for staff new to a caring role. Two senior staff were undertaking further training to enhance their knowledge of supporting and assessing staff undertaking this course. All staff received training in topics considered mandatory by the provider including fire safety, safeguarding, infection control, health and safety and food hygiene.

Refresher training was provided and the training matrix indicated training was up to date. Where training was about to expire further updates had been arranged. The manager told us they had reviewed some of the current training and in future more face to face sessions were to be included to supplement the DVD and eLearning training. This was to include topics such as safeguarding and the MCA and DoLS. The matron told us she or a registered nurse spent time observing staff to ensure they were competent. Staff confirmed checks were made on their work and we saw evidence of observations including hand washing skills and administration of medicines in staff files. One staff member told us, "Matron observes practice, this is good because we need to know if we make mistakes so we can learn."

Specific training relating to the needs of people was also provided. Examples included, awareness of dementia, behaviours that challenge and dysphagia. More recently training had been provided in care planning and record keeping as this had been identified as a training need. Further training in use of pressure relieving equipment had also been organised. Staff who held professional qualifications such as the registered nurses confirmed they were given opportunities to attend professional development sessions. This was in order to meet the requirements of their registration. Examples included, venepuncture and catheterisation.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

The manager and matron were aware of the legal requirements in relation to DoLS. They explained when they would make an application to the supervisory body. A tracking system was used to monitor all applications and authorisations. We noted that when a review of an authorisation was due this had been requested. Where delays had been experienced in the supervisory body responding we saw evidence of the service following the applications up. Some people's files indicated that they had appointed attorneys to make decisions on their behalf. We saw documents relating to Lasting Power of Attorney (LPA) were verified and recorded what decisions the attorney had the authority to make.

People were supported effectively by staff who had received training in the MCA and DoLS. Staff were able to explain to us how the MCA and DoLS related to their work. We observed staff seeking people's consent before doing anything for or with them. They explained what they were doing to people and then checked they were happy. One member of staff told us that sometimes people found it difficult to make decisions. They gave an example of a person who refused to have support with their personal care and told us, "Sometimes it's just at that time but later they may be able to decide to let us help. So we leave them for a bit and go back, often they then say yes. Also, sometimes we talk about things they like and then they let us help them."

People were offered choices in everyday decisions such as what they wanted to do or what they wanted to eat and drink. When people were unable to make decisions for themselves, best interest meetings were held between the care team, appropriate professionals and family members. Examples included, receiving personal care, use of bed rails and covert administration of medicines. In people's files we saw an assessment of the person's mental capacity to make a particular decision had been recorded along with the details of the best interest meeting. Although best interests decisions were in place we noted clear guidance was provided to staff to continue to involve the person and seek their consent whenever possible.

Staff said they felt supported by the manager. Those we spoke with all felt reassured that the operations manager was currently managing the service on a day to day basis. One commented, "It's like fresh air. It's good to have [Name] back." The manager had good knowledge of the service and staff told us they felt this was important to maintain the improvements already achieved and to maintain stability. This was further emphasised and evidenced when during a staff meeting which we attended, a spontaneous round of applause met the news that the operations manager had agreed to register with the Care Quality Commission to manage the service.

Nurses and staff also commented on the support they received from matron. One said, "Matron is the best, she knows so much and is happy to share." Another told us, "Whenever I need help I receive it, Matron really helps me." Staff were supported through one to one supervision meetings with their line manager and in addition group supervision meetings gave an opportunity for wider discussion and reflection. A matrix was maintained by the manager to ensure regular meetings were held and future meetings planned. Staff confirmed they attended these meetings and found them useful. One commented that they could get support at any time and did not have to wait for supervision but never the less it was "good to have a planned time to talk about things". Annual appraisals also provided a support system, allowing staff to reflect on and review their performance over the past year.

Staff meetings were held regularly between various groups of staff. They included heads of department, general staff meetings and clinical governance with the nursing staff. During the inspection we attended one of the general staff meetings as a guest. The atmosphere was relaxed and the meeting was well attended by a cross section of the staff team. We noted there were distinct sections of the meeting to address a variety of topics. Following a warm introduction from the manager a refresher session relating to health and safety and safeguarding was held. This involved questions and answers and all staff were encouraged to take part.

Staff responded well and the information extracted served to refresh and instil knowledge for all. An information giving exercise followed along with a demonstration of the new grab bags available for emergencies. Staff were given time to raise issues or express views and whenever possible their queries were answered or noted so an answer could be sought. Throughout the meeting staff appeared relaxed and comfortable to raise points and make suggestions.

Where necessary, people were supported to eat and they received encouragement during meal times. We used the short observational framework for inspection (SOFI) to observe lunch time on day one of the inspection. We saw staff took time to sit with people and assist them to eat at their own pace. They gave encouragement when necessary and showed people the different choices of food available. One person was asked "Are you ready for a bit more" before the next spoonful was offered while another was gently prompted when they began to fall asleep. People's likes and dislikes in relation to food and drink were noted in their care plans and had been discussed with the catering staff. People praised the new chef and told us improvements had been made. For example, one person told us, "The chef comes to the dining room now and shows us the options available then they serve it up. It means that if you don't fancy what you chose originally you can change your mind. I've noticed a big difference." Another person told us there were alternatives available if you did not want the meals on the daily menu. The manager told us there were plans in place for a 'snack menu' to be printed so that people would be aware of the variety of alternatives available.

Where there were concerns regarding a person's nutritional intake they were assessed using a recognised tool. When necessary a referral was made to health professionals such as dietitians or speech and language therapists. Records were maintained of food and fluid intake and people's weight was monitored. The manager and the activity co-ordinator told us of an initiative to encourage people to eat fresh fruit. Each morning the activity co-ordinator spent time individually encouraging people to taste fruit using this as sensory and stimulating experience.

People were able to access healthcare services when required. Records indicated people had seen healthcare professionals including, GP, physiotherapists, consultant neurologists and tissue viability nurses. Dentists and opticians had also visited the service to provide consultations for people who were unable to go to their practices. When advice had been provided by a professional this had been incorporated in to care plans and followed. For example, one person had clear guidance on how to support them effectively with oral care.

Good

Is the service caring?

Our findings

People received care and support from staff who were caring, compassionate and kind. People told us they liked the staff and described them as, "So, very good", "Wonderful" and "Kind". One person said, "I'm very well looked after, they're absolutely wonderful." Relatives and visitors also spoke positively about the staff team. One relative said, "Staff seem to be very kind." Another praised the care their family member received and told us, "Staff are lovely, they can get [family member] to do things even we can't."

We observed staff talking to people in a polite and respectful manner. They interacted with people as they went about their daily work stopping to say a few words to people as they passed by. People told us the staff gave them choice and control over their day to day lives. One person told us, "They know when I like to get up and what I like to do." Another explained, "I can please myself but they're always on hand if I need them." A third person said, "They respect my choice of staying in my room when I want to."

We saw staff were gentle and considerate in their approach to people. They spoke quietly to people who showed signs of distress or agitation, and were successful in calming or distracting them. We also saw people were encouraged to be playful and jokes were shared between them. This indicated staff knew people well and what they would respond to.

People appeared comfortable with staff who were caring and friendly towards them. For example, after lunch, when care staff were escorting people from the dining room back to the lounge, they did so without rushing them and chatted as they went. They assisted people to sit where they wished. When staff carried out tasks for people they bent down to speak to them, so they were at eye level and could engage fully with them. For example, one person needed a great deal of encouragement to take their medicine and the nurse sat next to them offering encouragement while at the same time engaging the person in conversation.

Whatever they were doing for people the staff had a calm approach and made sure people were comfortable. People told us staff treated them respectfully and maintained their privacy. We saw staff knocking on people's doors and asking if they could go in. They told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing.

Staff were very familiar with the people using the service and they had a good knowledge of their personal preferences, routines, health conditions and nursing needs. A nurse was able to describe examples of the actions taken when people showed signs of ill health, the plans for their care, and the other professionals who had been consulted and involved. Another member of staff told us how one person had been in the Navy while another had lost their mother at an early age. This demonstrated how staff had taken time to get to know the people they cared for. They used this knowledge of the person to provide individualised care.

People were made to feel special, valued and important. Special occasions were celebrated and during the inspection we saw one person being supported to celebrate their birthday. The chef had made a special cake and a fancy party hat had been bought for the person to wear. In the afternoon people and staff

gathered around and sang happy birthday before sharing the cake. We noted the person looked happy and appeared to be enjoying the celebration. Photographs were taken of occasions such as this so that they could be used to share memories.

People and staff told us visitors were welcome at any time. We observed visitors came and went freely during the inspection. Those we spoke with said they visited regularly at various times of the day and were always made to feel welcome. One person told us they had lots of friends who enjoyed visiting and they often came and ate a meal with them. We observed this on the first day of the inspection and it was clear this was an important part of the person's life

Meetings were held with people who lived at the service and their relatives. Suggestions were listened to and acted on. For example, at one meeting it was commented on that relatives would like information on new staff joining and staff leaving as well as other information about the service. A newsletter was suggested and it was agreed that this was a good idea. The activity co-ordinator was working on the first edition of the newsletter at the time of the inspection.

People had the opportunity to express their wishes with regard to the care they would like to receive at the end of their lives. Some people had made advanced decisions and others had made living wills. Details were contained in their care plans so that staff were able to follow people's wishes. Some people had do not attempt cardiopulmonary resuscitation forms which the GP had discussed with them and /or their relatives as appropriate.

Good

Is the service responsive?

Our findings

At the inspection of 25, 28 & 29 November 2016 the provider was not meeting the requirements of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not design care with a view to achieving service users' preferences and ensuring their needs were met.

A requirement notice was issued with respect to the breach of Regulation 9. The provider sent us an action plan in January 2017 describing the actions they were going to take to meet the requirements of the regulation. At this inspection on 7 and 8 June 2017 we found the provider had taken action to address the concerns identified and improvements had been made. This meant the service now met the Regulations.

People were assessed prior to them receiving a service. The assessment gathered information which was used to develop an individual care plan designed to meet people's needs. Care plans were in date and reviewed monthly. We found improvements had been made in the amount and consistency of detail included in both the assessments and the care plans. The manager, nurses and care staff all told us a great deal of 'hard work' had gone into working on the care plans. They explained this was in order for them to reflect the individual preferences of the people living at the service. One staff member said, "Everyone's unique, they have their own personality and we need to know as much as possible about them." They told us additional training in care planning had been provided which had helped them recognise the importance of including good detail in order to provide person-centred care.

An experienced registered nurse had recently been employed and had specific duties relating to monitoring and improving care planning in line with best practice. They told us they were promoting evidence based practice into planning people's care. They showed us how this had led to changes in one person's care plan to ensure the care they received reflected appropriate guidelines and codes of practice. They told us, "It is important to use appropriate evidence based practice as it can show up risks to a person (with a particular condition) that may not otherwise be identified and addressed."

It was clear that whenever possible people had been involved in the care planning process and when appropriate families had also contributed. For example, where a person had memory loss due to living with dementia, families had been asked to provide information such as people's past employment, their extended family, hobbies and interests. Staff told us this enabled them to engage people in meaningful conversations which often sparked a memory for them.

The care plans provided clear and detailed guidance for staff. For example, one described how a person liked a teabag on the side of their cup of hot water at breakfast time. Another guided staff on how to support someone with personal care when they had a tendency to lash out by giving the person something to occupy their hands. People's preferred times to get up and go to bed were recorded as well as times when they may like to return to their room to rest. In addition to the care plans we saw one page profiles were available for quick reference in people's rooms. Care plans were now mostly typed and although some hand written records remained those we reviewed were clear to read and legible. A system known as 'resident of

the day' had been introduced. This meant each day one person's care plan was checked and reviewed in detail. Their room was spring cleaned and the service looked at all aspects of the care provided to that person to ensure it was the best it could be.

The service worked collaboratively with other services to be responsive to peoples' needs, for example, the Rapid Action Treatment Team. For one person this had prevented an admission to hospital. The person was very pleased that they had not required a hospital stay and matron told us that this had also meant the person had made a quicker recovery. In another example a person had requested a piece of equipment to enhance their independence. This had been sourced for someone from a local charity and the service had worked with them to ensure the appropriateness and safety of the equipment. This had given the person freedom to go out independently and had clearly had a positive impact on their lives.

A programme of activities was provided each day by activity staff. The programme included music and movement, chair exercises, arts and crafts, quizzes, and games. People were encouraged to join in the activities of their choice. If people did not wish to take part, this was respected and one person told us, "There's lots going on but I like my own room and I do what I want." Another person said, "We can join in any of the activities we want to, I enjoyed the singing we had recently and the birds of prey." People who were unable to leave their room were visited by activity staff to help avoid social isolation. An activity co-ordinator explained that one to one activities usually took place in the mornings. They told us they included sensory stimulation with fresh fruit, hand pampering and reading newspapers with people.

The 'Daily Sparkle' had been introduced recently and we were told it was proving to be a hit. This is a newspaper containing news that happened on the same day in the past and encouraged people to think back and remember those times. The staff member said, "It helps to get people talking." They also told us they had recently been spending time talking to people and their relatives about previous interests and what people liked. This had resulted in one person getting a bird table outside their room so they could watch the birds. Another who had worked in insurance now had a calculator and notebook to "write their numbers down" as they had done at work. A third person kept a diary and was helped each day with this. In addition other activities were organised. They included, visits by religious ministers to provide for people's spiritual and religious needs. Animals such as a 'pat dog' and guinea pigs were introduced to people and professional entertainers put on shows which people and their relatives could enjoy.

There was a complaints procedure and information on how to make a complaint was displayed in the reception areas of the service. People and their relatives told us they were aware of how to make a complaint or raise a concern. We reviewed the complaints log and noted three complaints had been made since the previous inspection. All had been recorded, investigated and responded to in line with the provider's policy. We saw actions had been taken as a result to make improvements. Examples included, additional staff training, observation of care practice and discussions with the staff team.

Good

Is the service well-led?

Our findings

At the inspection of 25, 28 & 29 November 2016 the provider was not meeting the requirements of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not assess, monitor and improve the quality and safety of services provided. The provider did not maintain a complete and contemporaneous record in respect of each service user.

A requirement notice was issued with respect to the breach of Regulation 17. The provider sent us an action plan in January 2017 describing the actions they were going to take to meet the requirements of the regulation. At this inspection on 7 and 8 June 2017 we found the provider had taken action to address the concerns identified and improvements had been made. This meant the service now met the Regulations.

The provider had improved the systems to monitor the delivery and quality of the service. Regular audits were carried out and included checks on care plans, medicines, health and safety, infection control and accidents. Other areas such as the home presentation and environment were also monitored. These systems had been consistently followed since the previous inspection and where they had highlighted deficits these had been addressed using an action plan. We saw actions had been completed and had led to improvements being made. For example, the infection control audit had revealed not all staff used good hand washing technique. This had been addressed by individual training, the provision of information and observation of competency for all staff. An infection control champion had also been introduced in order to maintain standards. In addition, a monthly monitoring audit of the service was completed by an operations manager. This too resulted in an action plan if deficits were identified. We noted that actions were checked at the following audit to ensure they had been completed.

Quality assurance questionnaires were sent to people and their relatives to gain their views on the service and to help the provider identify ways to improve. We saw a survey had been carried out in April 2017. An analysis of the survey had shown people were satisfied with their care and had given positive feedback about the kindness they were shown by staff. Where less positive comments had been made these had been discussed to find ways to improve. This meant people's views were sought and acted upon whenever possible. For example, one person had suggested a way to provide information to new residents on the different meals available. This had been discussed with the catering team and a decision had been made to introduce a snack menu in each room.

Records relating to people's care were observed to be completed fully and accurately. We saw staff filled out repositioning charts and other records in a timely manner. Duplicated records that had been seen at the previous inspection had been removed. This meant staff did not have conflicting information and could rely on the records in order to provide safe and effective care for people.

At the time of this inspection there was no registered manager in post. The service had been without a registered manager since May 2016. The provider had employed two managers during this period. Both had submitted applications to register with the Care Quality Commission to manage the service. However, both resigned before the registration process was completed. We discussed this with the provider prior to the

inspection. We were informed that the operations manager who had worked with the service for a long period of time was now managing the service on a day to day basis and they had agreed to apply to become the registered manager. At the time of the inspection they had begun the process and were waiting for the appropriate checks to be completed.

The service is required by law to send notifications to the CQC regarding significant events which happen in the service. We found the service had sent all the required notifications in a timely manner with the exception of two Deprivation of Liberty Safeguards authorisations. When we raised this with the manager they took immediate action and sent the notifications.

We found an open and honest culture within the service. The manager was visible in the service and it was clear both people and staff were relaxed in her company. Staff spoke positively of the manager and said she was both approachable and supportive. One commented, "I'm glad to have [Name] back. She's calm, approachable and dependable. " Another commented, "[Name] makes everyone feel part of the team. She promotes a good atmosphere (and) this helps us provide good care." Staff told us they enjoyed working at Bridge House Nursing Home. We received comments such as, "We are a good team, we help each other." and "It's a really good team here, we all get on."