Independence and Well Being Enfield Limited

Bridgewood House

Inspection report

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Enfield
Middlesex
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08 May 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bridgewood House is a modern purpose-built building covering three floors. There are six units, two on each floor, named after local parks and the home refers to each unit as a 'park', five of which were in use. Bridgewood House is run by Independence and Wellbeing Enfield Limited and the home is registered to provide care to 70 people. At the time of the inspection there were 39 people using the service.

This was the first inspection of this service since they registered with the Care Quality Commission (CQC) in March 2017. This inspection took place on 24, 25 and 26 April and 8 May 2018.

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

People received their medicines on time. However, arrangements for covert and 'as needed medicines' were not consistently in place. Staff that administered medicines had not received medicines competency assessments since the home opened. Equipment used for medicines administration was not always cleaned after use.

Risk assessments were inconsistent and did not always identify people's personal risks and there was a lack of guidance for staff on how to mitigate known risks. However, there were also examples of good risk assessments.

Staff did not have easy access to people's Personal Evacuation Plans (PEEP) as these had not been printed. Staff were not receiving regular supervision to support them in their role and assess their working practice. However, staff told us that they felt supported. Training was not always provided in a timely manner.

Staff knew people well and understood their needs. However, care plans were not person centred and failed to contain enough information about people to reflect their needs.

People were given prompt and empathetic care at the end of their lives. Arrangements were in place to ensure people were as comfortable as possible.

The home understood that activities and stimulation were important for people. A wide range of activities was in place and the home had two activities coordinators. However, the management team understood that this was an area that required further development.

People told us that they felt safe within the service and were well supported by staff. We saw positive and friendly interactions between staff and people. People were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had received safeguarding training.

The home was aware of infection control procedures when working with people. Staff were supplied with gloves and aprons to ensure that people were safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were well supported when moving between services. Appropriate assessments and support for both people and relatives were in place.

People were encouraged to have a healthy diet. People were given choice around what food they wanted to eat and staff knew what each person enjoyed. Snacks and drinks were readily available. People and relatives were complimentary about the food.

People and relatives were involved in planning their care. Relatives were positive about the input they were able to have.

People were able to personalise their rooms and the home was working towards making the environment more homely as care staff had recognised this area requiring further improvement.

People and relatives knew how to make a complaint or raise concerns. Where complaints had been received, these had been dealt with appropriately.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

Relatives felt that there was good communication between the home and themselves.

There were auditing systems in place to monitor the quality of care. However, these did not always pick up issues identified during the inspection.

We identified breaches of regulations 12 and 17 and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the 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. People received their medicines. However, adequate documentation was not in place for certain aspects of medicine administration. Equipment used for medicine administration was not always clean.

Risk assessments did not always provide adequate guidance for staff. Some people's personal risks had not been identified.

Staff did not have access to information around people's evacuation needs in case of a fire despite these having been completed.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

Staff understood infection control and had access to Personal Protective Equipment (PPE).

There were sufficient staff to support people and appropriate recruitment practices were being followed.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive regular supervision to support them in their role. Staff did receive training. However this was not always provided in a timely manner for new staff.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink so that their dietary needs were met. Where people had specialist dietary needs, these were understood and catered for.

Is the service caring?

Good

The service was caring. People were supported in a kind and

compassionate way and staff understood individual's needs.

We observed that people were treated with respect and staff maintained privacy and dignity. Staff treated people kindly and were patient and kind in their interactions.

People were encouraged to be as independent as possible, be part of the community and maintain relationships.

People were encouraged to have input into their care.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans were not person centred.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

People knew how to make a complaint. There was an appropriate complaints procedure in place. The home responded appropriately to any complaints.

People were supported at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well-led. Information was not always well documented. This had not been identified by the auditing process.

There had been issues with the building which had hindered the service focusing on care.

The home worked well with partnership agencies to ensure quality of care was provided to people.

Staff were positive about working at the home and said that they felt supported.

Relatives felt that the home was well managed.

Bridgewood House

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-site on 24, 25 April and 8 May 2018. The inspection was carried out by two adult social care inspectors, one nurse specialist advisor and four experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two experts by experience attended the inspection and spoke with people to gain their views and opinions of the home. Two other experts by experience supported this inspection by carrying out telephone calls to people's relatives on 26 April 2018.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

During the inspection we spoke with 16 people that used the service and three relatives. We also spoke with 19 staff including the registered manager, the managing director, the clinical lead, the development manager, the facilities manager, two team leaders, four nurses, the activities coordinator and eight care staff.

We looked at 11 people's care records and risk assessments, 13 people's medicines records, nine staff files, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. Following the inspection, we spoke with 17 relatives.

Requires Improvement

Is the service safe?

Our findings

Risk assessments to provide staff with guidance on how to minimise people's personal risks were not always in place. In some instances, a risk had not been identified and therefore not assessed. For example, whilst the home completed analysis on falls, we found that two people that had been identified as having multiple falls did not have a falls risk assessment in place. Another person that was at risk of falls did have a risk assessment. However, the assessment said, 'staff to keep an eye on me' with no further information. The risk assessment failed to explain to staff why the person was at risk or what staff should do to minimise the risk. For another person, there was a risk assessment around swallowing. The risk was noted as '[Person] is at risk of all oral intakes, aspiration'. Aspiration is where the person is at risk of inhaling food into their lungs due to swallowing difficulties and can lead to serious health complications. However, there was no explanation of this on the risk assessment. The risk assessment noted that fluids for the person must be thickened and that they should be supervised at meal times. However, there was no information on how much thickener should be added or how staff should support the person when eating. Whilst we saw other examples of good risk assessments, there was a lack of consistency in evaluating and documenting people's personal risks to ensure that staff understood how to minimise risks.

We checked medicines for 13 people on two units, of these, seven people were administered their medicines covertly. Covert medicines are where the home administers medicines without the person's consent and requires authorisation of the GP and dispensing pharmacist. There were authorisations for the administration of covert medicines in place for each person. However, authorisations were from previous homes and had not been adequately reviewed when people moved into Bridgewood House. There was no information on the administration of covert medicines form to state what medicines the person had been prescribed and which medicines needed to be administered covertly. Only one out of the seven stated how the covert medicine should be administered; 'medication to be crushed and mixed with yoghurt or banana'.

For another person there was a covert administration form in place. However, we were told that the person was not actually being administered covert medicines as it was not necessary. On the third day of the inspection we were shown three covert administration medicines forms that had been signed by the pharmacist since we had raised the issue. However, it was still unclear which medicines should be crushed or administered covertly. Relatives, where possible, had been consulted on the administration of covert medicines. One relative said, "They do it covertly. They hide it in chocolate and it works well." However, relative involvement had not been documented. Staff did not have enough information to ensure that covert medicines were being administered safely.

People were given 'as needed' medicines (PRN). PRN medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. For two people that we looked at, there was a PRN protocol in place that told staff in what circumstances PRN medicines should be offered and administered. However, for two other people, there was no information on why the person needed PRN or when to offer it. Documentation was inconsistent and there was not always sufficient information to ensure that staff had adequate guidance on when to administer these medicines.

Staff that administered medicines had received medicines administration training. However, they had not received a competency assessment at Bridgewood House to ensure that they were administering medicines safely. Staff told us that they had been competency assessed at the previous homes they had worked in before transferring to Bridgewood House. The registered manager said, "No, they [staff] have not had medication competency assessed."

We checked the pill cutter and pestle and mortar used to cut and crush medicines. This should be washed/wiped out each time it is used to prevent cross contamination. On one unit that we checked, the pill crusher and pestle and mortar had a large build-up of tablet residue. We showed the nurse on duty who said that staff should be washing or wiping the equipment between uses.

People did not have easily accessible Personal Evacuation Plans (PEEPs) in case of a fire. The registered manager told us that these had been done and we saw that they were on the office computer. PEEPs were detailed and assessed the needs of each person in case of fire. However, these had not been printed off. In the event of a fire the staff and fire service would have no access to relevant information. This placed people at risk of harm as important information was not readily available.

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

We also saw some good examples of risk assessments. For example, one person had been noted as being at risk of wandering and falling. The risk assessment noted that staff were to encourage the person to wear appropriate shoes when walking to reduce the risk of falls. The person also had a habit of eating when they were walking and required support and prompting when this happened. During the inspection we observed staff and relatives supporting the person when eating and walking and reminding them to wear appropriate shoes. For another person with swallowing difficulties, there was good guidance for staff on how to minimise the risk when the person was eating. Another person had detailed guidance on how to manage their swallowing difficulties including guidance from the Speech and Language Therapist (SALT).

People were identified as being at risk of pressure ulcers and we saw that people had pressure relieving equipment in place where necessary. We saw that one person had been noted to be spending longer in bed and used pressure relieving equipment. There were repositioning charts in place and these had been appropriately completed. However, the home did not use an assessment tool to assess a person's risk of developing a pressure ulcer such as The Waterlow Scale. This is a specific way of estimating the risk to an individual of developing a pressure ulcer. A staff member told us, "We don't do that but they want to introduce it." This meant that people's skin integrity was not routinely assessed.

People's medicines were recorded on Medicines Administration Record (MAR) and a blister pack system was used which was provided by the local pharmacy. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one-month supply. People's medicines were given on time and signed by the staff member administering to confirm that they had been given. However, we found two instances where a medicine had not been signed for. We spoke with the nurse on duty who was aware of the error having picked it up during a daily audit and an investigation was taking place. The home had medicines audit systems to ensure that administration errors were picked up and acted on.

There was a designated medicines room and each unit had a medicines trolley that was securely locked and attached to the wall. There was appropriate storage for controlled drugs including a separate controlled drugs cabinet. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations

(2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. We saw that there were detailed administration records for people that received controlled drugs and that two staff had signed each administration. We checked three people's controlled drugs and found that stock tallied with the medicines administered. There were appropriate arrangements in place for the disposal of medicines.

Staff that we spoke with were aware of people's PRN requirements and when to offer and administer these medicines. A relative told us that staff monitored the person's pain levels and said, "She only takes pain killers. They always ask her at medication time 'are you in any pain?', she will say either yes or no. They are very good."

People we spoke with told us that they received their medicines on time. We asked relatives if they felt that people received their medicines appropriately. Relatives were positive about people receiving their medicines in a timely manner. We were told, "Every time I go they give him his medication. They give it nicely, I'm pleased" and "He always gets his tablets."

All staff members that we spoke with had received safeguarding training and we saw that there was further training booked for July 2018. Staff were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. Staff comments about safeguarding included, "If someone was being abused you would report it and it would be a safeguarding issue and involve other agencies to investigate. I would report it to the nurses, the management and go straight to [the registered manager]" and "It's about protecting vulnerable service users and not being abused. I would report it. I would tell the manager, report it to the safeguarding team. If nobody did anything, I would whistle-blow." Staff understood what whistleblowing was and knew how to report concerns if necessary. However, prior to our inspection we received two safeguarding notifications which had not been completed in a timely manner. We discussed this with the registered manager who told us that she was aware of both incidents and recognised that any safeguarding incidents should be reported both to the local authority and CQC in a timely manner.

People told us that they felt safe and said, "It is very nice here. What have I got to be frightened of?", "I'm safe here, the staff make sure I am" and "It's safe, I can call staff anytime I want." People's representatives said that they thought their relatives were safe and that staff treated them well and with kindness and respect. Comments included, "I would say very safe. Many of the carers at the previous place where she lived transferred with her which is important", "I have no hesitation about saying how good the home is. I've found it wonderful" and 'Very safe, because I visit nearly every other day and I see how they are with her and how they treat her. They don't take any risks, they are always with her."

The service ensured adequate supplies of personal protective equipment (PPE) such as gloves, aprons and shoe covers were available. Staff told us that they always had access to PPE. We observed staff using PPE throughout the inspection. During the inspection we observed that one person had been incontinent of urine. Two staff assisted the person quickly and thoroughly cleaned the seat the person had been sitting on to prevent cross infection.

Accidents and incidents were documented. The incident itself and the immediate action had been recorded. The home had implemented improved systems for analysis of specific accident and incidents including clinical governance meetings, completing a root cause analysis which looked at why the accident or incident occurred and any learning from this. Following an assessment of falls at the home, staffing had been increased and there were more falls sensors in place to help staff quickly identify if a person at risk of falls had had a fall. The home completed a monthly falls analysis and submitted a monthly falls report to the

Care Home Assessment Team (CHAT). Where appropriate the CHAT team held falls clinics that looked at how the person could be supported to help minimise falls. However, despite the good practice noted, residents identified as having had falls or being at risk of falls did not always have a falls risk assessment.

The home had one specific dementia care unit. The home completed a dependency tool which looked at people's needs and staff required to meet those needs. At the time of the inspection, the dependency tool showed that the home was well staffed. Staff from the two homes that had closed down had transferred to Bridgewood House. However, the registered manager told us that there had been significant difficulties in recruiting permanent staff to the home. A team leader told us that staffing was reviewed daily and weekly to ensure that there were enough staff to meet people's needs.

The home used a lot of agency staff and the registered manager told us that these were regular agency staff. The home ensured that agency staff had received appropriate recruitment checks before allowing them to work at the home. Agency staff that we spoke with confirmed that they were regular.

Relatives felt that there were enough staff to meet people's needs and comments included, "Always plenty of staff around" and "Happy with all the staff." Some staff told us that they felt that there needed to be more permanent staff and were frustrated with, "Relying on agency staff" with one staff member saying, "The client group have dementia. There is an issue with non-familiar faces." Another staff member said, "Staff ups and downs. The amalgamation of two homes led to some competition between staff but things now more friendly."

The home did not hold recruitment information on-site for staff employed. Recruitment was outsourced to London Borough of Enfield human resources (HR) department who held all recruitment information. Following the inspection, we were sent recruitment information for nine staff. The service followed safe recruitment practices. Staff files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

We asked when fluid charts, where the home recorded people's fluid intake, were put in place. The clinical lead told us that fluid charts would be put in place when a person first moved in for three days to get a baseline, if a person had been discharged from hospital back to the home or if a person had a Urinary Tract Infection or for specific medical conditions. However, one person that required monitoring of their fluid intake had two fluid monitoring charts in place that were being used simultaneously. A staff member confirmed that there were two different fluid charts and staff recorded on both. This caused confusion as each chart had days that were not documented but had been documented on the other. There was no information on either chart about how much fluid the person should be having daily. Where fluid intake throughout the day had been recorded, this was not being totalled at the end of each day. This meant that staff were unaware if the person had had under or over the required daily intake. We raised this issue with the clinical lead. On the third day of the inspection we found that the home had addressed this and were using one consistent fluid chart. The fluid chart now also had the person's daily recommended allowance documented.

All bedrooms and bathrooms had a call bell system in case people required help. People told us that staff were quick to respond if they rang their call bells for help.

The home had been open under a year and we saw safety certificates for gas, electrical installation and fire equipment including the sprinkler system. Staff understood how to report any maintenance issues

regarding the building. The home was clean and we were told that there was a daily cleaner for each floor which we observed throughout the inspection.

Requires Improvement

Is the service effective?

Our findings

Staff did not receive regular supervision. The team leader told us that the home tried to provide staff with supervision every six to eight weeks. Staff files, including on-line records, showed that staff were receiving irregular supervisions. Of the eight staff files that we looked at, five staff had started since the home opened and three staff had transferred from previous homes. Supervisions that we saw were either one-to-one meetings or group supervisions. Of the new staff, that started between October and November 2017, four had one had one supervision and one had no supervision records. A staff member told us, "I had supervision about three weeks ago. My first since starting six months ago."

Staff were booked onto courses with an external provider as they came up. However, this meant that the home was dependant on the external training providers to provide certain training and training was not always provided in a timely manner. For example, we found that one staff member had started working with the home six months previously and had not yet received any mandatory training.

Manual handling had not been completed for all staff. We asked how competency was assessed for manual handling when training was not provided when staff were first employed. A senior staff member told us that they booked staff onto the next available date, which we saw could be months later but also said that new staff shadowed for a week and managers received feedback from senior staff. However, this was not a documented or signed off process. Medicines training was conducted face to face by an external company. However, one staff commented, "Not fit for purpose. Good on the legislation bit. Not on the practical side."

No staff had received training in working with people living with dementia since the home opened in March 2017. 20 staff had that transferred to Bridgewood House had completed the training with the most recent being in June 2016. However, no other staff had received this training since the home had opened. A staff member told us, "There is a gap in dementia training as its not mandatory." The home had a high proportion of people living with dementia.

Supervisions were not regular and staff were not always being supported appropriately to review their working practices. Training was not always provided in a timely manner.

Staff received an induction when they started working at the home. The initial induction was completed by the local authority with staff shadowing more experience staff at the home. The clinical lead completed nurses induction and team leaders completed care staff induction. The induction and probation period lasted for 22 weeks. There was no clear guidance for how agency staff received an induction. On the third day of the inspection we were shown a new agency induction checklist that had been implemented on 7 May 2018.

Where care staff had transferred from other homes we saw that training records took into account their previous training as this had also been completed by the same external training provider. The home had a system in place for the manager to identify when staff needed to refresh their training. Staff that we spoke with felt that the home provided enough training to enable them to do their job. Staff were being supported

to achieve the care certificate. The care certificate sets out standards of care that staff are expected to maintain

Team leaders were booked onto a three-day managers course in June 2018 around The Mental Capacity Act (MCA) as well as a three-day first aid course. This showed that the home was providing specialist training for senior staff to progress and improve skills.

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 authorisation 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. Where people required a DoLS we saw that this was in place with information on when these needed to be reviewed. The registered manager had informed CQC of all applications and authorisations as per the legislation. Staff had received training on the MCA were able to explain how it impacted on the care that was provided to people and what it meant for people in their day to day lives. Staff said, "It's an act meant to assess and cover people's capacity to see if they can make decisions. If there is no capacity we would apply for a DoLS, have best interest meetings to ensure they are not left vulnerable or taken advantage of" and "It's about capacity and decisions made in people's best interests."

Care plans were not signed by people or relatives confirming consent to care or involvement in the planning of care. It was unclear if this was because people lacked capacity. We raised this with the registered manager who told us that this was an area that the home was looking at and that the format of care plans was currently being reviewed. We saw a sample care plan but this had not yet been put in place.

We observed two lunch sittings during the inspection. For people that required a specialist pureed diet we saw that food was the correct consistency and each element of the meal was separate and presented well on the plate which helped pureed food to look appetising. For another person on a pureed diet we observed a staff member mixing the food together. We asked the staff member why the person's food was being mixed. The staff member told us, "He likes it mixed together, he will eat it when it is mixed but does not want to if its separate."

People that required help with eating were supported well and at a steady pace. Staff had good communication with the person when they were assisting. Staff told us that another person liked bread pudding and that the kitchen had made it the previous day. We observed the person ask if there was any left and the staff member said that the kitchen had saved some for him as they knew he liked it. We observed two people ask for more food after they had finished which was provided for them.

The kitchen was clean and well equipped. Fridges and freezers were clean, well-stocked and any opened food labelled with when it had been opened and needed to be discarded. There was a list of people on specialist diets such as diabetics and pureed food including information on each person's requirements. We discussed cultural and religious diets with the chef and found that these were catered for. For example, one

person liked Caribbean food such as jollof rice and plantain and the kitchen kept seasoned chicken in the freezer which we saw being served on day three of the inspection.

The menu was displayed on walls in the corridors. On day one of the inspection we saw that the menus showed the options as, chicken or fisherman's pie and chocolate pudding and custard for dessert. This matched what was served on the day. People were asked what they wanted to eat the day before and we observed the chef going around and talking to people. People told us that an alternative was available if they did not like what was on offer and one person said, "If I don't like the choices, the kitchen will do a jacket potato." Another person told us that they liked a cup of tea in bed before they went to sleep and that they received it each night. We also saw that one person had a supply of their preferred ice cream in the freezer which they were able to request at any time. Peoples feedback on the food included, "Nicely cooked", "Lovely food", "I enjoy the food" and "The food is very good." We saw that people were regularly offered drinks throughout the day and people had drinks in their rooms.

The home had an in-house café that people could use when relatives came to visit. We observed one person had a meal but did not want to eat as they wanted to see a relative that had come to visit. A staff member took their meal on a tray to the person's room so that they could eat and receive their visitor.

Two homes run by the local authority had been closed and the people moved into Bridgewood House. Prior to the move, people had been assessed by Bridgewood House and social workers and a transition plan put in place. People, where possible, had been consulted and relatives confirmed that they had been involved in this process. There were detailed plans in place to ensure a smooth transition between the services. A relative told us, "They [the home] kept us updated and talked to us about the move. They were good with [relative] and made sure she knew when she was moving and explained everything." Many of the staff from the two homes transferred to Bridgewood House which maintained a level of consistency for people. A staff member told us that they stayed working with the same people to help them settle in.

The home used technology to support care and had access to computer software used by the local authority and other healthcare professionals. The system allowed staff within the home to send referrals for healthcare such as Occupational Therapy and safeguarding. The team leader said, "We can communicate with professionals on it and make quick referrals."

People's personal files had details of healthcare visits, appointments and reviews. People were able to access healthcare with support from staff. Staff said that they knew about people's individual healthcare and how to refer people if necessary. This included referrals to dentists, doctors and opticians. Where people required referrals to specialist services such as SALT, there were records to show that this had been done and followed up by staff.

People were able to decorate their rooms with personal effects to ensure that it felt homely. However, the building was new and still felt quite clinical. We saw that people had decorated their rooms with pictures, ornaments and things that meant something to them. Staff that we spoke with said that they were aware of this and were trying to make the home more cosy. We saw that there were areas of the home where tactile surfaces had been put in place to help people with dementia through touch. A wall of soft artificial foliage had been set up in one corridor and we saw a person standing by it and running their fingers through it whilst gently humming to themselves. A relative said, "It is lovely and new, she calls it her new flat."

Good

Is the service caring?

Our findings

We asked people if they felt staff were kind and caring. People commented, "I feel well looked after. Better than the last home", "I am very well looked after. I can't find any fault with it" and "Most of the staff are lovely." Relatives were positive about the care and said they felt staff knew their loved ones well and looked after people in the way they liked. Relatives commented, "If she's a bit weepy the carer says don't worry, they really do love her. She was difficult last week but they are good with her like that", "The carers, regardless of grade, are very close to her and kind", "The general feel has been right. You go into some homes and go on gut feel, this one seems right. There's enough staff that nothing untoward would happen without it being noticed" and "Dad has not settled down, carers settle him, walk him in the garden."

We saw that if people became upset or distressed, care staff knew how to work with the person to comfort them. We observed a person becoming distressed, the care staff used distraction techniques to help calm them down, asking if they wanted a cup of tea and talking about the activities that were taking place that day. Relatives also gave us examples of how care staff worked with people when they became distressed. Examples included; "[Relative] is in a wheelchair and needs a hoist. Some staff are really great and comfort her as she gets scared and as she is lifted she panics, majority are comforting and encourage her" and "When she's anxious, the staff will sit with her and hold her hand."

In one instance we observed a carer taking with a person and their relative. The person was talking about their family history and anecdotes. Staff interacted in a warm and friendly manner, showing interest in the person and the conversation. A relative said, "They [staff] communicate well with [relative]. She is getting really good care. This home is well above the others."

On the first day of the inspection we observed some people returning from a day trip. People came in laughing and smiling and reached out to hug staff on duty. Staff hugged people and asked how their day had been. People appeared happy and comfortable with the staff.

We found that where possible, people were encouraged to maintain their independence. Relatives told us that what people could do was discussed with them and implemented by care staff. Relatives told us, "We had a discussion to help her keep some of her independence" and "They try and make her as mobile as possible, she uses the hoist and a lift into the bath."' We observed staff encouraging people to maintain their independence, for example we observed a staff member walking with a person and encouraging them, explaining that they needed to walk to "keep their legs working."

Where people were unable to talk about what they liked or did not like, relatives were consulted to find out. This helped to promote people's person-centred care. People and relatives told us that they were involved in planning their care, sharing their relative's like, dislikes and preferences. Relatives said, "I'm very happy they asked me about how he likes the place and when I first went to see them what he liked and disliked", "They ask me about what she likes and doesn't like" and "They assessed him, with me and talked about his likes and encouraged him to have a shower and change his clothes. I couldn't get him to do it. It's a big result!" We observed that staff knew people well and were also able to tell us about individuals' likes and

dislikes. Another relative said, "Staff look after her clinically and decided on her care, we discussed at length, they do anything to keep her comfortable." However, this information was not always documented in people's care plans.

People were treated with dignity and respect. When we approached staff to find people who might be willing to speak to us, the staff sought permission and introduced us to people. If they refused, the staff member spoke in a pleasant and calm way, thanking them for listening. Staff respected people's wishes if they did not want to talk to us.

Throughout the inspection, we observed that people's personal care was maintained and people were clean and well dressed. Staff told us that people were given a choice of what they wanted to wear for the day. Each person had an on-suite bathroom and people's personal care was carried out privately. Staff told us that they closed doors and drew curtains when conducting personal care. We observed staff asking people if they were ready to have personal care and waited until the person was ready. We also saw that staff knocked on people's bedroom doors and waited for an answer before entering. A relative commented, "If she [relative] gets a bee in her bonnet she will not do it, staff are kind and responsive to her needs."

All relatives that we spoke with said that they could visit at any time and were made to feel very welcome. We observed relatives and friends visiting throughout the inspection and saw friendly interactions with staff when they arrived on the units.

Requires Improvement

Is the service responsive?

Our findings

Staff knew people well and we observed that they were responsive to their needs. However, care plans did not always contain enough information for staff to understand how to support the person. One person's care plan said, 'staff to engage [person] in conversation and encourage them to communicate more with staff and other service users. To involve him in different activities with other residents and staff.' However, there was no information on what the person enjoyed or what the person would want to talk about or specific strategies on how to engage the person. This was the same for three of the care plans that we looked at. Another person's care plan noted activities for the person and noted, 'physical exercise, typing, making phone-calls and expressing views on current affairs.' These were not realistic activities given the person required assistance with all tasks. These had been things that the person had done before requiring care and this had not been reviewed to reflect the person's current abilities. Other care plans talked about personal care but failed to say how the person wanted to receive their personal care.

There was information in care plans around people's faith and they noted what a person's faith was. However, there was no further information to say how or if the person required support to maintain their faith. Care plans did not have information on people's wishes at the end of their lives and what they or their relatives wanted to happen.

Conditions around people's care noted on DoLS authorisation had not been carried forward into people's care plans and it was unclear if staff were aware of any specific conditions. This would have included things the person was able or unable to make decisions about. We raised this issue with the registered manager at the time of the inspection.

The home employed two full time activities coordinators. There was a large designated activities room with a kitchen on the ground floor. The activities room contained arts and crafts equipment as well as reminiscence and memory items. There was an activities timetable which was displayed in large font for people to read on each unit. On the first day of the inspection we observed some people going on a trip to the zoo. Where people were out on a day trip we observed that there were no other activities going on for those left in the home. Despite their caring attitude we saw staff speaking among themselves and not engaging people in activities. We raised this with the registered manager on the first day. On the third day we saw that a staff member on each unit had been assigned to oversee activities. We observed staff engaging people in board games, puzzles and general chit chat. The weather was warm during the inspection and we observed staff taking people into the garden with a bubble machine. People had drinks and snacks and chatted.

Relatives told us that there were always activities to do or to observe depending on people's ability to engage and staff encouraged people so they did not become isolated. One activities coordinator told us, "We are trying to mix care and activities so that everyone who can, is offered opportunity to participate in outings or within the home." The home promoted person centred activities. One person used to be a bus driver and the home had taken him him to the local bus depot. There were pictures of the day that were displayed in his room. There was a hairdressing room on site and a hairdresser attended regularly, people

were able to make appointments as they wished. We observed people seeing the hairdresser on day three of the inspection.

People said, "Lovely room, staff do my nails & I enjoy the singing and dancing" and "I take part when I want. They don't force me." Relatives commented, "Its brilliant they now have activities", "She's limited. She doesn't go on trips as much, but she does lots of knitting and she has just made a blanket for her bed. She still does her word search, she's quite happy doing that", "They try not to isolate her from others, they bring and connect her at meetings and for entertainment. It is excellent care" and "There are activities to do, have food in the dining room where they meet other. They gave him a summer hat, he had lunch in the garden with all the other residents. I can take him out for the day."

We saw that five complaints had been documented since the home opened. This was primarily around, missing or damaged clothes in laundry, inappropriate moving and handling techniques, and overall dissatisfaction with service. All complaints were initially acknowledged, investigated and a response to the complainant was provided. Actions were taken where necessary such as replacing missing clothes, meetings with relatives and feedback sessions to staff. People that we spoke with told us that they would tell someone if they were not happy. One person said, "If I'm upset by something, I would tell the carer." Relatives knew how to make a complaint and felt that the home would listen if they raised any concerns. Where a relative had made a complaint, we were told that the home had acted on this and there had been improvements. Another relative said, "My daughter heard a carer getting short with mum. I spoke up straight away and it was resolved. If I ask for something, like she had a crack in the toilet, it is done straight away."

Relatives felt that there were always staff around if they or their relative needed help and that staff were responsive to people's needs. Feedback included, "When I need somebody I talk to them. I brought him some new clothes in and the nurse came with me to help me sort them out", "In the living and dining rooms there is always someone sat, at least one attendant. There are usually three about at any one time" and "When I've been in I've been more than happy. My cousin came to visit from Ireland, she said she was very impressed. She saw one carer holding a man's hand, she said that wouldn't have happened in the home her parent was in."

The home worked with people who may have been approaching the end of their life. Where appropriate, people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place. These had been signed by a healthcare professional and relatives where they had been involved in the decision. The clinical lead told us, "The Care Home Assessment Team (CHAT) do them [DNACPR's] and we only do them when we think that people are deteriorating." During the inspection we observed the clinical lead contacting the GP regarding a person who was likely to become palliative care. On the same day the CHAT team nurse had attended and confirmed to us that she had completed an advanced care plan for the person.

On day two of the inspection we were made aware of a person whose symptoms of a pre-existing medical condition had rapidly increased. We observed that the team leader knew the person well and that they would only feel comfortable with certain staff to accompany them to the GP. The clinical lead liaised with the GP to have the person immediately assessed. The home ensured that they got anticipatory medicines for this person as they were concerned she would deteriorate further quickly to end of life care. The person was also seen by the CHAT and an advance care plan put in place.

Requires Improvement

Is the service well-led?

Our findings

Documentation was not consistent. Risk assessments that documented how staff could minimise the known risk were in place for some people but not others. Some people's personal risks had not been adequately identified or risk assessed. There were insufficient systems in place to monitor risk assessments and ensure consistency and quality of information documented and provided to staff. Information in people's personal files was often difficult to find or documented in the wrong place. This made it difficult for staff to be able to find information quickly without reading through the entire file.

The registered manager said that they were aware that staff supervision had not been as regular as it should have been and were beginning to address this. However, there was no clear system in place to monitor staff supervision. We raised the training issues with both the registered manager and the managing director who said that they were aware that there were teething problems and were looking at how training was provided.

Information on DoLS was held securely in the registered manager's office. However, information regarding the authorisation and conditions that had been set as part of the DoLS assessment had not been included in care plans and staff did not have easy access to the information.

Peoples likes and dislikes were not always documented in care plans, despite relatives having input and staff knowing people well. Staff and relative's knowledge about people was not being used to help develop person-centred care plans.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew who the registered manager was. However, some staff that we spoke with told us that they felt that management had often been confusing and there had been several consultants brought in that had led to this. A staff member talked about changes made by different managers and said, "Seems to be a lot of one person says something and another person says something else." The home was also using a high number of, all be it regular, agency staff. We spoke with the managing director on the third day of the inspection around how this was being addressed. The managing director explained that recruitment had been difficult and they were currently on a recruitment drive to employ nurses and carers.

Some relatives that we spoke with said that they did not know the registered manager but felt that the home was well-run. Relatives told us, "If we have any concerns we know who to approach and the home invite us to meetings", "Home seems to be well run. I've had emails from managers and deputy manager with updates. I also have emails inviting me to open days. I'm well informed" and "Everything is well run I've never had to speak to the manager."

The registered manager was responsive to feedback we provided during the inspection. This was around the lack of activities for people when no activities coordinators were in the building. On the third day we saw

that a staff member was assigned to promote activities on each unit. A staff member told us that they had lots of ideas regarding activities but felt that management could be more responsive to their feedback.

The home completed weekly medicines audits and we looked at two months of audits. Where issues were identified, this was documented and actions taken to address any issues were also documented. The development manager told us, "I noticed from doing my audits that there was no action plan if there was a problem. This is now in place." The home also completed audits that looked at fire safety, DoLS, and health and safety. Where issues were identified, these had been addressed. There had been a care plan audit that had identified the lack of person-centred care planning and the management were aware of this. New care plan formats had been suggested but this was not yet in place. The registered manager or person in charge that day completed daily walk round checks. This looked at staff on duty versus rotas, access to PPE, overview of people's well-being and any accidents and incidents.

The clinical lead had begun to complete root cause analysis investigations for specific incidents such as falls. These identified what had happened and how the incident could be prevented from happening again. There were also clinical governance meetings to promote learning. Clinical governance meetings provided a framework to ensure that the home was reviewing incidents, understanding the factors that lead to specific incidents and putting in measures to prevent the recurrence of the incident.

There was good care being provided at Bridgewood House. However, good practice was not always documented and a staff member commented, "We are not documenting what we do well."

There were feedback forms on a table in the reception area where people and relatives were able to provide feedback if they wished. The home had not yet completed an annual survey yet.

People's care files showed that the home worked well with partnership agencies, including the local authority and healthcare professionals. We also observed examples of good partnership working throughout the inspection. The registered manager told us that they felt working closely with other agencies provided support and integration to ensure the best quality of care for people.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not always managed safely. Risk assessments were inconsistent and often failed to provide staff with adequate information on how to minimise the risk. Personal fire evacuation plans were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes had not been effectively established to ensure good governance with regards to record keeping.