Blake UK Care Services Limited

Bridlington Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Bridlington Lodge is a residential care home that is registered to provide accommodation and personal care for up to 20 adults and people living with dementia. The service also supported people with reablement following hospital discharge before they returned home. At the time of our inspection 17 people were using the service.

People's experience of using this service: Some people had been exposed to risk within the environment; some areas of the service were unsafe. When safety equipment was required this was not always in working order. Assessments had not always been carried out or followed to ensure people's safety. Risk management was not always effective and placed people at risk of harm. Lessons were not always learnt following accidents and incidents.

Systems had failed to effectively identify and mitigate risks to people. Auditing systems had failed to identify when required equipment was not in working order such as door sensors.

Staff had been recruited safely and staffing levels were adequate to meet people's needs. Infection control procedures had been followed and the service was clean and tidy.

People and staff were engaged with the running of the service. Staff felt supported by the registered manager.

Rating at last inspection: At the last inspection this service was rated good. (Published on 27 March 2018).

Why we inspected: We were notified about two serious incidents in which two people using the service were seriously injured. We looked at risks associated with this. Further information is in the full report. This was a focused inspection which looked only at the domains of safe and well-led.

Enforcement: The provider was found to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 12, Safe care and treatment and Regulation 17, Good governance. You can see what action we told the provider to take at the back of the full version of the report.

Follow up: The rating of this service has deteriorated to requires improvement. We have asked the provider to send us an action plan to indicate how they are going to address the shortfalls in regulation that we have identified at this inspection. We will review this action plan and continue to monitor all intelligence received about the service to ensure the next planned inspection is scheduled accordingly. We will also work with partner agencies to monitor the service.

For more details, please see the full report which is at the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Bridlington Lodge

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 prompted in part by information we received of two incidents following which two people using the service sustained a serious injury. These incidents are subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC indicated potential concerns about the risk of falls and environmental risks. This inspection examined those risks.

Inspection team: The inspection was carried out by two inspectors.

Service and service type: Bridlington Lodge is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did: Before our inspection visit we reviewed information we had received about the service since the last inspection. This included details about incidents and events that the provider must notify us about in line with their legal responsibilities and regulations.

During the inspection we spoke with two people who used the service and three relatives to ask about the care the service provided. We spoke with four members of staff and the registered manager. We spoke to one visiting health professional. We reviewed a range of records. This included three people's care records and multiple medication records. We reviewed a variety of documents including the provider's policies and

procedures and the governance and monitoring systems in place. We also carried out observations around the premises.

After the inspection we sought assurances from the registered manager about premises safety and they submitted documentary evidence to confirm that an issue we had identified with an outside bedroom had been addressed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Some regulations may or may not have been met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

- Monitoring systems in place were not used effectively to identify safety concerns and risks to people. For example, an external door which led to an outside area which presented a potential risk. There were no safety measures in place to alert staff if people were accessing this area unaccompanied. The provider was in the process of getting a lock system fitted.
- Safety equipment was not always in working order. For example, one-person door sensor was not in working order and left that person at risk of falls because it did not alert staff to when they left their bedroom.
- The service provided support for people with reablement, prior to them returning home when being discharged from hospital. Risk assessments had not been carried out for these people in relation to identified risks. Only assessments completed by external professionals were available to staff, they contained very little detail.
- Some areas of the service were unsafe. An outside room had been converted into a bedroom, this had ramped access inside the room. People who had limited mobility had been placed in this area, without risks being properly assessed.
- Lessons were not always learnt following accidents and incidents which continued to put people at risk.
- Some completed accident forms had insufficient factual detail.

The failure to manage risks to people's health and safety, were a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We raised our concerns with the registered manager and following our inspection they informed us this room would no longer be used as a bedroom. The registered manager also confirmed a door lock had been fitted to the external area following the inspection.

Systems and processes to safeguard people from the risk of abuse.

- Procedures were in place to follow for safeguarding incidents.
- Staff had received safeguarding training and could explain the action they would take if they suspected abuse.
- People told us they were safe. One person told us, "Yes I feel safe here."

Staffing and recruitment.

- Staff had been recruited safely. Appropriate checks had been undertaken to ensure staff were suitable to work with vulnerable people.

● There was an adequate number of staff to meet people's needs. People confirmed there was enough staff. One person told us, "Yes there is always staff about if we need them."

Using medicines safely.
● We noted some recording errors on one person's medicines record. We discussed this with the registered manager who addressed this during the inspection.
● Only trained and competent staff supported people with their medication. The registered manager carried out competency assessments on staff to ensure they were following best practice guidance with medicines management.

Preventing and controlling infection.
● The environment was clean and cleaning schedules were in place to maintain this.
● Staff had access to personal protective equipment to help prevent the spread of infection and we saw this was used appropriately.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

- Systems had failed to effectively identify and mitigate risks to people. Risk assessments had not always been carried out or followed.
- There was lack of risk assessments to guide staff in delivering effective support to people who used the service.
- Auditing systems had failed to identify when safety equipment was not in working order such as door sensors.
- There had not always been continuous learning following accidents and incidents. The service had identified and taken some action following accidents, however they had not fully learnt from these and mitigated future risks.

Systems and process were not operated effectively to ensure the risk to people was assessed, monitored and reduced. People were at risk of avoidable harm. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- Some people were isolated in a part of the building that wasn't suitable for them. One bedroom was separated from the main building and people were unable to access the main building without staff support. A relative told us, "I don't think it's good the outside room, they are all by themselves and can't go in to the main building if it is raining."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.

- Feedback was obtained from people and their relatives via surveys and in resident meetings. People were given opportunities to discuss ideas they had regarding the operation of the service.
- Staff told us team meetings took place. Records we looked at confirmed staff had attended these and a variety of topics were discussed.
- People and staff were complimentary about the registered manager. Staff told us they were approachable and supportive.
- The service was working in partnership with the City Health Care Partnership to provide support to people who required rehabilitation before going home after a stay in hospital.
- The registered manager was very open and transparent throughout the inspection.

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 Risks to the health and safety of people had not always been mitigated. Action had not been taken following accidents leaving people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process had failed to ensure risks were assessed, monitored and mitigated.