

Bradwell Hall Nursing Home Limited

Bradwell Hall Nursing Home

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

Bradwell Hall is a nursing home that provides personal and nursing care for up to 187 people. Bradwell Hall accommodates people in seven units across five different wings, each of which has separate adapted facilities. At the time of the inspection, 160 people were using the service.

People's experience of using this service and what we found

People were not always protected from the risk of harm and abuse because some staff were not always confident in identifying what may constitute abuse and the mechanisms in place for staff to report concerns were not fully understood. Safeguarding concerns were not always reported in a timely and safe way.

Some systems had been introduced to improve the governance of the service. However, these had not yet been imbedded into practice and we were unable to determine the impact of the effectiveness of the changes.

There had been some changes to the management at the home to try and improve the day-to-day running of the units and provide the registered manager with a full oversight of the service. This was newly implemented, and it was not yet possible to review the success of the practice.

There were mechanisms in place to learn lessons when things went wrong; however, some errors were still occurring, and these had not been reviewed to ensure the risk of reoccurrence was mitigated. Some regulatory requirements had not been met.

There was a high number of agency care staff working at the home, but this was balanced against the improvements made to the number of permanent nursing staff now employed at the service.

Since the last inspection, people's individual risks had been reviewed and care records amended to reflect people's specific needs.

Medicine management had improved, and the risks associated with infection prevention and control had been reduced.

The home was working well with other professionals to try and improve outcomes for people.

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

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 15 November 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been

made and the provider was no longer in breach of some of the regulations. However, we found one further breach of regulation and we noted further improvements were required in some areas and the provider was still in breach of some regulations.

Why we inspected

We received information in relation to how safeguarding allegations were managed. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

The overall rating for the service has not changed. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bradwell Hall Nursing Home on our website at www.cqc.org.uk.

Enforcement

The provider had failed to notify us, without delay of incidents related to abuse or an allegation of abuse in relation to a service user. This was a breach of Regulation 18 (Notification of other incidents) Care Quality Commission (Registrations) Regulations 2009.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will continue to monitor information we receive about the service. We will continue to request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Bradwell Hall Nursing Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was carried out by three inspectors and two Expert 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.

Service and service type

Bradwell Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. 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 inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with 10 people who used the service and eight relatives about their experience of the care provided. We spoke with 15 members of staff including the provider, registered manager, deputy manager, senior care workers and care workers.

We reviewed a range of records. This included nine people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant 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.

Systems and processes to safeguard people from the risk of abuse

- Some staff we spoke with were not able to tell us about the systems in place to help safeguard people from the risk of abuse and harm.
- The provider had issued staff with lanyards that contained relevant contact numbers so staff could report their safeguarding concerns. Three members of staff were not wearing their lanyards and told us they were unsure of its purpose.
- Not all staff were aware they were able to report concerns to anyone other than management at the home. As a result, we became aware of delays that had occurred in reporting some concerns about alleged abuse. Therefore, we could not be assured people would not be placed at risk.
- Staff had received safeguarding training however the shortfalls we identified meant the training had not be fully effective.
- People we spoke with told us they had no concerns about their safety. One person said, "I do feel safe here; safe and secure."
- The provider was working with the local authority to try and improve safeguarding procedures.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had been made and the provider was no longer in breach of regulation 12.

- The provider had employed a specialised nurse to specifically address some of the concerns we identified at the last inspection and we saw the improvements that had been made.
- People had the correct risk assessments in place and specific guidance about people's health conditions were documented in care plans to enable staff to support people in the most appropriate and effective way.
- Risks relating to specific conditions such as skin and tissue viability were addressed and reviewed regularly to ensure people were in receipt of the correct care and to reduce the risk of deterioration.

Staffing and recruitment

At our last inspection the provider had failed to always deploy sufficient numbers of suitably qualified, competent and skilled staff on some of the units. Some staff did not receive appropriate support or training

and staff did not always receive supervisions and appraisals as was necessary to enable them to carry out their duties and enhance their professional development. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of regulation 18.

- There had been an improvement to the number of permanent nursing staff employed at the home. However, there had been an increase in the number of agency care staff but feedback we received from people, their relatives and staff about staffing levels were generally positive. One person said, "I always have faith the staff will respond when I need them." A relative told us, "There are more staff here now, I am much happier." People were observed receiving support in a timelier way.
- The providers had employed new members of staff to take on specific roles such as an operations director and a clinical lead to oversee the everyday practice and drive improvements throughout the home.
- Staff supervisions had become more frequent and staff we spoke with told us they were in receipt of regular supervisions.
- Staffing levels and requirements were brought to the attention of the registered manager in a meeting each morning to ensure staff ratios were sufficient to meet people's needs.

Preventing and controlling infection

At the last inspection, the provider had failed to sufficiently assess the risk of, and prevent, detect and control the spread of, infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had been made and the provider was no longer in breach of regulation 12.

- Safety issues and hazards identified during the last inspection had been addressed and rectified.
- Some areas of the home had been refurbished however, there were still parts of the home where we identified equipment that was still compromised by rust or worn paint. There was an action plan in place to redecorate the whole home and work was taking place during our inspection.
- Risk assessments were in place to make staff aware of potential hazards and dangers and rooms such as the kitchenettes were kept locked when staff were not present.
- Staff were aware of infection control policy and procedures and told us the actions they took to protect themselves and others from the risk of the spread of infection.

Using medicines safely

- Medicines were managed in a safer way.
- People we spoke with told us they received their medicines on time.
- Stock checks we completed were accurate and corresponded with medication records.
- The registered manager had recently changed the pharmacy supplier to improve the quality and safety of medicine management.
- There was a full time medication auditor in post to enable errors and shortfalls to be identified earlier and therefore actions taken in a more timely way.

Learning lessons when things go wrong

- Some mechanisms had been put into place to improve the quality and care for people.
- New roles for staff had been created to enable them to have individual responsibilities and to be accountable for specific actions to improve outcomes for people.

- Some staff we spoke with were aware of the improvements required from the last inspection. However, not all staff we spoke with knew where changes were needed to enhance the quality and safety of care for people. The registered manager said, "Staff should see changes and will benefit from the new structure that has been put into place."

We could not improve the rating for Safe from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure systems in place were operated effectively to continually assess, monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had been a small shift in the culture at Bradwell Hall and this was evident from speaking with staff and through our observations. However, there were still improvements required to ensure people received person-centred, inclusive care and support.
- The registered manager said, "We are making changes and have a way to go. I want the home to achieve a good rating. I will take great pride in achieving a good rating. We are not yet at a point of no return."

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were not made aware of the outcomes of the last inspection. The registered manager said, "We have been solely concentrating on make the immediate changes that were required. We have not asked for formal feedback from people. We haven't hidden the report but we have not advertised the fact we needed to make changes either. This is something we can do to get more feedback to help us get better."
- The providers had begun to take actions to address issues we identified during the last inspection. Risks that posed immediate harm to people had been removed and there was an on-going plan to look at ways the provider could make changes for the better. For example, the operations director had been employed to work with the providers and the registered manager to utilise their knowledge and expertise to change practices and make improvements.
- Staff were more involved in the sharing of information between each other. A 'huddle' meeting had been introduced on some of the units to enable staff to get key information from one another about people's needs to ensure support they provided was consistent. A staff member said, "This huddle works really well as we get updates on important issues." This was not yet however rolled out over all of the units although

staff we spoke with told us this was due to be implemented.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance systems were not yet ingrained in the culture at Bradwell Hall and therefore actions that had been taken to improve the quality of care could not be measured effectively.
- Not all staff at Bradwell Hall were clear about their roles and responsibilities. Some staff were unsure of the correct safeguarding policies and procedures as already highlighted in this report. This placed people at risk of harm.
- The lack of staff knowledge in this area impacted on the registered manager's regulatory and registration obligations to make us aware of key events that happened at the service, as required by law.
- There had been significant delays in the provider informing of us of safeguarding concerns. This delay meant concerns were not always addressed effectively or actions taken in a timely way.

The provider did not always notify the Commission without delay of allegations of abuse in relation to service users. This was a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others

- The providers continued to work with commissioners with their Provider Improvement Response Team to look at ways to develop practice and change the care and support people received for the better.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their obligations and responsibilities under duty of candour.

We could not improve the rating for Well- Led from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents There was a failure to notify the Care Quality Commission of safeguarding incidents, without delay.

The enforcement action we took:

The provider was issued with a fixed penalty notice to the sum of £1250.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not fully embedded into practice and therefore not yet effective to sufficiently monitor the quality and safety of the service.

The enforcement action we took:

The provider is required to continue to submit monthly action plans telling us what they will do to improve the standards of quality and safety.