BM Care Warwick Limited

# Bromson Hill Care Home

## Inspection report

Ashorne
Warwick
Warwickshire
CV35 9AD

Tel: 01926651166
Website: www.bromsonhill.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Bromson Hill Care Home provides nursing care to a maximum of 34 older people, younger adults and people who may have a physical disability. At the time of our visit 27 people lived in the home.

People's experience of using this service
People's individual risks were not always identified, assessed and well-managed. The provider could not demonstrate all planned care had been provided safely because records were not always completed accurately or clearly to demonstrate safe practice and enable effective monitoring to take place.

Some environmental hazards which posed a risk to people, staff and visitors to the home had not been identified.

Medicines were not always stored securely, and staff did not consistently follow nationally recognised guidance to ensure medicines were managed safely.

At the time of our inspection visit there were enough staff on duty to meet people's needs, but there was a reliance on agency staff to ensure safe staffing levels were maintained. The staffing arrangements did not ensure the staff team always had the right mix of experience and skills to meet people's needs safely and effectively. Following our inspection, the provider explained the actions they had taken and those planned to try to address staffing challenges.

The provider was not consistently acting in accordance with up to date guidance to minimise the risks of infections spreading.

Audit processes had failed to identify areas needing improvement which placed people at unnecessary risk.

At the time of our inspection, the registered manager was absent from the service on extended planned leave and there was no deputy manager. The permanent registered nurse was providing interim managerial cover and was on call to provide support to the service 24 hours a day, seven days a week. These arrangements were not sustainable.

The provider had failed to provide effective support for the interim manager or to maintain sufficient and accurate oversight of the service. This meant risk management was ineffective and that regulations were not being met.

Following our feedback, the provider implemented an action plan to improve standards and practice at the home.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 5 August 2019).

Why we inspected
The inspection was prompted in part due to information received about staffing levels in the home and the management of risk within the service. A decision was made for us to inspect and examine those risks.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service is now inadequate. 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bromson Hill Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches of regulations in relation to safe care and treatment and good governance at this inspection. 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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# Bromson Hill Care 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. 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a nurse specialist advisor and an Expert by Experience who contacted relatives by telephone. 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
Bromson Hill Care Home 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. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager was on planned leave and an interim manager had been appointed to manage the home during the registered manager's absence.

Notice of inspection
Our inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and any recurrent

themes of concerns. We sought feedback from the local authority and commissioners who work with the service. We also contacted Healthwatch and an advocacy service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We carried out observations to assess people's experiences of the care provided. We spoke with the interim manager, an agency nurse, two care staff, the administrator and the maintenance person. We spoke with two people and seven relatives to gather their experiences of the care provided.

We reviewed five people's care records and a selection of daily records for people. We looked at 27 people's medicines records. We looked at a sample of records relating to the management of the service including health and safety checks, accident and incident records and safeguarding records.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to ensure immediate action was taken to address our concerns. We also shared our inspection findings with the local authority and the local Clinical Commissioning Group.

Inadequate

# 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 changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risk was not always identified, assessed and well-managed. For example, there were not always care plans to inform staff how to manage risks around catheter care, diabetes and epilepsy.
- One person had a catheter connected to a urine collection bag. The bag must be kept at a lower height than the person's bladder to prevent urine flowing back into the bladder increasing risk of infection. This person's urine bag was laying on their bed and fluid input and output was not being consistently monitored to support early recognition of an infection.
- Risks to people's safety were not always well managed because staff had not followed instructions within people's care plans. Records did not demonstrate people at risk of skin damage received regular pressure relief and fluid charts did not evidence people at risk of dehydration were regularly offered drinks. This exposed people to the potential risk of becoming unwell which was avoidable.
- One person had an area of skin damage to their ankle. There were significant gaps in records of the wound being assessed, measured and dressed. This meant the wound was not being sufficiently monitored to identify any early signs of deterioration which placed the person at risk.
- Staff had not ensured people had their call bells to hand if they needed to call for assistance. This placed people at risk if they were not able to get assistance in a timely way.
- Environmental hazards which posed a risk to people, staff and visitors to the home had not been identified. A grab rail was secured to the frame of the porch to assist people to safely use the stairs to the front entrance of the building. Due to the porch frames being rotten, the rail came away in a visitor's hand as they used it to support themselves down the stairs. This placed people at risk of avoidable harm or injury.
- A recent fire authority inspection carried out on 29 November 2021 identified a number of deficiencies relating to fire safety and systems, and identified actions were needed in order to comply with The Regulatory Reform (Fire Safety) Order 2005. We found no evidence of action taken in response to the fire authority visit and could not be assured a robust plan of action was implemented to address fire safety risks by the provider.

Using medicines safely

- Medicines were not always stored securely. A medicines trolley in a communal area had a loose chain across the doors which could be opened wide enough to get a hand inside. We found 18 tablets for pain relief had been left unsupervised on top of the trolley.This posed a risk people may access other people's medicines.
- Medicines which had shortened expiry dates when opened, did not always have the date of opening recorded on them. This meant we could not be assured of the continued effectiveness of some medicines.
- We identified concerns over the management and monitoring of medicines that require extra checks

because of their potential for abuse. We found discrepancies in the recorded stock amounts and the actual stock amounts in respect of two people's medicines. This posed a risk that misuse of these medicines may not be identified or addressed.
● There were some gaps on Medicines Administration Records (MARs) where staff had not signed to confirm people had received their medicines. Stock checks of medicines confirmed some doses had not been given,

● The provider was not working in line with national medicines guidance. Guidance was not always in place to inform staff when medicines prescribed 'as required' needed to be given. That meant people could have been given too much or not enough of those medicines.
● Some people were given their medicines covertly, that is hidden in food or drinks without their knowledge. Records had not been fully completed to evidence there had been a full mental capacity assessment, or a formal best interests meeting had taken place to ensure it was in the person's best interests. There was no guidance from a pharmacist on safe administration methods for medicines given covertly.
● People prescribed medicines to control their diabetes, did not always have their blood glucose levels recorded prior to the medicine being given. One person was prescribed a variable insulin dose dependent on their blood glucose level. Their levels had not been recorded for seven days on one occasion which meant we were not assured they had received the correct dose.

Preventing and controlling infection
● Infection prevention and control practices did not ensure infection risks to people were robustly mitigated. Odours in some areas of the home indicated hygiene practices were not sufficient or effective.
● Personal Protective Equipment (PPE) was not disposed of according to infection control guidelines. Staff were observed to place used PPE in a standard bin which had no lid or clinical waste bin liner.
● Furniture in shared areas of the home could not be effectively cleaned due to the surface peeling and bubbling. Some people's bed linen was dirty and tables in their bedrooms used for food and drinks were not clean. There were splits in bed bumpers which exposed the core. This increased risks of cross contamination and infection.
● Containers for the disposal of needles or sharps were not always disposed of in accordance with NICE guidelines. As well as the physical effects of a sharps injury, there was also the risk of getting a serious infection caused by any viruses on the needles.
● Clean laundry was stored in communal areas of the home and on top of trolleys used for dirty laundry which increased risks of infections spreading.
● Changes to government guidelines on COVID-19 testing in care homes had not been implemented. Staff continued to test for COVID-19 based on previous guidelines.

Learning lessons when things go wrong
● Accidents and incidents were not consistently reported or recorded. We found one person with a cut to their arm. This injury had not been recorded in the person's records or on a body map and no action had been taken to identify the potential cause. There was no information as to the action taken to manage the injury and staff spoken with could not tell us when or how the injury occurred.
● We could not be sure action had been taken to mitigate individual risks or to ensure any trends or patterns at service level were effectively identified.

Systems and processes were not sufficient to demonstrate risk was identified, assessed and mitigated. This exposed people to the risk of avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Care homes (Vaccinations as Condition of Deployment)

● From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

We identified a breach of Regulation 12(3), as the vaccination status of temporary workers supplied via an agency and healthcare professionals was not routinely checked. However, the Government has announced its intention to change the legal requirement for vaccination in care homes.

Visiting in care homes
● Visiting was being facilitated in line with government guidelines.

Staffing and recruitment
● Records showed there were enough staff to meet the needs of the people living at the home, however there was a heavy reliance on agency staff. For example, apart from the interim manager, there was only one other part-time nurse employed at the service and there were no permanent night nurses. The interim manager commented, "We have continuity this week because the RGN has been here before, but last week it was a different RGN turn up each day."
● Due to the high level of agency staff, the staffing arrangements did not ensure the staff team had the right mix of experience and skills to meet people's needs safely and effectively.
● Systems to ensure agency staff profiles and photographic identification were received before they worked at the home were not in place. On the day of our inspection no agency profiles had been received for the agency care worker on shift, or the two agency care workers from the previous day. This meant the provider could not be assured agency staff had received basic training or been vaccinated against COVID-19, as per current regulatory requirements.
● A high number of people at the home required two members of staff to support them. There had been no recent fire drills with night staff to ensure that staffing levels during this period were sufficient in the event of an emergency.
● The provider acknowledged the recruitment and retention of staff was the biggest challenge the service faced. Following our inspection, they explained the actions they had taken and those planned to try to address this. They confirmed they had appointed a registered general nurse who was going through recruitment processes. New care staff had been recruited and were being inducted into the service.
● The provider had a recruitment process to ensure staff were suitable for their roles by conducting relevant pre-employment checks. However, we found the process for verifying references needed to be improved.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risks of abuse. Relatives had no concerns about their family member's safety. One relative explained their confidence because, "I think [Name] would say something, she would tell me and I have got to know the manager a bit more and I feel confident in her and how she supports her staff and how the staff respond to her."
● Some staff were confident reporting potential safeguarding concerns. However, the systems and processes to investigate those concerns were not robust.
● Safeguarding records did not contain sufficient detail to evidence concerns were thoroughly investigated or that any learning/analysis had been identified to mitigate the risk of them happening again.

Inadequate

# 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 changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Audit processes had failed to identify areas needing improvement which placed people at unnecessary risk. For example, audits had not identified and addressed shortfalls in medicines and infection control practices. Environmental risks were not always identified to ensure they were managed safely and fire safety was not routinely assessed or monitored.
- The provider did not have sufficient oversight of the care provided to people. Risks were not always assessed, and staff had not always followed instructions to keep people safe. Records were not always completed accurately or clearly to demonstrate safe practice and enable effective monitoring to take place.
- The provider had not ensured COVID-19 national guidance was followed to keep people as safe as possible during the Coronavirus pandemic.
- At the time of our inspection, the registered manager was absent from the service on planned leave and there was no deputy manager. The only permanent registered nurse was providing interim managerial cover and was on call to provide support to the service 24 hours a day, seven days a week. These arrangements were not sustainable.
- High use of agency staff meant the interim manager was unable to focus their attention on the management of the home and maintain effective clinical oversight of risks. The provider had not implemented extra checks or support to ensure agency staff had the appropriate knowledge or understanding of people's needs.
- The interim manager was open about the challenges and told us her focus had been on supporting the agency nurses in the home. They commented, "When I took this on I thought it was only for a couple of months, but it has gone on and on and it has got more and more difficult watching the standards not being what they should be."
- The interim manager told us they were due to leave the service the day after our inspection visit. We had no assurance the provider had plans for a replacement manager or effective oversight and understanding of staffing pressures within the home.
- The provider had failed to maintain sufficient and accurate oversight of the service and to identify risk management was ineffective and that regulations were not being met. Therefore, people were not in always in receipt of safe care.

Governance and service oversight were ineffective. Systems and processes were not established and operated correctly. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● Following our inspection visit, the provider confirmed the interim manager had agreed to stay in post on a temporary basis.

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
● Following our feedback, the provider implemented an action plan to improve standards and practice at the home.
● However, records did not evidence that complaints were thoroughly investigated and responded to and learning had been taken to improve outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working with others
● Despite our concerns, relatives spoke highly about the service. One relative told us, "The atmosphere is good. The response from staff members is good and they care about [Name]."
● Relatives felt communication was good and they were kept up to date with any changes in their family member's health. One relative told us, "The home has constantly kept in touch with us about anything that happens, such as staff Covid cases or anything to do with [Name]. They make us very welcome." Another relative said, "If anything is concerning, they phone me straight away. They tell me if anything is wrong or is happening."
● Relatives were very positive about the interim manager who they described as being available, approachable, supportive and caring. Comments included: "The manager is very kind, helpful and understanding. She puts my mind at rest by talking to her" and, "I speak to the manager because she seems to be on top of everything, they always respond very quickly."
● Staff felt supported and had confidence in the interim manager. One staff member said, "[Interim manager] is a very good manager. She leaves the office to come and help us."
● Staff worked with other organisations including social workers and health professionals to support people's needs.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 (1) (2) (a) (b) (h) (3) HSCA RA Regulations 2014: Safe care and treatment<br><br>The provider had not ensured care and treatment was consistently provided in a safe way.<br><br>The provider had not ensured risk associated with people's care and the environment was identified, assessed and well-managed.<br><br>The provider had not taken all practicably reasonable actions to mitigate risk.<br><br>The provider had not ensured risk associated with fire safety was well managed.<br><br>The provider had not ensured temporary staff working with people had been vaccinated, unless exempt. |

**The enforcement action we took:**

We served a Warning Notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) (2) (a) (b) (c) HSCA RA Regulations 2014: Good governance<br><br>The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided.<br><br>The provider had not ensured they had effective systems in place to identify, assess and mitigate |

risk to the health, safety and/or welfare of people who used the service.

The provider had not ensured records relating to the care and treatment of each person using the service were accurate and up to date.

**The enforcement action we took:**

We served a Warning Notice.