Bradwell Hall Nursing Home Limited

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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

We carried out an unannounced comprehensive inspection of this service in June 2017. After that inspection we received concerns in relation to how a person was supported with their continence needs. As a result, we undertook a focused inspection to look into those concerns and only looked at the safe and well-led key questions. This report only covers our findings in relation to those key questions. 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

Bradwell Hall Nursing Home 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. Bradwell Hall Nursing Home is registered to provide personal care and accommodate up to 187 people, based in one building. There were six 'units'. The units were called, Keele & Breward, Tunstall, Chatterley, Chester, Sneyd and Audley & Little Audley. There were 176 people using the service at the time of our inspection.

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.

Quality assurance systems in place were not always effective in identifying when improvements were required. Lessons had not been fully learned following the identification of a risk regarding peoples' continence care.

Improvements were required about how people were supported to have their prescribed medicines. There was mixed feedback about staffing, but overall staff were not effectively deployed to ensure people did not have to wait for support. Staff were recruited safely and they had their character checked before supporting people.

People felt safe but there was a delay in making a referral to the necessary organisation following two incidents occurring. People were protected as infection control measures were in place and the building was appropriately maintained and checks took place.

People, relatives and staff felt the management team were approachable and were able to give feedback about their care. The registered manager and provider were receptive to feedback and wanted to improve the service.

Notifications were made as required and the previous CQC rating was being displayed as required.

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 consistently safe.

Medicines were not managed safely across all units in the home.

Further improvements were required to support peoples' continence needs.

Staff were not always deployed effectively.

People felt safe but there had been a delay in reporting some potential abuse.

People were protected by infection control measures and the building was appropriately maintained.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems in place had failed to identify and sufficiently remedy some concerns.

The provider and registered manager wanted to improve the quality of care for people.

People, relatives and staff felt able to approach the management team if necessary and were asked for feedback.

Bradwell Hall Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was 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.

We carried out this focussed inspection to check improvements had been made following concerns being highlighted regarding the safety of the support a person had received to help manage their continence needs.

The inspection took place on 16 and 20 August 2018 and was unannounced. The inspection was carried out by two inspectors and a pharmacist inspector. There were also two 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.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked the local authority for feedback. We used this information to help plan our inspection.

We spoke with 24 people who used the service and 15 relatives. We also spoke with eight members of staff – this included unit managers, care staff and nurses. We also spoke with two visiting health and social care professionals. In addition to this we spoke with the registered manager, deputy manager, a director of the company and a trainer. We made observations in communal areas. We reviewed the care plans for seven people who used the service. We also made observations of staff giving medicines and looked at medicine records. We looked at management records such as quality audits and the ways in which the registered manager and provider monitored the home. We also looked at recruitment files for three members of staff.

Requires Improvement

Is the service safe?

Our findings

At the last inspection this key question was rated as requires improvement. At this inspection we found that improvements were still required so it continues to be rated as requires improvement.

People told us they had varying experiences when receiving their medicines. One person said, "Sometimes the time varies, it was 8.30am today, other days will be 10am. It was early today." A relative said, "We do not see our relative take their pills, but I have seen other residents take theirs. The staff seem to make sure they do take them." Our medicines inspector visited three of the seven units at the home. We found that medicines were handled safely on two of the units but saw some instances of poor practice and poor recording of medicines on another unit. We observed staff giving people their medicines. One person was given three liquid medicines in a beaker which had not been thickened. The person was prescribed a thickening powder for all drinks because they found it difficult to swallow, so taking their liquid medicines in this way could have made them choke. The nurse did not follow national guidelines for recording medicines administration as some medicines were recorded as administered on the Medicine Administration Record (MAR) before they had been taken by some people. They also offered a person a medicine to be taken at exact times (in order to be fully effective) too early. On another unit we saw this medicine being given at the right time.

We looked at the records for people who were prescribed a powder to thicken their drinks on all three units we visited. Information was available about the consistency of drinks each person needed but there were no records of when drinks were made or the number of scoops added to a specified volume of liquid. These records are important because a thickening agent is a prescribed medicine and the person could choke if their drink is the wrong consistency. We saw the nurse on Audley unit make a thickened drink for a person which was thicker than the consistency stated in the person's records. A staff member explained to us that the nurse did this because the person's swallowing had got worse in the last few weeks. This person would be at risk if looked after by a new staff member or an agency staff member who didn't know them, as their records did not match the care they were receiving.

The use of people's moisturising and barrier creams was recorded well on two units. On another unit we found a cream in one person's room that carers were applying was different to the cream printed and signed for on their topical medication administration record (TMAR). The pharmacy label had been torn off. A carer told us, "Whatever [person's name] has got in her room we put on". Care staff were also signing to indicate they applied a medicated cream that should be applied by nurses.
Medicines were stored securely and at the right room temperature. However, the maximum recorded temperature of the medicines fridge on one unit had been too high for the last three readings and no action had been taken to rectify this. We saw gaps in the daily fridge temperature record on Sneyd unit. These gaps meant the provider could not be confident that medicines were being stored at the correct temperatures. If medicines in the fridge are not kept at the temperature stated by the manufacturer they may become ineffective or unsafe.

The home was in the process of introducing a new medicines system to improve safety and recording of the

administration of medicines following it being identified that improvements were required. Units which had already employed the new system had fewer issues identified than a unit without the new system. The registered manager and provider explained the new system would be in place very shortly across the entire home which would resolve many of the concerns.

We checked how people were supported with their continence needs and risks managed following concerns being reported to us about how a person was supported to manage their continence needs. The service had received feedback about a specific incident regarding a person's continence so we went to check action had been taken to make improvements. We found that some improvements had been made; however, we still found that less-invasive methods to support peoples' continence had not always been tried prior to using more invasive methods. For example, one person was prescribed two doses of laxative medicine per day, however for one month they were only being given one dose per day. Within the same month they had to have suppositories to help them relieve their constipation. This meant that the person had suppositories without having their full prescribed dose of other less-invasive medicines first. There was a lack of detail within some people's plans about how to prevent constipation. The records regarding peoples' continence were not always clear to enable staff to easily monitor people who may need additional support with their continence. There was an overall procedure about how to help manage constipation, however this did not effectively prioritise how to support people to be less constipated by using more appropriate methods. This meant that lessons had not been fully learned following an incident occurring. When we spoke with the registered manager about this, they said, "It is still evident we need to do more." Following our feedback, the registered manager updated the procedure and met with the local continence service to seek additional advice. The registered manager also said they would explore additional training and that they had implemented competency checks in relation to peoples' continence care.

There was mixed feedback about staffing levels. Staff were not always deployed effectively which sometimes left people waiting for support. One person said, "Sometimes I can't get to the toilet and I have to do it in my pants and I hate that." Another person said, "I press the buzzer and sometimes wait forever, I feel like they've abandoned me. I can hear the staff, but they don't come." Another person said, "The staff don't always come when I want the toilet. You've got to wait while they do their job. I understand that, but sometimes you see two or three of them stood talking and I shout them but they ignore me. They don't seem to care." A relative said, "There are not always enough staff and that is why the staff do not come to attend at the right time." We also received positive comments from some people and relatives, that they did not have to wait long. One person said, "There are enough staff." One relative told us, "Yes there's enough staff. They turn my relative every two hours. I can always find staff." Other comments from relatives included, "My relative does not have to wait overlong for support. If I ask for help they come straight away" and, "Staff support is good, they (the staff) come quite quickly."

Staff also told us they felt they were not always effectively deployed. One staff member from the Tunstall Unit said, "There are three staff [on the rota] but only two staff [supporting people] really. This is because one of us has to go into the kitchen to serve food. We are late sometimes getting people up. Then they are not happy." Another staff member from Tunstall Unit said, "There's not enough staff on here. There were people who needed changing to stop them getting sore and one person who wished to get up. We cannot do everything." One person had not been supported to get out of bed when they should have been. A member of staff from the Keele Unit said, "There's not enough staff. Staffing levels can be poor but the turnover of staff is terrible. We use agency and new staff but this does not help as they are not up to speed." Another member of staff, not based on a particular unit said, "I have never known such a high turnover of staff. It is really having an impact." There was a high number of people who needed one to one support on some units. This meant there would be a high number of staff required to ensure everyone had their one to one support, and additional staff to carry out other support. Staff sometimes went on their breaks at the

same time, as that was the only way of managing their time across their shift but this left the unit short of staff. The registered manager was already aware of this and had stopped accepting any new people who would require one to one support to avoid needing an increase in staff. They were also seeking to recruit new staff members on different shift patterns to avoid staff needing breaks at the same time. The registered manager and provider were proactive in trying to manage staffing levels. They would undertake daily checks across all units to find out if they were short of staff or not. There was a permanent staff member employed solely to monitor staffing levels and they used a monitoring tool to ensure staffing levels were at the required numbers. They would consider staffing across all units and move staff around and request agency staff when required.

Staff were recruited safely. They had appropriate pre-employment checks carried out such as checking two references and checks done with the Disclosure and Barring Service (DBS). This was to check if staff had any convictions and check they are of a suitable character to support the people using the service. If a member of staff did have a conviction, this had been considered and an assessment of their suitability was made prior to them starting work in order to protect people.

People told us they generally felt safe. Staff understood their responsibilities to keep people safe and knew how to recognise and what action to take if they suspected someone was being abused. However, there were two instances of potential abuse which had taken a number of days to refer to the local safeguarding authority, which should have been reported immediately. When we asked about this, it was explained that the registered manager usually looked at safeguarding on their daily walk around to each unit; however, the registered manager was not working at the time the incidents occurred. When we spoke with the registered manager about the delay they said, "That is really unusual for us, the only thing it could be is poor communication." We saw multiple other appropriate referrals had been made when there was potential abuse. People told us they felt safe. One person said, "No one shouts at me or treats me bad. The staff are nice." Another person told us, "Yes, I feel quite safe here, they (the staff) help me to move around and get me in and out of my wheelchair." Another person, "I feel safe when the staff use the hoist to move me for a bath." A relative said, "I have 100% faith in the staff and the nurses are absolutely marvellous." Another relative said, "We have no concerns on safety."

People told us that staff wore appropriate personal protective equipment (PPE) such as gloves and aprons when necessary. One person said, "The cleaners are gems – they do a good job, so thorough." We saw staff wearing PPE when necessary. There had been recent instances of an infection outbreak and appropriate steps were taken to minimise the spread, such as increased cleaning, not moving staff between units and advising relatives not to visit until the infection had cleared. We saw the provider carried out regular checks on the building and equipment to ensure it remained safe. People had a Personal Emergency Evacuation Plan (PEEP) to assist them to leave the building in the event of an emergency.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection this key question was rated as good. At this inspection we found that improvements were required so it is now rated as requires improvement.

There were systems in place to monitor the quality of care people were receiving. Many of these checks had identified areas for improvement, however issues we found during our inspection had not all been identified. Improvements were needed in relation to peoples' continence support and medicines. In another example, audits were carried out on the supplements that people needed to help maintain enough calorie intake. These audits identified that some peoples' supplements were out of stock, and had been for a number of days. When we discussed this with staff they explained there was sometimes a supply issue from the pharmacy. A staff member said, "People weren't going without [their supplements], they were having others in stock." The administration of supplements was also not always recorded in the same place, which made it more difficult to monitor what people were having and the service could not always evidence people were receiving supplements. The registered manager said in relation to one person, "On review of the diet and fluid charts it is unclear what the person actually had as staff were recording diet only and not fluid. Staff have said they have always got spare and have used that but I cannot prove that." This meant the recording system in place were not always effective in evidencing people received the necessary supplements. The registered manager told us, "I have taken this as a recording error and will be dealing with this through training." Staff were not effectively monitoring peoples' bowel movements following a risk being identified. Different documents or systems were being used by staff, meaning there was not a consistent approach to recording this information. This meant that nurses responsible for monitoring peoples' continence and bowel movements in order to help keep people safe, did not have effective information available to them. This meant concerns may not be identified quickly enough to help keep people healthy. Systems in place had also not operated effectively when the registered manager was not present as two incidents had not been referred to the local safeguarding authority in a timely way.

The provider and registered manager were proactive in trying to improve the quality of care people received. When we fed back some of our findings the provider said, "We want the feedback so we can change things. We will review things immediately." The registered manager made us aware they were employing additional resources to carry out audits to prevent issues reoccurring. Other audits had been effective at identifying concerns and action was taken to improve peoples' care. For example, the registered manager had recognised that some units with high usage of staff supporting people one to one needed changes making and were already trying to change this. The provider had a staff member dedicated to ensuring there were enough staff to support people. They would cover rotas and move staff around the site to ensure all units had sufficient cover. A new medicines system was also being introduced to improve how people were supported to take their prescribed medicines. People, relatives and staff were asked for their feedback about the care in the home. One staff member said, "We have a staff meeting every couple of months." We saw a survey with relatives had been carried out, analysed and action taken when improvements were suggested by respondents. For example, ensuring people and relatives knew how to complain, by putting up additional visible notices.

Each unit had a unit manager and the registered manager oversaw the entire home. People and relatives felt able to approach staff in the management team. One person said, "There is a lady manager who is nice to me." A relative said, "I speak to [unit manager] and they seem on top of everything. They are approachable." Another relative said, "All the staff are very nice and approachable." Another relative said, "We do talk to [manager] and they are approachable. The manager and the staff do listen." A member of staff said, "[Unit manager] is approachable. Their concern is the residents and the staff. Issues get dealt with."

The service worked in partnership with other organisations. One visiting health professional said, "I have no concerns. When I ask for information it is provided quickly and I can access online care plans and records which is good". Another visiting health professional said, "We're able to raise concerns to the unit managers or nurses" and went on to say, "We have a multi-disciplinary team meeting every week." This meant a range of professionals could meet together to discuss people's care to ensure they were supported appropriately. We saw notifications were submitted as required and the rating was being displayed, as required by law.