Berrystead Nursing and Residential Home Limited

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Inspection report

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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

Berrystead nursing home is a residential care home providing personal and nursing care to 28 people at the time of the inspection. The service can support up to 46 people.

People's experience of using this service and what we found
People were not always safe because risks within the environment were not identified or managed effectively. People were not protected from the risk of infection. The environment was poorly maintained and not fit for purpose in multiple areas. There was only one working shower in the building and this shower was not clean or fit for purpose. This meant people did not have access to suitable and accessible baths or showers. These issues had been identified at our last inspection on the 5 & 9 of November 2021 and were ongoing.

Hot water supply temperatures in 16 people's rooms were in excess of safe limits, this put people at risk of scalds and burns. There was no management of water storage or legionella risk. Risks were not identified or not managed in a safe way. People were not protected from the risk of abuse because staff did not follow the correct procedures and did not report concerns to the local authority safeguarding team as they are required to.

Staffing numbers were not sufficient to meet people's needs or keep them safe. People with high dependency needs or identified risk of falling were unsupervised and alone for the majority of the time. Care was task orientated and not person centred or based on people's individual needs and preferences.

There was a lack of oversight and support at director level. Quality monitoring and governance was not taking place. There were no opportunities for people to be involved with or feedback about their care and support. There were many risks in the environment and many areas of the home were poorly maintained, unsightly and not fit for purpose. A fire risk assessment had been carried out In December 2021, However the report was not available to view at the time of this inspection. The provider sent us the fire risk assessment following this inspection. There remained a number of high and moderate risks identified requiring action.

Some people were distressed and had difficulties communicating their needs and were not always offered reassurance because staff did not have the time. Some people did not receive personal hygiene to acceptable standard, they were visibly unclean and looked dishevelled.

Staff were recruited in a safe away. Most people said they liked the staff.

Rating at last inspection and update.
The last rating for this service was Inadequate (report published 7 January 2022)

The overall rating for the service has remained the same. This is based on the findings at this inspection.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. At this inspection, improvement had not been made and the provider was still in breach of regulations.

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 have identified breaches in relation to the premises and equipment, safety, protecting people from abuse, staffing and governance.

The provider is required to adhere to conditions imposed by way of a consent order agreed at the First Tier Tribunal on 19 April 2022. The provider must inform CQC when they believe the conditions have been complied with and the CQC will check by conducting a further inspection. There is no one living at the service and the provider cannot admit any service users until the conditions are met.

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.

Berrystead Nursing and Residential Home Limited

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.

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
This inspection was carried out by three inspectors and a specialist advisor. The specialist advisor was a chartered engineer and provided advice about the hot water system and water storage.

Service and service type
Berrystead Nursing and Residential home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
The inspection was unannounced.

What we did before the 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and two relatives about their experience of the care provided. We spoke with ten members of staff including the provider, registered nurses, care workers, and a housekeeper.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 inadequate. At this inspection this key question remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection
At our last inspection risks were not identified or managed, and people were not protected from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

- Risk in the environment was not identified or managed effectively. The provider's own fire risk assessment dated March 2020 identified a number of very high risks requiring immediate attention. Not all the required action had been taken to ensure fire safety. A further fire risk assessment was completed in December 2021. A number of high and moderate remained.
- We identified hot water supplied in a number of people's rooms was delivered at unsafe high temperatures and this put people at risk of burns and scalds.
- There was no legionella risk management plan. There was no management of water storage and water was below the required temperature to prevent bacteria growth in water tanks.
- Risk of choking was not being managed for two people. One person had been assessed as requiring an easy chew diet by a speech and language therapist because of swallowing difficulties. This person was given meals which did not comply with an easy chew diet. Another person was at risk of choking but there was no risk assessment or effective management plan in place.
- A person at risk of falling and leaving the building unsupervised had a sensor mat to alert staff when they were walking. This mat was faulty and was not working during our visit or for several days before. There were no alternative arrangements in place to ensure their safety.
- Some areas of the service were in a poor state of repair such as carpets and bathroom/shower rooms. There was chipped paintwork, and the sanitary ware was old and dirty and not fit to use.
- There was only one working communal shower in the entire building and no bath people could access. The one working communal shower room was not clean with rust in the hand basin and limescale in the toilet and shower head. The water in the hand wash basin was only nine degrees.

Risks were not identified or managed, and people were not protected from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
- The provider did not recognise the signs of abuse. They did not take the required action when a person reported safety concerns or when unexplained bruising was identified.

● There was no investigation or referral to the local authority safeguarding team as is required.
● Some people were neglected because care and treatment significantly disregarded people's needs. Some people were left in bed for most of the time and some people were not supported to use the toilet when they needed to. Staff did not have time to spend with people or to offer reassurance when people were distressed.

People were not protected from abuse or improper treatment. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection staffing numbers were not sufficient to meet people's needs or keep them safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 18

● Staffing numbers were not determined based on any staffing tool or on the dependency needs of people living at the service.
● The majority of people had physical needs and required two staff members to support them with mobility and other needs. Sixteen people required the support of two staff and a hoist for mobility needs. There were five care staff on duty in the morning, four in the afternoon/evening and three at night. These numbers were not sufficient to meet people's needs or keep them safe.
● Short notice staff absences were not always replaced. On the second day of our inspection, only three care staff were on duty.
● Staff did not have time to spend with people and many people were alone and unsupervised for the majority of the time. This included people with high dependency needs and people at risk of falling and at risk of choking.

Staffing numbers were not sufficient to meet people's needs or keep them safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited in a safe way. Checks were carried out before employment was offered to make sure staff employed had the right skills and experience. The registered manager carried out monthly checks of nursing registrations to ensure professional registrations were valid and up to date.

Learning lessons when things go wrong
● Very little progress had been made since our last inspection in November 2021. The premises and environment was still in need of maintenance and refurbishment in multiple areas.
● A person became trapped in their bedrail and sustained significant bruising in November 2021, not enough action had been taken to prevent this happening again.

Using medicines safely
● People told us they received their medicines at the right time and in the right way.
● Staff had training about managing medicines and had their competency assessed.

- People's medicines were stored correctly and securely.

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 inadequate. At this inspection this key question remained the same. 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

At our last inspection the provider was in breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

- Quality monitoring and audit failed to identify risks in the environment or the lack of maintenance and refurbishment. This resulted in bathrooms and shower rooms being out of order and not fit for use. These issues were identified at our last inspection. Minimal improvements had been made
- Very few audits were taking place. The provider sent us a very basic health and safety audit they carried out. This was not signed or dated and failed to identify hot water temperatures found to be in excess of safe limits causing a risk of burns and scalds or water storage and legionella risks.
- Action to remedy the urgent risks identified in the provider's own fire risk assessment were still outstanding.
- There was no registered manager or person acting as manager. Staff felt unsupported by the provider and said they had no one to address their ongoing concerns with. A relative told us communication was poor and there was a lack of leadership since the registered manager left.
- Staff were worried about low staffing numbers and about the poor state of the environment. We saw staff struggling to manoeuvre hoists and wheelchairs through fire doors because the magnets designed to hold these doors open were not working. Staff told us the magnets had not been working for several months and this made their job very difficult.
- There were no mechanisms in place to involve people who used the service or to seek feedback about their experience of care and support.
- Many people were neglected and not protected from risk or able use the toilet when they wanted to. Staff did not have time to spend with people or to give the reassurance required when they were distressed.
- Parts of the service such as some people's bedrooms and communal areas were not maintained to an acceptable standard. People's views and experience of this poor environment were not considered.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we identified the premises and equipment where care and treatment are delivered were not clean or suitable for the intended purpose or well maintained. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 15.

● There were multiple concerns about the cleanliness of bathrooms and the storage of equipment and combustible materials in communal areas.
● Window glazing was blown causing a cloudy and unsightly appearance. Not all windows were fitted with the required glazing to meet British safety standards. Many areas in the environment were unsightly and clearly in a poor state of repair. These were longstanding issues which had not been rectified. There were no clear plans or timescales in place to carry out the work required.

This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

● Not enough improvement had been made since our last inspection in November 2021. People remained at risk of harm and people did not receive the care and support they required.
● The provider had not consulted with the local authority safeguarding team when concerns had been raised or unexplained bruising identified as they are required to.
● The provider had failed to take action required by the local authority as part of their action plan to address concerns they had identified.