Meridian Healthcare Limited

Bridgewater Park Care Home

Inspection report

Bridgewater Road
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bridgewater Park Care Home is a care home with nursing providing care for older people and younger adults who may be living with a physical disability or dementia. The service is registered to support up to 63 people in one adapted building. Forty-five people were using the service when we inspected.

People's experience of using this service and what we found
There were not enough staff to give people timely care, provide the reassurance and support people required when they were distressed and keep the home clean. Areas of the service needed redecoration and renewal. Maintenance issues made it difficult to effectively clean the service.

Some people's health needs had not been managed effectively to ensure they received timely emergency care, pain management and oversight from professionals involved in their care. Lessons were learned when things went wrong. Staff had been provided with additional training, support and guidance in recent weeks to develop their confidence and competence when assessing and monitoring people's needs, completing care tasks and records.

For people who lacked the mental capacity to make decisions about their care, the policies and systems in the service did not support people to have maximum choice and control of their lives.

Quality assurance systems were not operated effectively and failed to ensure compliance with regulations. Where issues had been identified the provider had not always acted in a timely manner to address these. Staff morale was low. Not all staff felt confident to speak up or felt they would be listened to.

People told us they felt safe, liked the staff and were happy and settled in the service. Staff understood how to identify and report safeguarding concerns.

Good practice guidance had been followed to help minimise risks relating to COVID-19. Risk assessments were in place to guide staff on how to safely meet people's needs. The management team reviewed all accidents and incidents to identify any actions that could be taken to prevent a similar thing happening again.

Medicines were managed and administered safely. People's nutritional needs were met.

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

Rating at last inspection.
The last rating for this service was good (published 27 January 2018).

Why we inspected
We received concerns in relation to the timeliness of a person's health care support and the approach and skills of staff. As a result, we undertook a focused inspection to review the key questions of safe, effective 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this 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 Bridgewater Park 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 in relation to safe care, decisions on behalf of people, the environment, staffing, records and overseeing quality monitoring at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bridgewater Park 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. 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
Three inspectors visited the service on 8 March 2021 and two inspectors visited on 9 March 2021.

Service and service type
Bridgewater Park Care 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.

The service had a manager registered with the Care Quality Commission who had resigned three weeks before the inspection. The provider had deployed their turnaround manager, already in post, to support the service. During the inspection the nominated individual (provider's representative) confirmed recruitment for a new permanent manager was underway. The registered manager 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 on the first day and announced on the second day.

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 safeguarding and commissioning teams, professionals who work with the service and Healthwatch. 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 all information to plan our inspection.

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.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with the nominated individual and 13 members of staff including the area directors for operations and quality, the turnaround manager, registered nurse, two nursing assistants, two senior care assistants, three care staff, a housekeeper and a laundry assistant. We reviewed a range of records. This included nine people's care records, multiple medication records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We reviewed additional evidence requested from the provider and continued to seek clarification to validate evidence found. We spoke with six relatives.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. 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.

Staffing and recruitment

- The provider had a system in place to calculate safe staffing levels. However, there were not always enough staff on duty or effectively deployed to meet people's needs and maintain the cleanliness of the environment.
- No activities were provided during the inspection to engage people and we observed people wandering in corridors and shouting for long periods of time, becoming distressed.
- Rotas showed there had been shortfalls of care, housekeeping, laundry and catering staff. The area director also confirmed some staffing hours allocated for additional support with catering had not been utilised. The rotas were not clear or reliable.
- The call bells rang for long periods of time during the first day of the inspection and there were delays in staff response. There were mixed comments from people about staffing, and these included, "At times I have to wait a long time for staff to come and on occasion they have just switched off the call bell" and "There have been delays, sometimes it depends who is on" and "Seem to have enough staff on duty."
- All the staff we spoke with voiced concerns about staffing in the service. Comments included, "We are often short staffed having to cover the other unit. Staff sickness is very high", "There just aren't enough kitchen and cleaning staff" and "They [management team] try and cover the shortages with home staff or get agency, but often they can't. There are people on the dementia unit who really need some one-to-one support and we don't have enough time to spend with them."

Failure to deploy appropriate numbers of suitably qualified, skilled, experienced and competent staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Recruitment processes were safe with all required checks in place before new staff started employment.
- During the inspection, the area director confirmed recruitment was underway to employ a new manager, deputy manager, additional nursing, care, catering, laundry, domestic and activity staff.

Preventing and controlling infection

- Shortfalls with environmental renewal were impacting on the maintenance of standards of hygiene, for example the limescale build up on taps and sinks throughout areas of the service and worn flooring in the kitchen and in toilets. The shelving in the laundry was heavily damaged and paint was peeling off the walls.
- Not all areas of the service were clean. For example, items of equipment needed cleaning and standards of hygiene in the kitchen were poor. On the second day of the inspection the kitchen areas, a lounge and dining room were deep cleaned. This work had been organised by the provider prior to the inspection.

● The laundry arrangements were poorly organised; the washing machines were sited in a room accessed through the clean laundry area. This meant soiled laundry was taken through the clean laundry area, where laundered items were stored on open shelving, which presented a risk of cross contamination.

Failure to ensure the premises and equipment were clean and properly maintained was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider's estates team completed a review of the environment and produced an action plan for renewal.
● COVID-19 guidance had been put into practice. We were assured the provider had good stocks of PPE, accessed testing for people who used the service and staff, and admitted people safely to the service.

Systems and processes to safeguard people from the risk of abuse
● Staff were trained in safeguarding and had the skills and knowledge to identify and report concerns. However, some staff told us they had not always felt confident reporting concerns to the previous manager due to fear of reprisal. Some staff had recently followed the provider's whistle blowing procedures and external reporting procedures to raise concerns with CQC and the local safeguarding team. The provider was currently working with staff to provide assurance that all concerns reported to the new management team would be dealt with appropriately.
● Concerns under investigation by the local safeguarding team in relation to the care one person had received at the home had been broadened to a whole service review. Safeguarding and commissioning officers had visited the service to talk with people, members of staff and review people's care support. The provider had completed an investigation and they shared their findings with CQC following the inspection.
● The provider reported safeguarding incidents to the local safeguarding authority and CQC.
● Everyone we spoke with told us they felt safe in the company of staff.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● There were systems in place to assess risk and keep these under review. People had individual risk assessments for areas such as moving and handling, falls, distressed behaviour, nutrition and skin damage. The standard of recording in the care files was inconsistent and senior staff had started to rewrite people's care plans and risk assessments to ensure they were sufficiently detailed and more personalised.
● Risk assessments had been completed in response to the COVID-19 pandemic. These included an awareness of health conditions and ethnicity, which could impact on the vulnerability of people and staff.
● Accidents and incidents were monitored, analysed and action taken to prevent reoccurrence. Key clinical areas such as pressure care and weight management were also monitored closely to improve people's outcomes.

Using medicines safely
● There was a safe system for managing medicines. This included policies and procedures, safe storage, staff training and audits to identify shortfalls for corrective action.
● We spoke with the area quality director about some minor recording issues in relation to hand transcribed medication administration records and the consistent use of protocols for 'as and when required' medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff worked with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Staff had not always been proactive in identifying changes in people's needs and subsequent health concerns. This meant some people experienced delays in accessing support and treatment in a timely way. For example, one person's changing health needs had not been monitored effectively and their pain control had been poorly managed. Another person had not received timely emergency care and treatment.
- Although staff liaised and worked closely with a range of health care professionals, there was evidence some concerns raised and initial requests for review were not always followed up by the home staff. Guidance and support from healthcare professionals was not always recorded.

Failure to effectively monitor and manage people's health needs safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had arranged for the nursing staff to complete additional clinical skills training to ensure improvements in identifying any deterioration with people's health.
- People's needs were assessed and recorded. This included information to enable staff to determine if people's needs could be met safely within the service.
- Whilst some care plans contained more person-centred information than others, they did include guidance for staff in how to care for people.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not following the principles of the MCA. There was a lack of records to show mental capacity assessments and best interest meeting records had been completed for some people who lacked capacity to consent to their care, the sharing of information and photographs.
● Restrictions were in place, for example the use of bedrails. People's capacity to make these decisions was not always completed and the decision for the restrictions had not been discussed and recorded as in their best interest and as the least restrictive option for people.
● In one person's file a member of staff had signed the person's consent to care record on the person's behalf, which showed their lack of understanding of MCA. Where people's records indicated their representatives had legal authority to make decisions on their behalf, there was no information to support this.
● For those people who lacked capacity there were no records to show consent had been sought for their first COVID-19 vaccinations.

Failure to ensure consent to care in line with the law was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had deprivation of liberty authorisations in place. These were monitored and liaison took place with the local authority regarding review and renewal.
● The area director had scheduled MCA training sessions for staff following the inspection and confirmed consent records were included in the programme to review and update each person's care records.

Staff support: induction, training, skills and experience
● New staff received an induction to the service and were supported to complete a range of training.
● Systems were in place to identify gaps in staff's training and when their training needed to be updated. The management team were supporting staff to complete all outstanding mandatory training to ensure 100% compliance.
● Additional training and support had been arranged and some courses delivered in areas such as record keeping, care planning, MCA and clinical skills.
● Staff had not always received supervision and appraisal at the frequency as outlined in the provider's policies and procedures. Some staff told us their supervision meetings were not an open discussion and they had not felt supported or valued by the management team. A new appraisal programme had been put in place and a supervision meeting for each member of staff had been scheduled with the turnaround manager.

Supporting people to eat and drink enough to maintain a balanced diet
● People enjoyed the food at the service. They were provided with a variety of meals and refreshments throughout the day.
● Each person had a care plan regarding their nutritional needs and assessments of any potential risk, for example choking or poor intake. Monitoring charts for food and fluid intake were not completed consistently and people's individual fluid targets were not always identified.
● Any concerns regarding weight loss or gain were monitored and discussed with GP's and dieticians where necessary. Each person's body mass index had recently been reviewed to ensure this was accurate and to confirm appropriate weight monitoring systems and frequencies were in place.

Adapting service, design, decoration to meet people's needs

● The service had been designed to meet people's needs. There were grab rails in bathrooms/toilets and handrails in corridors, which were wide enough for people who used wheelchairs.
● People's rooms were personalised to individual's tastes and preferences. Pictorial signage and photos helped people living with dementia find their way about their home.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires Improvement. 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.

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

- Systems and processes in place had not been operated effectively to ensure compliance with regulations. Shortfalls were identified at this inspection relating to safe care, staffing, consent, the environment and good governance.
- Governance systems used to monitor the quality and safety of the service provided had failed to identify and address all issues and shortfalls in a timely manner. For example, an external inspection by the community infection control team took place in October 2020. The service received their inspection report in January 2021 which identified issues in relation to the laundry and standards of hygiene which were still present on the day of the inspection.
- In August 2020 improvements needed with the standard of detailed and person-centred information contained in the care plans were recorded in the home improvement plan. The target date for this work to commence had been delayed at each review and effective action to rewrite the care plan records only started in February 2021.
- There were shortfalls in recording systems. These included records for care monitoring, cleaning and consent.
- A lack of effective provider oversight and monitoring had not identified the negative culture at the service. Staff did not always feel listened to, valued or supported. Some staff expressed they did not feel able to raise issues and when they had they were not always acted on. Some staff felt communication from certain members of the management team had not always been appropriate and at times they had felt 'bullied.'

The provider failed to maintain accurate records and ensure systems to assess, monitor and improve the service were sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The longstanding registered manager had recently left the service and recruitment was underway for a new manager. The provider had deployed their turnaround manager who was working closely with the senior management team to improve the day-to-day management of the service.

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; Learning lessons when things go wrong; Working in

partnership with others

● The provider notified agencies such as the local safeguarding team and the Care Quality Commission when incidents occurred which affected the safety and wellbeing of people who used the service.

● The provider and management team were aware of the need to admit when things went wrong, to attempt to put things right and to offer apologies.

● Following the recent safeguarding investigation, the senior management team had acted positively on the areas of concern identified. A specific action plan had been put in place. Communication and recording systems were being reviewed and developed. Staff were involved in workshops, meetings and receiving additional training.

● The senior management team were developing better partnership working with key health and social care agencies to ensure good outcomes for people. A professional we spoke with said they were satisfied with the level of care delivered to their patients, staff communicated well with their team and followed guidance given.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had mechanisms in place to gather feedback from people, their relatives and members of staff. Feedback was analysed to look for themes and trends, so appropriate and proportionate action could be taken.

● Staff and the management team have risen to the challenges presented by the Covid-19 pandemic, although mixed feedback from relatives about the communication and support throughout the pandemic was received. Comments included, "The manager and staff have been brilliant in keeping us informed about everything" and "The communication has been quite limited. I was able to have one video call during the lockdown as the nurse kindly arranged this; I wasn't really sure what the arrangements were."

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not followed the principles of the MCA. People's consent to care was not sought in line with the Mental Capacity Act. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured people's health care needs were monitored and managed safely. Regulation 12 (1) (2) (a) (b) (c) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure the premises and equipment were clean and properly maintained. Regulation 15 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to maintain

	accurate records and ensure systems to assess, monitor and improve the service were sufficiently robust. Regulation 17 (1)(2)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at all times. Regulation 18(1)