Maria Mallaband Limited

Bridge House Care Home

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

About the service
Bridge House Care Home is a residential care home providing personal care to up to 30 people aged 65 and over. At the time of the inspection there were 13 people living there. The home accommodates people over two floors separated in to four wings, some of who have physical needs and some people who are living with dementia.

People's experience of using this service and what we found
Risks were not always managed correctly and accidents and incidents continued to be inconsistently recorded leaving people at risk of further harm.

There were not enough staff to meet the needs of people living in the home. The home was relying heavily on agency staff during an outbreak of Covid-19. This, in addition to the lack of details in risk assessments meant people's care needs were not always known by the staff supporting them.

People were not always being kept safe from the risk of the spread of infection. The provider had not implemented regular environment checks or ensured staff knowledge was up to date with the most recent guidance.

Since the last inspection there was a new manager in post who had started to implement changes. However, enough time had not passed for these to be embedded in the service or to confirm whether any changes were sustainable. People, staff and relatives did not always feel supported by the provider.
Quality assurance audits had not highlighted the shortfalls found in the inspection. The action plan from the last inspection had not yet been fully implemented.

Recruitment processes had improved and staff received regular training. People were supported with their medicines at the correct times of day by competent staff.

Staff knowledge in identifying safeguarding and reporting incidents correctly had improved. Staff were confident to discuss this topic and new, improved training had been delivered since the last inspection.

The manager and the management team were working closely with the local authority and health professionals to drive improvement within 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 (and update)

The last rating for this service was requires improvement (published 2 December 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made

and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of infection control, staff knowledge of the use of personal protection equipment (PPE) and staff levels in the home. 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 have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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 focused and comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bridge House 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 in relation to the safe care and treatment of people, the management and provider oversight of the home and staff levels at the inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The 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.

Bridge House 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
This inspection was carried out by two inspectors.

Service and service type
Bridge House 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 who was completing the registration process, however not yet registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the 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.

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. We also spoke with relatives who had contacted us with feedback about their experience of the care provided at Bridge House Care Home. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with seven members of staff including the interim manager, senior care staff, agency care staff, housekeeping staff, the chef and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We requested immediate assurances in relation to concerns found regarding infection control and staffing levels within the home. We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas and quality assurance records. We spoke with the health and social care professionals who worked alongside the home. We also spoke with a further member of staff and two relatives about their experience of the care provided.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly record and analyse incidents which could have been avoided or minimised. 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 been made at this inspection and the provider was still in breach of regulation 12

● Risk associated with people's care was not always managed in a safe way. There was a risk of people developing pressure sores as appropriate measures were not in place to reduce the risk of them occurring. One person was being cared for in bed. There were no re-positioning charts or risk assessments for pressure areas. There was also no adequate moving and handling equipment to support this person to be repositioned and staff had not been appropriately trained in the use of equipment to safely move the person. There was no evidence of how staff were safely re-positioning this person to support them with personal care.
● Care plans did not always contain up to date and relevant information concerning the risks associated with people. One person's care plan stated they needed to be on a softened diet. The chef was unaware of this person's restricted diet and staff told us that they had encouraged them to begin to eat more solid food. There was no evidence of this person being referred to a speech and language therapist (SALT) team to determine whether they were now safe to eat more solid food. The manager was also unable to establish where the guidance for a softened diet guidance came from. This lack of guidance was also a concern raised by the clinical commissioning group (CCG) visit to the service in December 2020 but had not been addressed.
● There was SALT guidance for another person that stated "Coughing/choking incidents would occur" if the person was not positioned correctly when they were being supported to eat. However, there was no risk assessment for this in place or guidance for staff to follow in relation to this.
● In one care plan it stated the person would, on occasion, show behaviour that challenged staff. However, there was no risk assessment or positive behaviour plan was in place or guidance for staff to follow.
● There were a number of people living in the home that suffered with anxiety and/or depression. There were no risk assessments in place for this or guidance for staff on how to manage these risks to improve the person's wellbeing.
● Staff told us that they were not always aware of people's individual risks. One member of staff said, "With regards to individual residents. No, I don't think there is enough information about their risks based on their

needs. We have been verbally told about people's needs."

● There had been a recent increase of agency staff in the service due to a number of permanent staff who were isolating or off sick due to Covid-19. The agency staff were unsure of people's needs and confirmed they referred to care plans to find all the details. One member of staff told us, "I find out what people's needs are from the care plans. Sometimes it is not always clear, I try to ask a permanent member of staff if they are available."

● The impact of a large amount of agency staff and overwhelmed permanent staff was noticed during the inspection. For example, there had been a delivery of controlled drugs and a further prescription that were left on the reception desk in the reception area of the home. This was against the policy and procedure for the booking in of all medicines into the home. It was confirmed that this had been a misunderstanding between the delivery driver and an agency worker and was immediately rectified.

● Due to the recent outbreak of covid-19 there had been a dramatic change in people's care needs. Some people that had tested positive for the virus had deteriorated considerably and required a lot more support than previously. For example, some people required more support with eating and drinking or personal care as their energy levels had depleted. Action taken by staff was not always recorded to confirm correct care was being provided to respond to a deterioration in people's health. An example of this was a person's health had deteriorated after they had received a positive covid-19 result and there had been no recording of how they had been supported to eat or drink sufficiently. This person was admitted to hospital two days before our inspection where they were treated for dehydration.

● Where accidents and incidents occurred, steps were not always taken to prevent further occurrences. Accident and incident forms were not always signed off as being reviewed by the manager. The lack of management reviews were also highlighted in the audit completed by the provider in December 2020. This audit showed that this lack of management review had meant that the accidents and incidents did not always get submitted to the online system that analysed trends and patterns. This was also highlighted in the previous inspection. Despite an action plan being sent in following the last inspection sufficient improvements had not been made. For example, one of the action plan points detailed how all accident and incident forms would be collated from each month by the 3rd of the following month and the form reviewed and signed by a manager. This had not been done and on some occasions examples of forms from November 2020 without a manager's signature were seen.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. At the time of the inspection the home was experiencing an outbreak of covid-19 and this had a direct impact on the care for people in the home. Staff were unsure of what guidance they were to follow in relation to the correct use of Personal Protection Equipment (PPE). For example, staff members were observed not wearing correct PPE when supporting people who had tested positive for Covid-19. Current guidance states that when staff are providing personal care or within 2 metres of a person with confirmed or suspected Covid-19 should wear an apron, gloves, surgical mask and eye protection. Disposable gloves and aprons should be disposed of and changed before providing care to another person. One staff member was seen to only wear a face mask without an apron or gloves when supporting a person who had Covid-19. Another staff member was seen to leave a room of a person that was Covid-19 positive without removing any of their PPE, walk in to the corridor and enter another person's room.

● Current guidance indicates that bedroom doors of Covid-19 positive service users should be kept closed where possible to reduce the risk of the inspection spreading. During the inspection bedroom doors were seen to be wedged open of people that had tested positive for Covid-19 which put other people at risk of getting the infection. There were no risk assessments in place for why bedroom doors would need to be wedged open or any apparent attempts for people to be in the furthest point of the room to achieve a two metre distance.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. During the time of the outbreak we were told by staff there had been an ongoing issue with the clinical waste disposal. Clinical waste needed to be contained in a designated area in a locked bin. However, we found that the waste had accumulated as it had not been collected and the bin and was overflowing into the general waste area. This increased the potential of the spread of the virus.
● Housekeeping staff numbers had been affected by the outbreak where staff were absent due to positive Covid-19 results. There was no evidence to demonstrate how routine cleaning had been adapted to respond to the Covid-19 risk, including increase in frequency of cleaning commonly used areas and surfaces. With the absence of staff and no evidence of increased cleaning this increased the risk of the virus spreading.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was meeting shielding and social distancing rules. For example, people who were shielding were not supported by staff wearing the correct PPE. Another example was staff did not have appropriate facilities to socially distance when supporting visiting health professionals and updating records.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were not assured that the provider was making sure infection outbreaks can be effectively managed.
● We were not assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

A lack of proper recording of people's change in care needs, risk assessments and management as well as a lack of correct infection control procedures placed people at risk of harm. This is a continued breach of regulation 12 (Safe Care and Treatment) of The Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

● The provider responded immediately during and after the inspection. They confirmed risk assessments were being progressed, new systems had been implemented to record people's care needs and more robust infection control procedures were being followed. We were also informed that all staff would be trained in the correct moving and handling technique immediately after the inspection. We will follow this up at the next inspection.

Staffing and recruitment
● At the time of the inspection there was an outbreak of Covid-19 in the home. A large percentage of the permanent staff team, including the registered manager and the regional manager were isolating, this left the home with two permanent members of staff that knew the home and the needs of the people living there. Whilst we acknowledge that the provider took appropriate action to deploy agency staff to ensure appropriate numbers of staff to support people, the way in which staff skills and knowledge were deployed did not always ensure people's safety and continuity of care. Due to some gaps in the completeness/accuracy of care records, agency staff did not always have reliable written guidance with which to care for people confidently. The two permanent members of staff with knowledge of people's needs were not always able to support the agency staff who were less knowledgeable and experienced in working with people who lived at Bridge house.
● People told us there were not enough staff. One person said, "I see few staff, as they are so busy". Another person said, "Staff are short of time, and have no time to chat".
● Staff told us that they were overwhelmed with the lack of staff when a large number of the permanent staff had to isolate in quick succession of each other and there was a period of time before agency staff were

organised. One staff member said, "We've just been so short for two weeks, we're at breaking point." Another member of staff said, "The staff that are off are asking us how are we coping? And quite honestly I don't actually know."
● In the four days prior to our inspection an interim manager had attended to support the home and organised more agency staff to cover shifts. One agency worker said, "I feel sorry for the permanent staff here, they have been very short and now they are tired."
● The permanent members of staff confirmed that they had completed handovers to agency staff that had never worked in the home. One staff member said, "We do our best to go through all care needs in handover so the agency staff are briefed of people's needs." It was not clear how agency staff retain all of this information and there was no written evidence to show how important information was handed over in the absence of clear guidance to refer to in people's care plans and risk assessments.
● Some relatives told us that there had been an inconsistent staffing team for the past year and that this had directly affected the level of care. One relative said, "All of the good ones (staff) have gone. Nobody knows [person] at all, her likes/dislikes, nothing." Another relative said, "I feel that the best way to describe the staffing situation is inconsistent. [Person] gets very frustrated as they don't know her needs at all. The level of care has definitely deteriorated.

The number of staff deployed as well as the lack of staff with adequate knowledge of the home and the care needs of the people living there had impacted the care provided. This is a breach of regulation 18 (Staffing) of The Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

At our last inspection the provider had failed to ensure safe recruitment checks had been completed prior to staff working at the service. This was a breach of regulation 19 (Fit and Proper Person Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The provider and registered manager followed safe recruitment processes. This included reference checks, an interview and a check with Disclosure and Barring Service (DBS). This check confirmed whether a potential future employee was known to police and whether they were suitable to support the people living at the home.

Systems and processes to safeguard people from the risk of abuse

At our last inspection safeguarding concerns had not been addressed in a timely way through lack of reporting and knowledge of staff which left people at risk of ongoing harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People told us that they felt safe living at the home even though they knew staff were rushed. One person said, "I know they will keep me safe." A relative also told us, "With everything that is going on I still know that [person] is safe."
● Since the last inspection staff had received in depth training on how to identify and report a safeguarding concern.

● Staff told us that they were confident to report any safeguarding concerns. One staff member said, "If anything happened like a serious incident, then I would report to the manger or report to HR. We are told by the manager that we can report to the local authority and CQC."
● The provider had a safeguarding policy in place that was available to all members of staff.

Using medicines safely
● People told us that they had access to their medicines and staff supported them with this. One person said, "Yes, staff support me with my medicines when I need them."
● There were medicine audits that had been recently introduced. These identified if there were any medicine errors so they could be addressed in a timely way. Medicine administration records (MARs) were checked during the inspection and all charts that were checked had been completed correctly.
● People's medicine care plans had clear details of what medicines they received and had guidance for staff on how to support people with "as and when medicines" (PRN).
● Staff received regular medicine administration training and the management team completed regular competency checks to ensure staff were supporting people safely.

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 now deteriorated 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.

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

At our last inspection there was a lack of oversight and effective audits resulting in a lack of effective governance at the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives told us of their frustration of lack of communication with the home. One relative said, "I was so worried about [person] after receiving the news that she is positive with Covid-19. I never had any updates, even though they promised they would regularly call me. Whenever I tried to call the home I could never get through." Another relative said, "I would like to be able to give them [staff] the benefit of the doubt and say that the communication issue was down to the recent outbreak, but if I'm being completely honest it has been pretty awful for over a year now."
● The provider had completed monthly quality assurance (QA) audits, however these were not effective in addressing shortfalls. They had identified inaccuracies with the recording and reporting of accident and incidents, however we continued to find concerns with how they were being recorded.
● The audits taking place were not always effective in identifying shortfalls. For example, audits had not picked up on the shortfalls around the lack of appropriate risk assessments in people's care plans.
● Whilst the home experienced the outbreak of Covid-19 the provider has confirmed management arrangements that had been made but this wasn't clearly understood by staff. Staff were unsure of the management cover and who to contact to provide updates about the concerns regarding the home. One staff member said, "The new manager started at the end of last year, but she has been off sick. We have had managers helping us from other homes within the company. It has been quite stressful as they all have their own ideas on how things need to be done." Another member of staff said, "It's just been chaos to be honest, [regional manager] was really supportive, but then she went off as well. It's just been really challenging and confusing who to contact."
● Correct infection control policies and audits had not been introduced in a timely way by the provider in response to the pandemic. This had led to confusion amongst staff as to what their responsibilities were and what guidance to follow. There was lack of signage to support agency staff showing areas where people

were positive with Covid-19. There was also lack of effective training in PPE for staff to follow correct, up to date guidance.
● The provider had not ensured care plans for new admissions to the home were completed in a timely way. A person had moved to the home for a respite stay ten days before our inspection. There was no paperwork in place to assess immediate risks or for staff to know about the person's care needs. The only paperwork present was the hospital discharge documents.
● The action plan submitted as a result of the last inspection stated that the manager and quality lead would complete audits to ensure that accident risk management has been reflected into the care plan to reduce future risk. This had not been effective as some care plans lacked falls risk assessments where they had experienced falls and these had been recorded on accident and incident forms.

There was a lack of oversight and effective audits resulting in a lack of effective governance at the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● Relatives that were spoken with appreciated the compassion that had been showed by the staff following the outbreak at the home. One relative said, "It's so obvious that staff are trying their best in an awful situation. They are the true heroes, the ones on the ground, trying to keep life as normal as possible for [person]." Another relative said, "I know they (staff) are doing their best to keep us updated, has it fallen short? Yes, but they are experiencing a terrible outbreak at the moment and still trying their hardest to include us in updates."
● Staff were continuously trying to seek feedback from people living in the home. An example of this was the new chef in post had lists of people's likes and dislikes. The chef also said, "At this time when people need to be eating and drinking more, I think it's important to give them what they like. If anyone requests something, I try everything to make sure I can accommodate so people have more chance of eating more of something they like and building up their strength again."
● Since the last inspection the registered manager and the provider had worked with the local authority and the clinical commissioning group (CCG) who supported their visits to the home. The home manager told us how they were striving to ensure improvement. They said, "We want to work with everyone in an open, transparent way to ensure the home improves and continues to improve."
● In response to the recent outbreak of Covid-19 staff were working alongside health professionals who were attending the home to support with additional resources. One health professional said, "They [staff] are very responsive to our advice and they are in a very tricky situation so it is refreshing they [staff] are trying to do everything they can."
● Staff told us that before the outbreak support for staff had improved since the last inspection. One member of staff said, "In normal circumstances, I can go to management if I need to and talk to them. If I have an idea about something, then I could always ensure it is heard."

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	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of staff with adequate knowledge of the home and the care needs of the people living there had impacted the care provided. This is a breach of regulation 18 (Staffing) of The Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A lack of proper recording of people's change in care needs, risk assessments and management as well as a lack of correct infection control procedures placed people at risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of The Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight and effective audits resulting in a lack of effective governance at the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice