Bridge House Holdings Limited

Bridge House Nursing Home

Inspection report

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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
Bridge House Nursing Home is a care home providing personal and nursing care to people aged 65 and over who may also live with dementia, a physical disability or a sensory impairment. Bridge House Nursing Home accommodates up to 54 people across two separate buildings, each of which has separate adapted facilities. At the time of inspection, 36 people used the service.

The service is also registered to provide care to people in their own homes. At the time of inspection no one who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People told us they felt safe. People and relatives felt there was not always enough staff deployed. Staff training records were reviewed, and we made a recommendation. Staff understood their responsibilities to raise concerns and report incidents or allegations of abuse. The staff team followed procedures and practices to control the spread of infection using personal protective equipment. Medicines were not always managed safely. The registered person did not ensure that all required information was recorded, and appropriate checks were carried out.

People were supported with their nutrition and staff worked well with people, families and health and social care agencies to support people's wellbeing.

People's care was individualised in order to best meet their needs and activities were in place to support with stimulation. Care plans were person centred and included the input of the relevant person. We made a recommendation about the building and premises.

Systems were in place for people to raise concerns and they felt they would be listened to. People felt that staff were caring, and regular activities were available for them to take part in if they wished to.

Prior to the inspection, the provider had written their own action plan in August 2021 and identified areas of improvement, however actions were outstanding.
The provider did not ensure systems were embedded to oversee the service and ensure compliance with the fundamental standards. They did not have evidence to support effective governance. The service had an open and transparent way of working to ensure the safety of the people living at the service. Staff knew people they supported well and cared about their wellbeing. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

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

Rating at last inspection
The last rating for this service was good (published 17th January 2020).

Why we inspected
We received concerns in relation to the management of medicines, people's nursing care needs, and staffing levels. 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 COVID-19 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 full 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 Bridge House Nursing 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 good governance, medicines management, safe recruitment of staff and premises. 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 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.

Bridge House Nursing 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
The inspection was carried out by three inspectors, one medicines inspector and an Expert 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.

Service and service type
Bridge House Nursing Home is a 'care home' and domiciliary care agency. 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. As the service is also a domiciliary care agency, it also provides personal care to people living in their own houses. In domiciliary care, we do not look at the premises.

Notice of inspection
This 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. 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 10 people who use the service and seven relatives about their experience of the care provided. We spoke with 11 members of staff including the strategic service development manager, registered manager, deputy manager, care workers, nurses, activities coordinator and the chef.

We reviewed a range of records. This included six people's care records and multiple medicines records. We looked at four 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 also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed training data and quality assurance records.

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 service failed to ensure all necessary checks required prior to staff employment were available.
- Although the staff files we looked at contained some of the information required by the regulation, the provider had not obtained all required information prior to deploying staff to work at the service.
- In one file, there was satisfactory verification of the reason why the staff member had left a previous employment working with vulnerable adults. However, the provider had failed to verify the applicants reasons for leaving previous work with vulnerable adults for the remaining three newly recruited staff members.
- Three files did not include evidence of conduct in all previous jobs with children or vulnerable adults or reasonable attempts to retrieve the evidence. This meant the provider could not be assured that applicants for roles at the service were fit and proper prior to their employment

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and staff felt insufficient staff were deployed and this impacted on the quality of care provided.
- Staff reported they felt pressured carrying out their roles, due to low staff retention and high levels of absence.
- People reported due to short staffing, call bells can take a long time to be answered. People told us, "Staffing is very low" and, "Don't bother ringing the bell as they don't answer it." One relative told us, "…bells are left unanswered for lengthy periods of time. From reviewing the call bell audits, there are multiple occasions people were waiting between seven to eight minutes.
- We reviewed the staffing rota for Bridge House and Bridge Court which evidenced on some occasions insufficient staff were deployed compared to the dependency tool used by the provider to calculate safe staffing levels.
- According to the dependency tool, five staff were required per shift. One example of insufficient staff was on the 6th September 2021. There were three staff allocated to work a full 12 hour shift and one agency staff working an eight hour shift; this would mean that at times throughout the day, there were two staff below the required amount and one staff below all day. This meant people were at risk of not having their care provided in a timely manner.
- We spoke to the registered manager, deputy manager and strategic service development manager who acknowledged our finding of insufficient staff deployed. They explained how they attempt to increase staff deployed by using agency staff or contacting staff off duty to increase staffing levels, however due to

challenges recruiting within the sector, this was not always possible.
● The registered manager also reported they were waiting for four new staff members to commence employment within the next few weeks.

Using medicines safely
● People's medicines were not safely managed.
● Medicines were usually stored safely and securely. However, medicines trolleys were not secured to the wall when not in use. Medicines cabinets were not locked when not in use. This meant there was a risk medicines could be inappropriately accessed by others. The service had taken action to minimise the risk of unauthorised access to medicine storage areas.

● Medicines awaiting destruction were not secured away and logged. The service failed to ensure the safe disposable of medicines in accordance with regulations and guidance.
● Documents to help staff to administer 'when required' (PRN) medicines were not always in place. The service failed to follow medicines guidelines designed to protect people from harm by medicines being given incorrectly.
● There was no record of the calibration of blood glucose monitoring machines to ensure that the readings given were correct. This meant there was an increased risk that readings were inaccurate and could lead to incorrect care of people's diabetes
●Controlled drugs (those subject to strict controls by law) were stored safely and securely. However, twice daily stock checks were not always completed. The provider was not following their own policies and procedures."
● There were out of date medicines in the homely remedy cabinet. Homely remedies are over the counter medicines, such as paracetamol. Expired medicines may not work as intended, and therefore were a risk if given to people.
● Medicine audits were completed and did identify some of the issues we found. However, there were no records of whether remedial actions were completed. The provider could not be sure changes to improve the safety of medicines were completed.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed that people were being given their medicines as prescribed. Medicines administration round times were conducted at the same time each day.

Learning lessons when things go wrong
● An effective system was in place to record individual incidents and accidents.
● Accidents and incidents were recorded and reported to ensure that harm to people was appropriately documented and reviewed.
● There was evidence that the management team investigated incidents and accidents appropriately.
● However, there was no evidence the service analysed themes and trends in the accident and incident reports and ensured measures were in place to reduce the likelihood of repeat events. This had been identified by the provider through their action plan however had not yet been actioned
● The incident and accident log did not always contain written evidence of learning or action taken to improve the service and learning lessons when things go wrong.

We recommend the provider reviews how they use information and learn from incidents and accidents in order to ensure they follow best practice and drive improvement in safety.

Systems and processes to safeguard people from the risk of abuse

● All staff had received safeguarding training. Staff were aware of what actions to take if they felt people were at risk of abuse or neglect, including to contact the outside organisations.

● Staff knew how to recognise abuse and protect people from the risk of abuse. One staff member said, "I would raise concerns to my manager and also I can contact the local authority and CQC."

● People felt safe in the home and liked the staff who supported them.

● When safeguarding concerns were raised, the registered manager dealt with them appropriately and recorded all actions taken.

Assessing risk, safety monitoring and management

● There was some evidence that environmental safety had been managed. We saw records of Legionella checks, fire systems and electrical checks that took place.

● Routine safety checks were carried out and were within the safe and expected levels, such as monthly hot water temperatures at taps accessible to people who used the service.

● There was also no evidence that cold water temperatures and the temperature of the hot water outlet (where hot water is stored) was checked. We spoke to the maintenance team who reported that these were checked on a regular basis however results were not recorded. The provider has stated they will implement the documentation of cold water checks going forward.

● People had individualised fire risk assessments and emergency evacuation plans in place.

● Fire drill records showed staff were involved in regular fire drills. This meant that both staff and people were aware of what action to take in the case of an emergency.

● People's needs were known to staff. People had risk assessments in place and actions in place to mitigate the risks. Staff knew people and how to protect them.

● The provider had a business continuity plan that covered various emergencies including evacuation or an outbreak.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

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

At our last inspection we recommended the provider considers current guidance on dementia friendly environments as part of the ongoing refurbishment plan. The provider had not made improvements.

- The premises was not suitable for people living with dementia. Best practice guidance was not used to inform the decoration and adaptation of the building and environment.
- At the time of inspection, there was insufficient signage and use of contrasting colours, to enable people to find their way around and identify their rooms, toilets and other rooms. People with dementia rely on adapted and sufficiently decorated premises to ensure their orientation and memory of place. The provider has stated that they have arranged for further signage in the home to be displayed.
- There was minimal use of contrasting colours on bathroom fittings, which could make them easier for people to see and use, thereby promoting their independence and helping with continence. Proper colour contrast on bathroom fittings make toilets easier to find and see, promoting good continence management.
- There was a lack of orientation signage, which would enable people to easily navigate their way to different parts of the building, for example to their bedroom or dining room.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and strategic service development manager stated they planned to complete a review of the decoration of the premises. This was to ensure the environment was as dementia-friendly as possible and help to encourage and promote people's independence and sense of wellbeing.

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.

● People's care plans and consent forms documented if the person had capacity or if they required any support with making decisions.
● All staff received training in the MCA, and this was renewed annually.
● People's care plans showed whether they had a Lasting Power of Attorney and the provider had sought evidence of this.
● Although mental capacity assessments took place, not all people had decision specific capacity assessments. This had been identified by the provider's action plan in August 2021. For example, one person who lacked capacity had bed rails in place, however there was no evidence of a best interest decision or a mental capacity assessment specific to bed rails use.

We recommend the provider reviews their mental capacity assessment process to ensure decisions are made in line with the MCA codes of practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Plans were person centred and contained information covering a summary of daily routines, including how the person would like their care to be carried out.
● People felt involved in their care. One relative told us, "[There has been] a comprehensive review of her care. Two staff members were present, and it was reassuring and comforting for me."
● People's care plans were reviewed every month. This ensured they were accurate, up to date and reflected the current needs and preferences of people.
● Daily notes of people's care were satisfactory. We noted that emotional and psychological welfare were not always routinely recorded. This meant a holistic record of the person's day was not in place.

Staff support: induction, training, skills and experience
● All new staff were placed on an induction which included shadowing senior staff and completing all practical training required including manual handling.
● People felt that staff had enough training and experience to care for them.
●Staff felt they received the training they needed to enable them to effectively meet people's needs, choices and preferences.
● The service provided training in topics they considered mandatory, such as fire awareness, manual handling, medicines and food hygiene.
● Staff received additional training in specialist areas, such as dementia. This meant staff could provide better care to people who used the service.
● However, the service's mandatory training was not in line with best practice for ongoing adult social care staff. For example, the service's mandatory training did not include person centred care, oral health, dignity, communication or recording and reporting which are recommended for registered nurses and care workers.

We recommend the provider reviews their staff training provision in line with the current best practice guidance for adult social care staff.

Supporting people to eat and drink enough to maintain a balanced diet

● There was mixed feedback regarding the food provided by the service. Some people said, "The food is cold." and, "The food is not great." Whereas others said they liked the food and had been invited to contribute ideas to improve the meals further. For example, suggestions included having special meals, such as "Italian night". This was fed back to the registered manager during the inspection.
● Information about people's dietary needs had been recorded in their care files. This included special dietary requirements such as different textures to prevent choking.
● Some people's care plans did not include food and fluid charts despite being required their care plan. This was highlighted to the registered manager who ensured this was rectified at the time of inspection.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service had regular involvement with an occupational therapist, physiotherapist, GPs and the local authority to support people to have a healthy life.
● The service had an on-site rehabilitation area where occupational therapists and physiotherapists supported people to improve their mobility and general well-being.
● We found evidence of regular conversations between the provider and other professionals to ensure the best outcome for the person.
● Professionals reported good communication occurred with staff, in order to meet the needs of people.

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.

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

- The provider had completed an internal audit in August 2021 which identified multiple areas for improvement of the service. This had also been updated in September 2021 to identify the actions completed in the month prior. There was an action plan in place to improve the oversight and governance of care people received. However, many of the remedial actions in the audit were not in place and the changes required were not completed.
- The provider had not embedded an effective system to assess, monitor and improve the quality and safety of the service provided. For example, the provider did not always have contemporaneous notes and documentation identifying lessons learned and themes following incidents. Records of some maintenance completed were not maintained.
- The provider did not follow their own policies and procedures regarding the completion of medicines administration records and supporting documents.
- Themes and trends of audits were not identified in order to learn and improve the service and the care being provided to people.
- The provider's requirement for good management oversight stated that audits of care plans, medicines administration records, incidents and accidents and safeguarding incidents were to be completed monthly. However, there was no evidence care plans and medicines records were audited prior to June 2021. There was also no evidence call bell audits had been completed before June 2021. This meant the management team did not have information about what areas of the service required improvement during this period, and therefore did not have effective oversight of care people received. They could not be assured that care was safe, effective and high quality.

This was a breach of Regulation 17 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

- The management team were welcoming and demonstrated an open and transparent approach in their leadership.
- People told us, "I personally think it is great they [the management team] are so caring and on the ball at all times." Another person told us, "They recognise how undignified 'old age' can be and they all promote

dignity and respect towards residents."
● Team meetings were held and identified that staff had the opportunity to raise concerns with management.
● Staff told us they felt listened to by the management team, however, did not always know if action would be taken following concerns being raised. They were not always informed of the outcomes of any actions that the management team took as a result of their feedback.
● Due to COVID-19, 'residents' meetings' had stopped, however had been reintroduced from August 2021. People and relatives told us they felt they could raise a concern with the management.

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
● The regulations set out specific requirements that providers must follow when things go wrong. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The provider was aware of their responsibilities in relation to this standard.
● The management team ensured required notifications were promptly submitted to us when required.
● The management team had developed good relationships between people, family members and staff and actively encouraged feedback from people and family to help improve the service.
● A relative told us, "They call me anytime that there is a problem."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were opportunities for people and relatives to provide feedback. The management team operated an open-door policy and welcomed any feedback.
● An annual survey took place for relatives in which enabled a measure of their feedback. Results were analysed in order to identify areas where improvement was required.
● There was no evidence of appraisals having taken place with staff within the last year. This was confirmed by staff. This meant staff did not have the opportunity to discuss their work life and career objectives with their relevant line managers.
● Supervisions were due to take place on a 6 weekly basis however some staff told us that they had not had a supervision for extended periods of time. This was discussed with the registered manager who stated that they were in the process of arranging supervisions with all staff.

Working in partnership with others
● The team worked closely with the local social and health professionals.
● The service had an 'in-house' rehabilitation area where multiple professionals including occupational therapists and physiotherapists could regularly support people to improve their mobility and regain independence.
● Relatives confirmed collaborative working. They stated, "They got him [the person] a special wheelchair and organised physio for him. They really do care for him as a person" and, "He [the person] has physio twice a week as his legs aren't good. They have nearly got him to walk again."

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to ensure safe medicine management. Regulation 12 (1, 2g)

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 How the regulation was not being met: The provider had not ensured that the premises were suitable for people living with dementia. Regulation 15 (1c)

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 How the regulation was not being met: The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with the fundamental standards (Regulations 8 to 20A). Regulation 17 (1,2, a,b,c,d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The registered person had failed to ensure that information specified in Schedule 3 was available for each person employed. Regulation 19 (2b, 3a)