Care Quality Commission

Bradwell Hall Nursing Home Limited

Bradwell Hall 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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We inspected Bradwell Hall Nursing Home on 08 and 09 October 2014 and was unannounced. At the last inspection on 05 September 2013, we asked the provider to take action to make improvements that ensured people's dignity was respected. We found that some improvements had been made.

Bradwell Hall is registered to provide accommodation and nursing care for up to 171 people. People who use the service have physical health and/or mental health needs, such as dementia.

Bradwell Hall provided accommodation and care over five separate units. We inspected the Chester, Chatterley and Audley units. The Sneyd and Keele/Breward units had been closed to visitors due to vomiting and diarrhoea. We undertook the inspection on the Chester, Chatterley and Audley units so that the risk of cross contamination was reduced. At the time of our inspection there was 164 people who used the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Systems were not in place to ensure people received their medicines safely. We could not be assured that people received their medicines as required because medicines were not always ordered, stored, administered or recorded safely.

People told us they felt safe and we saw that staff carried out support in a safe way. We saw that improvements were needed to ensure that assessments of people's risks were reviewed.

We saw that there were insufficient staff available to meet people's assessed needs. The provider did not have an effective system in place to monitor the staffing levels and how staff were deployed against the dependency needs of people who used the service.

People who used the service and their relatives told us the staff treated them with compassion, dignity and respect. However, we saw that staff did not always treat people with dignity during mealtimes. Staff listened to people and encouraged them to make decisions about their care.

We found that the provider followed the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Staff received regular training which ensured they had the knowledge and skills required to meet people's needs. We found that improvements were needed to the way agency staff were inducted into the service and how their competencies were monitored.

The provider promoted an open culture. People and staff told us that the management were approachable and that they listened to them.

Systems were in place to monitor the quality of the service provided, but improvements were needed to ensure that the systems were assessed and monitored regularly and effectively.

During our inspection we identified breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not managed appropriately to protect people who used the service from harm.

We saw that there were insufficient staff deployed to meet people's needs. The provider had a system in place to assess the amount of staff required but this was not monitored effectively to ensure that there were enough staff deployed appropriately to keep people safe.

Risk assessments had been carried out for people's manual handling needs but people were at risk of receiving inappropriate care because the assessments were not up to date.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported effectively to ensure that they received sufficient amounts to eat and drink. Staff monitored people's health and wellbeing, but did not consistently seek the advice of other professionals when required.

Staff received training that enabled them to provide care and support to people who used the service. However, the provider did not have an effective system in place to monitor the competency of agency staff.

Where people did not have the ability to make decisions about their own care the staff followed the legal requirements which ensured decisions were made in people's best interests.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw that people were treated with dignity when staff provided support to mobilise. However we found that people were not always treated in a dignified way when they were being supported at mealtimes

People were treated in a caring and compassionate way by staff providing support and plans of care were written in a sensitive way.

People told us that they had choices and we saw that the staff listened to people and respected their wishes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

The provider employed staff to provide activities. However, we found that people were not consistently supported to undertake hobbies and interests that were important to them.

Staff responded to people's assessed needs and support was provided when people needed it.

People knew how to make a complaint and the provider responded to people's complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems in place to monitor the quality of the service. We saw that some audits had been completed. However, we found that improvements were needed that ensured risks were assessed and monitored regularly and effectively.

People and staff told us that the management were approachable and they listened to their concerns.

Systems were in place to gain feedback from people about the quality of the service provded and action was taken where required.

Bradwell Hall Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 October and 9 October 2014 and was unannounced.

The inspection team consisted three inspectors; a specialist dementia advisor; a specialist physical disability advisor and an Expert by Experience, who had experience of older people's care and dementia services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. We spoke with two social workers and reviewed information received from the commissioners of the service to obtain their views about the care provided in the home.

We spoke with 23 people living at Bradwell Hall Nursing Home, ten relatives, three nurses, 12 care staff, three unit managers, the registered manager and the provider. We observed care and support in communal areas. We viewed 14 records about people's care and records that showed how the home was managed which included staff training and induction records for staff employed at the home, audits completed by the registered manager and the provider. We also viewed 15 people's medication records, observed how medication was managed and administered to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We looked at medicines management on three units and found that medicines were managed appropriately on the Chatterley unit. However, we found that the medicines were not managed appropriately on the Audley and Chester units which meant people were at risk of receiving their medicines unsafely.

We saw that one person had not received their mood stabilising medicine on 21 occasions over a four week period. We spoke with the nurse on duty who was aware that the night staff had omitted to administer the medicine. The nurse told us, "The medicine is used to help symptoms of agitation and aggression. [The person who used the service] has been shouting out and has been agitated over the past few days as they are very restless". The records we viewed showed that this person had experienced heightened periods of agitation and aggression over a period of four days.

We observed medicines management and administration throughout the day and found that medicines were not always stored securely. We found medicines had been left unattended on the Audley and Chester Units, which put people at risk of taking medicines that were not prescribed for them. We also saw on the Audley and Chatterley Units that bottled medicines had been opened and there were no dates to show when these had been opened. We were unable to check if these were safe to use as the date of opening had not been recorded, which put people at risk of receiving out of date medicines.

We saw that PRN (as required) medicines on Audley and Chester units that had been prescribed for individual people were being administered to other people. People who had been prescribed the same medicines were being given these medicines out of one person's bottle and boxed medicines such as; pain relief and three types of laxatives. This meant we could not be assured that people were receiving their prescribed medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that staffing levels varied on the units we inspected. We observed sufficient staffing levels in place on the Audley and Chatterley units and we saw that staff were available to meet people's needs in a timely manner. However, we found that staffing levels on the Chester unit were not sufficient to meet people's needs. One relative we spoke with told us, "They genuinely need to have more staff around". We found that there were nine carers on duty on the Chester Unit but three of these carers were providing one to one support which meant that there were six staff available to provide support to 27 people who used the service. On one occasion we saw that there was one member of care staff in the kitchen alone who was responsible to support 17 people who used the service. We heard people calling out for help and crying but no support or interaction was given, which meant people were not supported to meet their needs because there were not enough staff available.

We visited the Chester unit at 4p.m. and heard four people calling for help. We saw that staff were unaware of the risks to people's safety because there were no staff available to monitor people's needs. We observed an altercation between two people who used the service and a hot drink was spilled which put the person at risk of scalding. We saw that people were in a distressed state and one person was seen trying to get up from a chair which was used to protect them from the risk of falls. This person was on the edge of their chair. We had to gain the attention of staff so that the person was kept safe from harm. We spoke with staff who told us that they did not always have enough staff to provide support to people.

We viewed staff rotas against the dependency tool used to assess the amount of staff to support people with their assessed needs and found that these were met. We also saw evidence that the registered manager had gained additional funding from commissioners where people had been re-assessed as requiring one to one support. We asked the provider and the registered manager how they monitored staffing levels and how staff were deployed throughout the day because we had seen that there were not enough staff on the Chester unit to keep people safe. The registered manager told us, "I complete a daily walk around and would raise any issues I had. I will make sure I spend some time on the units to ensure that there are enough staff and they are deployed appropriately now". The provider told us, "The clinical lead would carry out this monitoring on an annual basis; we are actively recruiting to the position". This meant that the provider had a system in place to assess the level of staff needed but how staff were

Requires Improvement

Is the service safe?

deployed across the units to keep people safe was not monitored regularly. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment checks had been carried out by the provider which ensured staff were suitable to provide support to vulnerable people. We saw that references were sought from previous employers and criminal record checks had been undertaken before staff provided support to people who used the service.

People we spoke with told us that they felt safe. Relatives told us that they felt people were safe and were well looked after. Staff had received training in safeguarding adults which was refreshed on an annual basis. Staff we spoke with on all of the units we visited confirmed that they had received training and were able to explain the signs of abuse and how they would report any concerns that they had identified. We saw that the provider had safeguarding and whistleblowing policies in place and the staff we spoke with were aware of these and how they needed to follow the procedures. We checked our records that we held before the inspection and found that the registered manager had notified us of any incidents of alleged abuse they had reported to the local safeguarding team.

We observed staff helping people to move against the risk assessments on the Audley and Chester units. The manual handling transfers and use of hoists were safe but the records viewed did not detail which slings needed to be used for individual people who used the service. We saw that half of the risk assessments viewed had not been updated regularly. We spoke with the unit manager who told us they were aware that these needed updating and they were in the process of updating people's assessments. We also saw that people in all of the units were left sitting on their hoist slings. This potentially increased the risk of pressure damage, because hoist slings were not intended to be used in this way. We fed this back to the registered manager who told us that they would ensure that staff were made aware that the slings needed to be removed.

Requires Improvement

Is the service effective?

Our findings

We observed five people for a 35 minute timeframe on both units. We found that people who were in the Chatterley unit were supported to have sufficient amounts to eat and drink. However, we found that people in the Chester and Audley units were not always supported to eat and drink sufficient amounts. We saw two people in the Chester unit were provided with their lunch and left for a period of 30 minutes without any support. One person was confused and experienced difficulties eating their food. After 30 minutes a member of staff asked the person if they had finished and took their lunch away. We looked at this person's care records which stated they required prompting with their meal, which had not happened. Therefore this person had not been supported to eat sufficient amounts because staff had not followed their plan of care.

We saw that the provider employed agency staff when they were unable to cover the units with permanent staff. We spoke with three agency staff on the day of the inspection who gave mixed accounts of their inductions. One member of agency staff told us, "I didn't have an induction I wasn't even shown around the unit, the fire exits etc". Another said, "I was shown around and was told about the person I was going to be allocated to. The care plan is in this folder we are given to record in, and I was asked to sign it to confirm I had read it". We asked the registered manager how they ensured that agency staff were aware of their role and had received appropriate training. The registered manager told us that they recently reviewed the procedure for agency staff induction. We spoke with the nurse in charge and unit manager about agency induction to the service who told us a new agency induction checklist had been circulated by the registered manager and explained the procedure they followed. This meant the registered manager had recognised that improvements were needed to the way agency staff were inducted and had taken action to implement a new system.

People we spoke with told us that they had confidence in the ability of staff and that staff knew how they needed to be supported. Staff told us that they had received training and that this was refreshed regularly. We saw training records that confirmed this. Staff also told us that they received supervision from their manager and that this was useful and gave them an opportunity to raise any concerns they had. Supervision provides staff with the opportunity to speak with a senior staff member about their role, their training and about people's care. This meant that staff were supported to develop their skills and knowledge.

We spoke with staff who understood their responsibilities under the Mental Capacity Act 2005 and explained how they helped people to make informed decisions. We viewed records that showed staff had received training. We saw that where people lacked mental capacity, assessments had been carried out that ensured decisions were made in their best interests. We saw that some people refused to have their prescribed medicines and mental capacity assessments had been carried out to administer the medicines covertly. The care plans gave staff clear guidance to follow and explained why and how these medicines were to be administered in the persons' best interests. This meant that the provider followed guidance which ensured that the human rights of people who may lack capacity to make specific decisions are protected.

The registered manager had a good understanding of their responsibilities with regards to Deprivation of Liberty Safeguards (DoLS) and had submitted applications to the local authority where they considered that a person's liberty may be restricted in their best interests. DoLS ensures that when people have their liberty restricted this is done in a manner that protects their human rights. We saw that one person was subject to a DoLS to keep them safe from harm because they would be unsafe if they left the service. The DoLS had been authorised by the Local Authority and there was clear guidance for staff to follow in the care plan. Staff we spoke with explained the support provided in the least restrictive way to keep this person safe.

We saw that some people had a Do Not Attempt Cardio Pulmonary Resucitation (DNACPR) in place. A relative we spoke with told us that they had been involved with the decision to put a DNACPR in place as their relative lacked capacity to make the decision. The records confirmed that this had taken place and that the DNACPR had been reviewed regularly. We saw that best interests assessments had been carried out where people lacked capacity to make an informed decision with regards to the DNACPR's, which ensured any decisions made were in the person's best interest.

People we spoke with told us that the food was good; however some people told us that the food was not very

Requires Improvement

Is the service effective?

hot when they received it. People told us that they were given a choice at mealtimes. One person told us, "I've had tea and toast this morning but you can have what you want, bacon and beans if you like". There was a choice of two meals at lunch and staff told us that people were asked what they wanted for their lunch after they had finished their breakfast. We saw that the lunch menu was displayed on a noticeboard for people who used the service on two of the units, but this was not accessible to all of the people who used the service which meant that some people would not be able to understand their choices.

We found that where people were at risk of malnutrition or dehydration there were charts in place to monitor that people were eating and drinking sufficient amounts. We asked a member of staff about one person who said, "They haven't done very well this morning and we have had to work hard to make sure they are encouraged to drink and eat. I am going to be off shift soon but I will make sure they have had a good amount to drink before I go". We observed that one person required soften food and thickened fluid which ensured that any risk of choking or aspiration was reduced. Staff we spoke with were aware of this person's needs and how they needed to support them at mealtimes. We saw that there had been an assessment carried out by the registered manager, which ensured that this person was protected from the risk of choking.

People told us that they saw the G.P if they felt unwell. Care records showed that people had been referred to other professionals where there had been concerns raised. We saw evidence that a Tissue Viability nurse had been requested to provide support when there had been concerns identified that a person's skin condition had deteriorated. This meant that most people had access to healthcare professionals and were supported to maintain their health.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found that improvements were needed in the way that staff engaged with people who used the service. At this inspection we found that the service still needed to make some improvements to the way that staff engaged with people during mealtimes. We observed that people on the Audley unit were left for long periods of time without staff checking they were okay or interacting with them. We saw how staff supported and engaged with people during lunch on the Chester unit and found that people who needed assistance from staff to eat their meal were not always treated with dignity and respect. We saw that two agency staff supported a person without talking to them, the staff did not inform the person what they were doing before they provided support and they did not engage with the person when they provided support.

People we spoke with told us that they were happy with the care provided on Chatterley Unit. One person told us, "I'm very satisfied, I like to keep myself busy and the staff are very good. Kind and lovely". We spoke with a family member of a person who used the service who was receiving end of life care because their condition had deteriorated. The relative we spoke with told us, "We have been extremely satisfied with the care and support we have received. Nothing has been too much trouble. Staff have gone that extra mile" and "They have shown real care and consideration, attention to detail is second to none. When I kissed [the person who used the service] this morning they smelled beautiful".

We were unable to talk to people who used the service on Chester Unit as they had communication difficulties because of their condition. We watched how staff treated people when they provided support. Staff provided support to people in a sensitive way and respected their dignity. Staff talked to people in a way that they understood and were patient when waiting for people to respond to questions. We saw that people were covered when being assisted to transfer which ensured their privacy and dignity was protected. We found that the care plans were sensitively written. For example the section on "recognition" was written with dignity and compassion and the section on death and dying contained details of how to care for someone compassionately and sensitively.

People told us that they were given choices; such as the meal they wanted, what time they got up and what they went to bed. We observed good interactions on Chatterley Unit. We saw that staff were kind and explained the support to be provided and listened to people's wishes. Staff were calm and patient when supporting people. Staff spoke to people in a respectful manner, calm tone referring to people by name. Staff took time to talk to people and hold a conversation and treated people in a way that protected their dignity.

We saw that relatives of people who used the service were able to visit without any restrictions. One person's relative told us they liked to visit at mealtimes and assist their relative with their meal and the staff supported them to do this. Staff we spoke with told us that relatives were always welcome and often go to their relatives bedrooms for privacy.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we saw that people had varied experiences to the way staff interacted with them and how their social needs were met. We found that people on the Audley and Chester units had less interaction with staff and there we did not see any activities provided for people on all three units. People were observed sitting in the lounge areas for long periods of time and one person told us, "It would be nice to do something". People on the Audley and Chester units had various stages of dementia and we did not see that the provider had taken this into consideration as these people were not always provided with mental stimulation or positive interaction from staff .

We looked at the record of one person who used the service and saw the person was at risk of isolation because they spent a lot of time in their room. The assessment showed that staff needed to provide one to one attention to reduce the risk of further isolation. We saw from the records that staff attended to the person's physical care needs on a regular basis and there had been at least two hourly contacts, but there was little evidence of any engagement or mental stimulation provided. The registered manager told us that this person liked to spend time in their room and staff regularly checked to see if the person was okay, but this hadn't been recorded.

One person told us about their health concerns they said: "I need to keep my feet up as much as I can, but I can't always find a stool or staff use it for someone else. This means my legs swell". We spoke with staff who told us, they encouraged the person to put their feet up during the day but confirmed that at lunchtimes when the person would be sitting at the dining table the stools would be used for staff to sit on while supporting people with their meals. During our observations on the 8 October 2014 the person did not have access to a stool while sitting in the lounge until we found one for them, but on the second day of the inspection we saw they had their feet resting on a stool. This meant that the provider was not always responsive to this person's health needs.

We observed some good interactions between staff and people who used the service on the Chatterley unit. We spoke with two people who told us they were supported to maintain their independence. One person told us, "I am independent, I've got a lock on my door and I can go out when I want to. I like going into the garden". We saw that staff were attentive to people's social needs and we observed staff sitting and chatting to people throughout the day.

One person who used the service said they liked to be occupied and usually an activities coordinator would be available to support them. They told us: "I enjoy knitting, I like to be involved in things, but there's nothing to do today. I can't stand having nothing to do". Staff told us an activities coordinator was allocated to the unit for five days per week between 9am - 5pm, but was not at work on the day of our inspection. We spoke with staff who went to find wool for the person. This meant that although arrangements were in place for people to be engaged in hobbies or interests, contingency plans were not in place when the dedicated activities coordinator was not available.

People we spoke with told us that they had been involved with the planning of their care. One person told us, "I was asked what I liked and how I wanted things done". A relative told us, "I am involved in the reviews for my relative which have been completed recently". The records we viewed showed that people were involved in the completion of their plans of care.

People we spoke with knew how to complain. One person told us, "I would complain to staff if I needed to, I could approach them easily". Staff we spoke with were aware of the procedures to follow if they received a complaint about the service. One member of staff told us, "I would try and help if I could, if not I would pass the concerns on to the manager". We saw that the provider had a complaints policy in place and we viewed the complaints received, which had been investigated and responded to appropriately. This meant that the provider was responsive to complaints that were raised.

Requires Improvement

Is the service well-led?

Our findings

We saw that the registered manager and provider had undertaken some monitoring of the service. For example; we viewed incident and accident monitoring and saw the actions that had been taken when areas of concern had been identified by the registered manager. We saw that the provider had undertaken the necessary fire and health and safety checks that ensured people were protected from harm because the environment was safe.

We found that medication audits had not been carried out on the Audley and Chester units. The registered manager told us, "There is nothing in place at the moment and I admit they haven't been audited since the Clinical Lead left in May 2014. The unit managers look through MARS to check for gaps". We spoke with three unit managers and one unit manager told us that they undertook monitoring on the Chatterley unit, but we were told that there was no monitoring in place on the two units where we had raised concerns. This meant that improvements were required to the way the way medicines were monitored.

People we spoke with told us that they could approach the management if they needed to. One person told us, "I see the manager walking around and they ask how I am". Staff told us that the unit managers were always available to them if they needed support and advice and the registered manager listened to them when they raised concerns. One member of staff told us, "I have no problems in approaching the manager; they have an open door policy". Another member of staff told us, "I observed poor manual handling practice in the home and reported it to the registered manager who listened and acted to address the concerns". The registered manager told us that they undertook a daily walk around of the service which ensured that any issues could be raised by staff or people who used the service. The registered manager told us that they were supported by the provider and where resources were needed to keep people safe they were made available. The registered manager told us "I can approach the provider, I have a very good relationship with them and I can discuss any problems or request any equipment. I feel comfortable to challenge and be challenged if needed". This meant that staff felt supported and were able to raise concerns with management.

We viewed questionnaires that had been sent to people who used the service and their relatives to gain feedback about the quality of the service provided. The questionnaires had only recently been sent out so we did not see any action plans in place from the feedback gained. We saw the action plan from the questionnaires sent out in 2013 and this showed that actions had been put in place to make improvements that had been fed back to the service.

The registered manager had notified us of any reportable events as required. For example, we were informed of deaths that occurred at the service and incidents that resulted in a serious injury. This showed that they understood their CQC registration responsibilities.

The registered manager told us that when they completed the Provider Information Return (PIR) this identified areas that they needed to improve. The registered manager said, "The PIR has identified shortcomings in evidencing the monitoring of the service, as I complete this on a daily basis and don't record everything that I do. I will be putting more formal records in place and ensuring that I record my actions". The provider told us they were recruiting to the Clinical Lead post who would be carrying out the monitoring of the service as they have been without a Clinical Lead for six months.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected from the risks associated with the management of medicines. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People were at risk of unsafe care because there were insufficient staff deployed at the service to meet people's needs effectively. Regulation 22.**

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.