Bridge House (Elmwood) 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 caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bridge House is a residential care home providing personal and nursing care to up to 66 older people. At the time of the inspection there were 65 people living at the home. The care home accommodates people across three separate floors, each of which has separate adapted facilities. The first floor supports people who need residential support. The second floor supports people who need nursing care. The third floor supports people who are living with dementia.

People's experience of using this service and what we found
People were not safe. They were at risk of harm as the provider had not assessed and mitigated the risks to people. Medicines were not managed safely. There were multiple instances when people had not been given their prescribed medicine.

There were not enough staff to keep people safe. We saw staff were kind and caring but they were rushed, and routines were often task orientated. People were regularly left on their own for long periods of time and there were limited opportunities for meaningful social interactions. Staff were not always able to respond quickly where people needed care, support or comfort. People were not always protected from abuse or neglect.

People had not been protected from the spread of infection because robust systems and processes were not in place.

The home was not well-led. Systems to assess, monitor and improve the service were not effective. Governance systems were ineffective, and the provider did not have oversight of key safety issues.

People and relatives were generally positive about the staff who cared for them and their experiences of the service. Staff were recruited safely.

The home was well maintained. The living environment was attractive and spacious and incorporated open communal spaces and leisure facilities such as a roof top garden, cinema room and hair dressing salon.

The provider was responsive to inspection findings and responded and acted during and after the inspection and shared detailed plans to improve their systems and processes. The registered manager left the service before the inspection was concluded. The provider kept us up to date with interim management arrangements for 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 31 December 2019). 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 safeguarding concerns and complaints from relatives about the quality of the management and care provided at Bridge House. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led.

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.

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.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report. We met with the provider after the first day of the inspection. We discussed our concerns about the risk to people due to inadequate medicines and risk management. The provider sent us an action plan and assured us they would take action to mitigate the urgent risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bridge House 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 medicines management, the assessment and management of risk, infection prevention and control, safeguarding, staffing and good governance.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Special Measures: 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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
The inspection was carried out by four inspectors and a specialist pharmacy advisor.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 18 August 2021and ended on 6 September 2021. We visited the service on 18 and 24 August 2021. The other dates were spent reviewing information off site and making phone calls to staff, the senior team and the nominated individual. The nominated individual is responsible for supervising the management pf the service on behalf of the provider.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We observed care and support in communal areas. We spoke with eight people who used the service, an advocate and seven relatives and friends about their experience of the care provided. We spoke with 13 members of staff including the nominated individual, registered manager, nurses, senior care workers, care workers and a hostess. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We held an online meeting with the nominated individual and representatives from the local authority to discuss our urgent concerns. We requested additional evidence and documentation from the provider, and we reviewed this.

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.

Using medicines safely

At the last inspection the provider had failed to manage medicines safely. 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.

● Medicines were not managed safely. The home operated an electronic Medicines Administration Record (eMAR). This was not being used safely. Some medicines, including time specific medicines had not been given as staff had recorded the person was asleep on the system. Staff were unaware this would then stop the dose from being given when the person woke up. Not receiving medicines as prescribed can have a significant impact on people's health and well-being.
● Medicines were not always available to give as there were not enough medicines in stock. The home did not have a clear system in place for addressing this as they only checked medicines received into the home but did not check for medicines that had not been ordered in error or medicines that had not arrived. On the first day of the inspection we found eight people did not have their medicines available to them. This included medicines prescribed for complex health conditions, pain and depression.
● When a person moved into the home or returned from hospital the home did not have a safe process to check what medicines a person was taking. We found medicines had been added incorrectly onto the eMAR.

● Staff who were responsible for administering medicines did not have their competency to administer medicines assessed. The eMAR systems had been recently introduced and one senior staff member told us, "We had very little training. It was 'rushed in'. I do not feel 100% confident with it."

Systems were either not in place or robust enough to demonstrate medicines were safely effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people's health and safety were not assessed and care plans did not contain detailed information. Where information was recorded on the electronic care planning system staff did not always know where to find this. We found multiple examples where care records were inconsistent and significant changes in people's health and care needs had not been updated in their care plans.

● People's nutritional needs were not being met and people were at increased risk of malnutrition and harm. For example, one person's risk assessments highlighted they were at a high risk of malnutrition and had been consistently losing weight. There was no information about how often they should be weighed. Their care plan stated meals should be fortified. We reviewed their meal records and it showed the person had very little to eat and there was no evidence of snacks or fortified meals being offered. Another person had consistently lost weight since they had been admitted to the home. Since July 2021 they had lost over 9kg. No action had been taken.
●Staff were not always aware of the required consistency of meals. For example, it had been recommended one person have a 'minced and moist' diet. Staff were not aware of this and meals of a regular consistency had been offered. We were not assured staff have the right skills and guidance to be able to monitor people's nutritional needs safely.
● Risks relating to people' skin integrity were not being identified and monitored effectively. People were not being repositioned as needed. There was lack of clarity about mattress settings and no clear wound or pressure care plans in place. For example, one person had a pressure sore and their skin integrity care plan recorded they should be repositioned every two hours. Their records had significant gaps of up to seven hours when they had not been supported to reposition. Another person had developed a sore which had not been assessed, and staff were applying a cream which had been prescribed for another unrelated condition. We also found two people's pressure mattresses turned off.
● People's care plans were not always reviewed after serious events. Systems were not effective in learning lessons when things went wrong. Accidents and incidents were recorded but there was no evidence of reviews or management oversight.

Systems were either not in place or robust enough to demonstrate risk to people's health and safety were effectively managed. This placed people at risk of harm. This contributed to the continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they had significantly increased clinical oversight of the service. This included appointing a suitably qualified pharmacist to oversee medicines management and an additional full-time clinical lead nurse.

● Routine safety and environmental checks were consistently in place. The home was well maintained. Communal areas, corridors and people's bedrooms were spacious, pleasant and clean.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were not in place to ensure people were protected from abuse and neglect.
● We were informed about a serious safeguarding incident that had occurred. There was an unwitnessed altercation between two people which had resulted in one person receiving a significant injury. The registered manager told us there were significant concerns about the risks of unprovoked attacks posed by the person who had been involved. We observed multiple occasions when people were in the vicinity of the person without any staff presence or intervention. This placed vulnerable people at a high risk of harm.
● Incidents were not escalated to relevant professionals. Another person had sustained a serious injury to their arm after an unwitnessed altercation with another person. There was no evidence to show a health care professional had been involved. Care plans and risk assessments had not been put in place to safeguard the person. The incident had taken place two days earlier and had not been referred to the local safeguarding authority.
● Staff had not received up to date safeguarding training. We found 26 staff did not have up to date training. This included staff who had started since February 2021 who had not received any training in safeguarding

vulnerable adults.

Systems were either not in place or robust enough to ensure people were protected from abuse and neglect. This placed people at risk of 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.

● People and relatives told us they thought people were safe living at the home. One person said, "They look after me. I do feel safe."
● Staff were able to describe different forms of abuse and the ways they can report this.

Staffing and recruitment
● Most staff we spoke with told us they did not think there were enough staff on duty to support people. Staff told us there were more people living at the home and staffing levels had not increased. Comments included, "I honestly don't think there are enough [staff]" and "We [staff] struggle and feel guilty that there is not enough time."
● Safe staffing levels were not maintained, and staff were not effectively deployed. We saw staff were rushed and did not have time to have meaningful conversations or participate in activities. Staff were not always able to respond promptly when people needed care support or comfort. We observed staff were consistently busy and at 12.44pm staff were still supporting people to get washed and dressed.

Systems were either not in place or robust enough to demonstrate there were enough staff deployed to care for people safely. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the use of a dependency tool to assess staffing levels with the provider. They informed us since the site visit, they were working closely with their quality team to implement a robust assessment to determine staffing levels for each floor.
● Feedback from people and relatives about the number of staff on duty was mixed. One person said, "Staff come in and see how I am." Another person said, "Sometimes staff seem to be rushing.
● Recruitment was managed safely, and all required checks were completed before staff started work.

Preventing and controlling infection
● Government guidance on the prevention and control of infections was not always followed. Personal protective equipment was not consistently worn by staff. We observed multiple occasions when staff were not wearing face masks properly. This meant risks to vulnerable people were increased and they were at a heightened risk of infection.
● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. We observed visitors completing a lateral flow test in line with guidance. However, they were not asked to wait the required half an hour to process the test before accessing communal areas of the home.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate infection prevention and control measures were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed visiting procedures with the provider and were assured this would be addressed immediately.

On the second day of the inspection we saw a clear process was in place for visitors.

● The service had a good supply of PPE and there were stations placed strategically in locations around the home.
● 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.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- We saw people going into other people's bedrooms and lying on their beds. This happened on numerous occasions and there was a culture where this was accepted.
- Staff were not always provided with the time and resources to provide high quality care. One care worker said, "There is just not enough time. We can only do the bare basics."
- People's experiences varied but most people and relatives were complimentary about the staff and the care and support they received. Comments included, "They [staff] are lovely. If you want anything, they are very nice and helpful" and "Staff are helpful, friendly and caring." A relative commented, "Everybody has a very friendly disposition. They always make time to talk to me."
- We observed some compassionate and caring interactions between people and staff. We saw a care worker singing gently with a person and chatting with them about a recent visit from a relative. The care worker referred to the person's children by name and we saw they had a warm and trusting relationship.
- Staff talked about promoting people's independence. One care worker told us, "There is one person who likes to open their bedroom curtains themselves. It is their home. It's important to them."

Supporting people to express their views and be involved in making decisions about their care

- There were no records to reflect how people and their families were involved in writing and reviewing their care plans.
- We observed staff offering people choices and waiting for their responses. Staff supported people to make decisions about their care and were able to give positive examples of how they did this on a daily basis.
- Where people did not have relatives, advocates were involved.

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.

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

- Significant shortfalls were identified at this inspection. Systems should have been in place to ensure the provider was aware of how the service was operating and to ensure compliance with regulations. Where audits were completed, they were not effective at identifying issues. For example, the medicines and care planning audits had not identified the widespread issues we found at the inspection.
- There was a lack of strong and effective leadership. The registered manager was not fully aware of what was happening in the service. The registered manager had delegated audits to other people. Where concerns had been identified they had not been addressed promptly. For example, the clinical lead conducted a weekly audit. Records show they identified shortfalls in the management of pressure care in July 2021.
- Issues we had identified on our first visit with the home and raised with the nominated individual and registered manager had not been addressed. This included concerns relating to medicines and risk management. The registered manager left the service before the inspection was concluded.
- There was no effective system in place to manage or assess the risks to people and improve the quality of care. This left people at risk of injury and their health and wellbeing deteriorating.

People were placed at significant risk of harm through the lack of effective governance systems. This was a 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

- Staff provided mixed feedback about how the service operated. They spoke about people in an affectionate and caring way and expressed their concern about how staffing levels impacted on how much time they could spend with people. Most staff spoke positively about the management team and described them as, "approachable and helpful." Some staff said communication was often poor and they did not think their increase in workload was recognised.
- People did not always receive person centred care that led to good outcomes for them. People's care records were not always up to date, or person centred. They did not contain individualised information and people had not been involved in their care planning.
- There was an activity lead in post. They worked Monday to Friday, but staff told us they were often

required to provide care instead of promoting individual and group activities. We observed there were limited opportunities for people to engage in person centred activities. One staff member said, "We need more activities. There are none on weekends." The provider told us they were currently recruiting to ensure more opportunities would be available for people.

● The provider was unable to demonstrate how they involved people and their relatives to share their views and contribute to developing the service.

● We received mixed feedback from relatives. Most relatives said they were happy with the care provided but we received conflicting comments about communication from the home.

● Regular staff meetings were held, and the provider had conducted a staff survey.

Continuous learning and improving care: Working in partnership with others; 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 registered manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things went wrong.

● After the inspection the nominated individual developed an action and improvement plan. The provider demonstrated they were working very closely with the local authority quality team and Clinical Commissioning Group to make improvements. They took immediate steps to strengthen the clinical and management oversight of the home. They spoke passionately about their commitment in ensuring the necessary improvements were made at Bridge House.