

Bradwell Hall Nursing Home Limited

Bradwell Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

Bradwell Hall Nursing Home is a residential care home providing nursing care to 116 people aged 65 and over at the time of the inspection. The service can support up to 187 people.

Bradwell Home Nursing Home has seven units, each with their own communal areas. During this inspection, we visited three of the units. People living in the home are living with dementia, mental health conditions, physical disabilities and sensory impairment.

People's experience of using this service and what we found

People were not always protected against the risk of abuse. Before and during our inspection we had safeguarding concerns and three safeguarding referrals were made during and after this inspection.

People's care and treatment was not always provided in a safe way. Staff did not always follow people's care plans, which increased the risk to their health and safety.

People's medicines were not always safely managed. Staff did not always follow the provider's infection prevention and control systems and this placed people at risk of cross infection.

The registered persons had not ensured all staff supported people safely with their care. Staff did not always report concerns about people's health needs.

We found widespread shortfalls in the way the service was managed and there was a risk of people receiving inappropriate care.

The provider had quality systems, including clear plans for improvement, in place. However, these were not always used effectively to help identify concerns to people's health, safety and wellbeing.

The provider ensured people lived in a safe building. Safety checks and on-going monitoring helped to ensure the environment and equipment were in a good state of repair.

At the time of our inspection, no one at the home had a positive test result for COVID-19. The provider ensured people and staff were tested in line with government guidance.

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 requires improvement (published 20 March 2020) and there were breaches of regulation.

Why we inspected

Since our previous inspection, the provider had improved on their reporting processes for safeguarding concerns. However, there had been a significant increase in safeguarding concerns of a specific nature to warrant further inspection. These concerns included allegations of abuse, altercations between people and how these were managed. This had resulted in the local safeguarding authority monitoring the home more closely. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. We did not inspect the key questions of effective, caring and responsive which are rated requires improvement. 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bradwell Hall 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 safeguarding people, the safe care and treatment of people and the management systems in place for the home at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Bradwell Hall 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.

Inspection team

The inspection team consisted of two inspectors and one inspection manager.

Service and service type

Bradwell Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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, however we telephoned the provider from outside the home because of the risks associated with Covid-19. This was so we could discuss how to ensure everyone remained safe during the inspection and the arrangements for putting on personal protective equipment (PPE).

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.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

Not everyone was able to talk with us due to their health conditions. However, we were able to communicate with three people who used the service who indicated they were happy.

We spoke with two visiting health professionals. We spoke with 18 members of staff including the deputy manager, the clinical nurse lead, care staff, domestic staff, the registered manager, the nominated individual, nursing staff and the clinical operations director. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed how staff interacted with people and how they received their care and support.

We reviewed a range of records. This included six people's care records and multiple medicine records. We looked at 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 looked at training data, people's care records and quality assurance records. The provider also kept us up to date on actions they took following our site visit.

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.

Systems and processes to safeguard people from the risk of abuse

- Staff told us they knew some people went into other people's bedrooms and when this happened there was a risk of conflict which could result in abuse. However, the registered persons had failed to ensure measures had been put in place to reduce the likelihood of this happening again.
- Staff did not always respond to people who were distressed. We found a repeat of an incident where one person had been found by a visiting health professional in their bedroom, shouting out, distressed and their safety was compromised. During this inspection we found the person in the same situation. Staff had not used their time effectively to make sure each person on the unit was safe because they were all sat in the lounge. This placed the person at risk of neglect and showed staff had not learnt from previous incidents.
- During our inspection we identified three incidents where abuse may have occurred. We told the registered manager to report one immediately to the local safeguarding authority and we reported two following our inspection visit.
- Staff used 'clinical holding' when some people became anxious. This is a technique where holding can be considered and used to safely deliver essential care and treatment. Staff had used this technique on one person where it had not been assessed to safely do so. Guidance states people must be assessed prior to the application of any such holding. A lack of assessment had placed the person at risk of unnecessary restraint and is an infringement of their human rights.
- Staff told us they had received training in recognising and responding to abuse. The provider had systems and policies in place to help protect people from the risk of abuse. We found these were not always effective because the concerns we found had not been identified by the registered persons and action had not been taken to protect people from any further potential harm.

Systems in place were not robust enough to identify safeguarding concerns. 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.

Assessing risk, safety monitoring and management

- The registered persons had not ensured staff took the required action to mitigate risk to people's health. People's care plans all stated the GP must be contacted for advice if they had not had their bowels open for more than three days. Staff had not always followed these instructions and for three people, had not contacted the person's GP for between five to nine days. This placed people at risk of prolonged discomfort and having their health compromised.
- When risk to people's health had been identified, staff did not always prevent the risk from reoccurring. Records showed one person had three occasions in two months where they did not have a bowel

movement for eight days or more. On the first occasion, staff identified the person's agitation could be caused by them not having their bowels open for eight days. Despite staff identifying this risk, they failed to protect the person from this occurring twice more. We shared this information with the local authority.

Learning lessons when things go wrong

- The registered persons had not demonstrated lessons had been learnt when things had gone wrong. This inspection was the seventh time they had failed to make improvements to the key question of safe or improve the rating from requires improvement.

Using medicines safely

- Since our previous inspection the registered persons had continued to make improvements to the management of medicines. However, at this inspection visit, we found significant concerns about how one particular medicine was managed at the home.
- Some people needed a medicine which helped to calm them if they were agitated or distressed. A care plan or protocol should be in place to tell staff how and when this medicine should be given. Although protocols were in place, these were not specific to each person. The protocols did not inform staff what agitation or distress looked like for each person. Therefore, staff and especially agency staff may not know when they should administer the medicine. This placed people at risk of receiving medicine which was not needed.
- People's medicine plans were generic and did not tell staff how to support individual people before the use of prescribed medicines was considered.
- Staff did not record why the person had needed the medicine or if any calming or distraction techniques had been used before giving them the medicine. Therefore, the effectiveness of the medicine was not being monitored to ensure it had the desired effects. The registered manager told us their governance systems did not monitor the use of this medicine.

Preventing and controlling infection

- People were not always protected from cross infection. Due to the COVID-19 pandemic, extra measures were in place to keep people safe, such as the use of enhanced personal protective equipment (PPE). However, the application of these measures by staff was not always consistent.
- Staff had received training in infection control and the correct use of PPE during the current pandemic. However, some staff touched their masks or pulled their masks below their noses and chins. They then did not wash their hands which did not demonstrate good hand hygiene and puts people at risk of cross infection from staff. We spoke with the registered persons about our concerns and they told us they would review staff's practice at the home.

People were placed at risk of harm due to inadequate risk management. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider responded during and after our inspection in response to our concerns. They provided evidence to show the concerns we identified had and were being addressed. New systems were either in the process of being put in place or had already been put in place. This helped to mitigate the risk of harm to people.

- The provider ensured people lived in a safe environment. Risks associated with the premises and equipment were managed through a programme of safety checks and maintenance at the home. This included areas such as fire safety, ensuring equipment was in good working order and ensuring all utilities were serviced and safe.

- The registered persons accessed testing for people who lived at the home and for staff. The provider had kept their emergency contingency plans under review during the COVID-19 pandemic, which would help to keep people safe from any cross infection throughout the home.
- Staff told us they had received infection prevention and control training. They also had received training and information specific to COVID-19. This should support staff's understanding about safe hygiene practices.

Staffing and recruitment

- The provider had enough staff working at the home and staff told us there were enough staff on duty. We found some improvement was needed to make sure staff on each unit had the mix of skills needed to meet people's individual needs at all times.
- The registered manager monitored staff numbers, including the use of agency staff each morning as part of a senior staff handover to them. Due to the reduction in the home's occupancy, the staffing levels had been higher recently.
- The provider followed safe recruitment practices to ensure staff were suitable to work with people at the home. Staff recruitment records were up to date and the required employment and identity checks had been completed prior to new staff starting work at the home.

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 significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the registered persons had failed to ensure systems in place were operated effectively to continually assess, monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

- This is the third consecutive inspection where we have found a breach in this regulation.
- The registered persons had failed to improve the service to ensure people received safe and good quality care. They had not achieved a good rating for the key question of safe for the previous six consecutive inspections. The key question of well-led had been rated requires improvement for five of the six previous consecutive inspections. People had been exposed to a consistent risk to their health, safety and welfare since 2014.
- People were not fully protected against the risks to their safety and welfare. The registered manager told us all incidents were reviewed daily by management. However, during our inspection we found evidence of incidents which had not been identified as a concern, such as people not having their bowels open for extended periods of time. Therefore, no action had been taken to mitigate any further risk.
- Despite the registered persons having quality assurance systems in place, these were not operated effectively to help identify concerns to people's health, safety and wellbeing. The registered manager received a twice daily update from staff from each unit. This was to provide the registered manager with a snapshot of each unit such as any service user concerns, any incidents which had happened, any safety concerns and any person who had not had a bowel movement for three days. However, the registered manager told us they were not aware of the incidents we found of people not having their bowels open for more than three days. This placed people's health and wellbeing at risk.
- The registered person's auditing systems had failed to ensure people's care records were accurate to minimise the risk of errors. One person's care plan referred to them as 'he' when they were 'she'. One person's care plan had another person's name within it. People's daily records often did not have the date on them. One person's medicine administration record had been recorded in the wrong month. Handwritten additions to people's medicine administration records were not done in line with national guidance. This placed people at risk of not receiving the care they needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People had differing experiences of care within the home dependent on which unit they lived on. Some staff did not act in a professional manner and used inappropriate language such as referring to people as feeders and wanderers. This demonstrated a lack of emphasis on people's dignity. The registered manager told us they were aware of issues with some staff practice but had yet to resolve this. This lack of consistent leadership throughout the home put people at risk of harm.
- Staff gave us mixed feedback about the culture at the home and on individual units. People were referred to by their room number, rather than their name by some staff. This showed us a culture where people were not always put first.

Quality systems were not robust enough to demonstrate safety was effectively managed. This placed people's health, safety and wellbeing at risk. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection there had been significant delays in the provider informing of us of safeguarding concerns. This was a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009 and we had issued the provider a fixed penalty notice, which they paid.

At this inspection we found sufficient improvement had been made and we have removed this breach.

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 persons were aware of their responsibilities under the duty of candour regulation.

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

- People had access to easy read materials about COVID-19 and were supported to keep in touch with their relatives. Bulletins and emails were produced for relatives to keep them up to date on events at the home.
- Staff told us they were aware of the current issues at the home and what they needed to do to be part of the required improvements. The registered persons held regular meetings with staff to keep them involved in the on-going improvements which were required.

Working in partnership with others

- One health professional told us they were building more positive relationships with management. However, they felt staff needed to get better at reporting issues to external professionals during situations rather than afterwards, such as when a person continually refused their medicine.
- The provider was currently working with the local authority to help make improvement within the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered persons had not ensured adequate risk management to ensure people were protected from the risk of harm. People were not always protected from the risk of cross infection. People's medicines were not always safely managed.</p> <p>The registered persons had not ensured when incidents occurred these were always investigated, and action taken to prevent further occurrences.</p>

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Although the provider had safeguarding systems in place, these had not identified where people were at risk of harm.</p>

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Although governance systems were in place, the registered persons had failed to use these effectively to improve the safety and quality of care where needed.</p>

The enforcement action we took:

We imposed a condition for the provider to address this breach and update us every 14 days with their progress.