GCH (Midlands) Ltd

Bletchley House Residential Care and 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bletchley House Residential Care and Nursing Home is a care home providing personal and nursing care for up to 44 people. At the time of the inspection 36 people were receiving support.

People's experience of using this service and what we found
Systems in place to ensure the proper and safe management of medicines were not robust and did not ensure people received their medicines as prescribed.

Staff were using both paper records and electronic records which made finding relevant information difficult. Some care records and risk assessments contained conflicting and out of date information.

Management of the service had been unstable and numerous managers had been recruited and then left the service. There had not been a manager registered with the Care Quality Commission since 21 December 2020. There had been a reliance on a high use of agency staff, which did not ensure consistency for people receiving care and support. The interim manager had recognised this as an area for improvement and had successfully recruited 11 new staff. Further recruitment was ongoing.

Provider level quality assurance audits to ensure effective oversight and safe care in the absence of a registered manager had not been effective in identifying areas for improvement and ensuring required improvements.

People felt safe living at Bletchley House. Staff were trained in safeguarding and understood their responsibilities to protect people from harm. Staff followed all necessary infection prevention measures. Staff wore appropriate Personal Protective Equipment (PPE) and received training in infection prevention and control.

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 supported this practice.

Staff continued to work in partnership with health professionals involved in monitoring and providing care and treatment for people using the service.

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 Good (published 18 March 2021)

Why we inspected

We received concerns in relation to the management of medicines, staffing and management instability and a lack of provider oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bletchley House on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to people receiving safe care and treatment, the safe management of medicine and a lack of provider oversight.

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 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bletchley House Residential Care and 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 Health and Social Care Act 2008.

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 two inspectors, a 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. Two inspectors visited on the first day with the Expert by Experience. On the second day two inspectors returned with the medicine's inspector.

Bletchley House is a care home. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Bletchley House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post, however there was an interim manager working at the service until a new manager commenced employment.

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 commissioning and safeguarding teams. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We met and spoke with 25 people who used the service about their experience of the care provided and two relatives. We had discussions with seven staff including the interim manager and quality manager, three nurses, two agency care and support staff and two permanent care and support staff. In addition, we also had discussions with two members of the housekeeping team, the chef and the maintenance person.

We used the Short Observation 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 four people's care plans and associated risk assessments. The medicines inspector reviewed medicine administration records (MAR) and medication care plans. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including health and safety records and environmental risk assessments, staff rotas and cleaning schedules were examined.

After the inspection we requested and received further information from the provider which included training data, quality assurance information, the providers improvement/action plan and accident and incident analysis.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

Using medicines safely

- Systems in place to ensure the proper and safe management of medicines were not robust. Some prescribed medicines were not available to people because medicines had not been ordered swiftly and stocks had run out.
- Care plans were not in place to manage people's complex medical conditions. For example, one person who was receiving time critical medicines did not receive their medicines at the time prescribed. There was no specific care plan in place to manage this safely. This meant the persons condition was not being effectively managed and placed them at risk of harm.
- Medicines were not always stored securely, and we observed unlocked medicines trolleys when staff went to give a person their medication. This area of good practice was not covered in the medicines policy. The medicines policy was not specific to the service and referred to tasks that were not carried out at the service and staff were not trained to deliver. The policy contained unnecessary detail and did not provide staff with all the necessary information to consistently follow safe administration procedures.
- We found discrepancies in medicines stock levels. This meant people were exposed to the risk of harm because medicines related errors and near misses were not being reported, investigated or being learnt from.
- Staff did not have enough information to administer eye drops safely. For example, Medication Administration Records (MAR) did not specify in which eye the drops should be administered. We observed MAR charts being signed in retrospect; this is not in line with good or safe practice.
- Some people had personalised PRN protocols for "when required" medicines that stated when they needed their medicines. However, these were not in place for all medicines that needed to be given this way and many needed a review.

Assessing risk, safety monitoring and management

- The provider was in the process of transferring the care plan and risk assessment documentation over to an electronic system. At the time of our visit staff were having to use both paper and electronic records making it difficult to find information needed to support people safely. We found inconsistencies in records and risk assessments and care plans had not always been updated as needed.
- There were risk assessments in place to reduce potential risks to people. However, we found that some risk assessments did not detail the actions needed to reduce the risks. For example, one person had been assessed as high risk of falls but there were no actions recorded to show how the risks would be mitigated.

The provider had failed to ensure that risks to people were monitored and managed appropriately so people were supported to stay safe. People did not receive their medicines safely or as prescribed because

the provider had failed to ensure proper and safe management of medicines.

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

● The interim manager told us they had appointed a nurse to be supernumerary on a full-time basis so they could review, update and transfer the records fully to the new electronic system. Training was also being provided to staff on how to use the new system. This would improve recording and make information more easily accessible to staff.
● Staff understood when people required support to reduce the risk of avoidable harm. For example, we saw staff support people to walk safely and staff were able to tell us which people were at risk of falls and what strategies had been put in place to keep them safe from falling.
● An emergency evacuation plan was in place for each person, to describe the support they would need in the event of a fire or other emergency requiring evacuation of the building. These were up to date and reflective of people's current needs.

Staffing and recruitment
● There were enough staff to ensure that people's needs were met safely. However, the feedback we received from people concerned a lack of consistency and a high use of agency staff. One person told us, "They need more permanent staff. They use too much agency staff and they don't know me or how I like things to be done." Another said, "Most of the staff are now agency, they are nice people, but they don't always know what to do. It's not nice having personal care from different people all the time."
● Staff told us that the service had to rely on large numbers of agency staff to make sure there were safe numbers of staff to support people, One told us, "There are lots of agency staff currently used. We are having to rely heavily on agency staff (including agency nurses) and this has put a strain on the service." Another commented, "We need less reliance on agency staff who do not always want to know about service users beyond the task and do not always want to be taught. They need lots of guidance."
● We spoke with the interim manager and quality manager about the high use of agency staff. They had already identified this as an area that needed to be addressed and had recently recruited 11 new care staff. Four had already commenced employment and the remaining six were to be phased in; two every week. In addition, a further nine interviews had been planned for the following week. This meant the service could reduce their use of agency staff and improve consistency.
● Staff underwent a robust recruitment process. Staff records included all required information to evidence their suitability to work with people who use this service. This included a Disclosure and Barring Service check (DBS). Records were in place to evidence nursing staff were registered with the Nursing and Midwifery Council (NMC).

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
● The interim manager sent us an analysis of accidents and incidents from April 2021 to March 2022. This showed that they had looked at the accidents and incidents monthly to see if there were any trends and lessons learned.
● We were unable to find reporting and analysis of medication errors to learn lessons when things went wrong or share any learning with the staff team to reduce the risk of further errors.
● People told us they felt safe living at Bletchley House. One person told us, "It's as safe as anywhere. The carers know how to use equipment and I feel safe when they move me."
● Systems and processes were in place to help identify and report abuse to help keep people safe. For example, staff received training in safeguarding and were knowledgeable on how to identify the signs of abuse and how to report concerns.

● Staff and the management team understood their role and responsibility in relation to safeguarding and had managed safeguarding concerns appropriately and promptly.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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.

● Visits to people living in the service were facilitated and arranged in line with national guidance. This included essential carers continuing to visit during an outbreak of COVID-19 when the service was closed to routine visits.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Management of the service had been unstable and numerous managers had been recruited and then left the service. There had not been a manager registered with the Care Quality Commission since 21 December 2020.
- People we spoke with did not know who the manager was. One person told us, "The manager changes every three weeks. Management fluctuates. You just get to know them, and they're gone. There have been about six here." Another person commented, "We have had a lot of managers. I don't know who the new manager is."
- There had been a reliance on a high use of agency staff, which did not ensure consistency for people receiving care and support. People we spoke with voiced their concerns about the lack of consistent staff. One person told us, "I don't know who will be coming through that door. They [meaning staff] are always different."
- The provider did not promote a culture where people had sufficient opportunities to do the things they wanted to and spend their time in the way they preferred. People on the nursing floor spent most of their day in bed with their televisions on loud volume. One person told us, "There is a weekly notice board, but it doesn't happen. [Name of staff] just does drawing." Another person commented, "I never go out. I wouldn't mind some fresh air." We did not observe any activities taking place on the nursing floor during our visit.
- Provider level quality assurance audits to ensure effective oversight in the absence of a registered manager had not been effective in identifying areas for improvement and driving the required improvements.
- Medicines audits had not identified the issues that we found with medicines administration; therefore, poor practice had continued to take place.
- The providers governance and oversight systems had failed to ensure staff had access to the information they needed and that records were accurate and contained the necessary information required to guide staff.

We found no evidence that people had been harmed however, oversight of the service was not effectively managed by the provider to ensure people received safe and person-centred care at all times. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the interim and operations manager took prompt action when issues were brought to their attention. For example, when we provided feedback about medicines the interim manager immediately arranged a multi-disciplinary meeting so they could look at how to improve their medication systems.
● Staff told us they felt supported by the interim provider and were confident if they raised issues these would be investigated. One staff member said, "We recently put forward an argument for mealtimes to be changed, which happened and is now much better."
● The interim manager had identified the high use of agency staff as an area that needed to be addressed and had taken action to successfully recruit 11 new staff. Further on-going recruitment was taking place.
● A new manager had been recruited and was due to commence at the beginning of May 2022. They had already commenced their application to register with the Care Quality Commission.

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; Working in partnership with others
● The interim manager understood their responsibility regarding the duty of candour. They had been working transparently with a family member following an incident and had been open and honest.
● The provider had a policy that covered what actions they would take to ensure the duty of candour would be met in instances of this nature.
● Staff continued to work in partnership with health professionals involved in monitoring and providing care and treatment for people using the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Regular meetings for people using the service had not taken place. We saw the minutes of the last meeting dated 22 February 2022 that referred to the previous meeting held on 31 March 2021. The interim manager had recommenced meetings for people to raise their concerns and give their views about the service.
● We received a lot of negative comments about the poor quality of food. One person told us, "The food is not very nice and it's not very wholesome." Another person commented, "The food is terrible, you get two choices, but it's not cooked well." We saw the menus had been discussed at the meeting held in March 2021 and in February 2022. A feedback survey had taken place for people, relatives and staff in May and June 2021. This showed that only 18% of people using the service were happy with the food. There remained a high level of dissatisfaction with meals and it was not evident that people's feedback had been used to drive improvement.
● People received feedback surveys so they could comment on the service and quality of care. Overall, the previous feedback survey undertaken in May and June 2021 was positive. The interim manager planned to issue feedback surveys shortly and use the results to help drive improvements to the care people received and the service overall.
● Staff supervisions had not been carried out regularly, but the interim manager had recommenced these. Staff were asked for their views at staff meetings and had completed feedback surveys. One staff member told us, "Staff meetings and handovers are opportunities for sharing information. I do feel listened to."
● The interim manager had developed an action and improvement plan and we could see that they were following their action plan. They were committed to the on-going improvement of 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to people were monitored and managed appropriately so people were supported to stay safe. People did not receive their medicines safely or as prescribed because the provider had failed to ensure proper and safe management of medicines.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight of the service was not effectively managed by the provider to ensure people received safe and person-centred care at all times. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice.