

Samkar Limited

Bridgeway Care Home

Inspection report

Gamull Lane
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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

Bridgeway Care Home is a residential care home providing personal and nursing care to up to 29 people. The service provides support to adults aged between 18 and 65. The service is registered to provide support to adults with a physical disability and adults with a learning disability and or autistic spectrum disorder. At the time of our inspection there were 28 people using the service.

The care home is a large building set across two floors. It has an accessible lift, communal areas and a good-sized garden available to use.

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

Medicines were not always managed safely, although we did not find any harm as a result.

People were supported by staff that knew them well and there were enough staff to keep people safe. A relative said, "The same staff always work with my relative." Another relative said, "They have the right skills." People were protected well from the risk of the spread of infection and the home was clean and comfortable.

The registered manager and clinical leads kept people and their relatives involved and up to date. A relative said, "Staff ring you to tell you things."

We found a positive culture amongst staff, and they told us they loved their jobs. Relatives were positive about the home and said, "It is the perfect place", another said, "(My relative) loves the home, it is brilliant, and the staff are calm."

We have made recommendations about audits and recruitment processes.

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.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led the service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Care took place within a care home environment making it difficult to have different opportunities to maximise people's choice, control and independence. However, at times people were supported with their own interests; for example, staff supported people who wanted to do their own shopping. Staff understood the importance of promoting people's dignity and privacy was respected. Staff used different methods to make sure people could make their own choices, for example using pictorial aids and other communication aids.

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

Rating at last inspection

The last rating for this service was good (published 18 August 2021).

At our last inspection we made recommendations about the incident recording process and audits. At this inspection we found that some improvements had been made in these areas.

Why we inspected

This inspection was prompted by a review of the information we held about this service and we inspected the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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 monitor the service and will take further action if needed.

We have identified a breach in relation to the safe management of medicines at this inspection.

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Bridgeway 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 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 undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Bridgeway Care home 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. Bridgeway Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

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 a registered manager in post.

Notice of inspection

This inspection was unannounced.

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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with four people that use the service and seven relatives. We spoke with 10 members of staff including the registered manager, clinical leads, care staff, domestic and kitchen staff.

We looked at a range of records including care plans and medicines records. We looked at health and safety documents, audits and policies and procedures.

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

- The service did not always manage medicines safely.
- We found a container of 'thickener' left in a communal area, which was not locked away. Thickeners are added to drinks to make them safer for people who are at risk of choking. Accidental ingestion of thickener could cause harm.
- Two people were prescribed thickeners according to their care plans. Staff described using different amounts of thickener to what the care plans stated, and we could not see any instructions for staff in the kitchen or dining room. Staff did not record how much thickener they added to people's drinks. This meant there was a risk the wrong amount of thickener could be added to a person's drink.
- Staff did not always document the date of opening for topical creams, to make sure that these were discarded when no longer safe to use.

Although we found no harm as a result, safe use of medicines and thickeners had not been established to protect people that used the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They completed several actions to address and minimise risks including putting information in kitchen and dining areas and arranged refresher training for all staff to make sure staff knowledge was up to date.

- Controlled drugs were being managed safely and in line with the provider's policy.
- The registered manager assessed staff competencies around administering medicines.
- Two people made decisions about managing their own medication and risk assessments were in place.

Staffing and recruitment

- There were safe staffing levels at the home although there were gaps in recruitment processes.
- We checked recruitment records for staff that were recruited since the last inspection. Necessary safety checks such as right to work documents and reference checks were completed. However, we found that one person had a Disclosure and Barring Service (DBS) check undertaken while they were working for their previous employer and had not been re-done with the current employer, as per guidance. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider applied for the check immediately when we fed this back.

We recommend the provider consider current guidance around DBS checks.

- There were adequate staffing numbers to keep people safe and the service did not use agency staff.
- People and relatives told us staff were busy and they could benefit from higher staffing numbers to support people to go out and take part in activities. A person said, "I don't go out very much as there does not seem to be enough staff."

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse.
- There was an up to date safeguarding policy and although it did not include some detail about who to contact if staff had concerns, staff could correctly describe what they would do.
- The registered manager provided safeguarding training to staff and this was up to date.
- Relatives told us they thought the service was safe and people were well cared for. A relative said, "I have confidence about the service".

Assessing risk, safety monitoring and management

- People were kept safe as the provider had systems to assess risk and manage health and safety requirements.
- We saw detailed risk assessments in people's records, and these were linked to care plans.
- We checked health and safety records and found the service was compliant, for example electrical and gas safety testing.
- The service completed necessary actions following their most recent fire risk assessment. We saw equipment blocking a fire door during the inspection, which was removed immediately when we fed this back.
- A maintenance manager completed regular audits of the building. This was recorded in a maintenance file and we could see what actions had been taken and when to address.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 appropriate mental capacity assessments regarding restrictive practices in people's records where people lacked capacity.
- Appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Learning lessons when things go wrong

At the last inspection we made a recommendation about how incidents were recorded and monitored. The provider had made improvements.

- There was a new electronic system in place and staff were starting to record incidents on this.
- Some further updates were needed to the electronic system to make sure that themes and lessons

learned could be recorded, as these were still being recorded on paper.

- The registered manager audited incidents to find out if there were any themes. For example, around falls and actions were taken to minimise the risk of these for people.

Preventing and controlling infection

- People were protected from the risk of spread of infection.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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 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.
- The provider facilitated visiting in line with guidance.

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. This meant the service leadership, management and governance did not always ensure the delivery of high-quality, person-centred care.

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

At our last inspection we made a recommendation about recording more detail in the auditing process. Although some improvements had been made, the medicines audit did not highlight issues about the safe management of medicines that we found during this inspection.

We recommend the provider reviews their auditing processes to make sure issues are identified and acted upon in a timely manner.

- Although there was a registered manager in post, they were also the proprietor of this home and another, which could cause difficulties in providing a high level of oversight for Bridgeway Care Home. To prevent such difficulties, the provider told us they were actively recruiting a different registered manager however had not yet found someone suitable
- The registered manager understood their regulatory requirements and notified CQC and others about any notifiable incidents.

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

- People benefitted from a positive and person-centred culture at Bridgeway Care Home.
- People gave us positive feedback about the service, one person said the care was, "absolutely brilliant".
- Staff told us they enjoyed their jobs, and many had worked there for several years.

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 their responsibilities around duty of candour.
- Relatives said they were kept informed if anything went wrong and were kept up to date about concerns and issues.

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

- People, their relatives and staff were involved in the service by the registered manager.

- There were regular resident's meetings, and review meetings with relatives.
- Staff attended staff meetings and could give feedback. The registered manager made changes as a result of feedback; for example, changing the menus.

Continuous learning and improving care; Working in partnership with others

- The registered manager was involved in continuous learning and worked in partnership with others.
- The registered manager identified training needs and the training co-ordinator arranged this both internally and externally.
- Staff worked in partnership with others and other agencies supported the service, for example the learning disability team, local authority and commissioners.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service was not managing medicines safely, putting people at risk of harm.