Inspection Report on

Bridell Manor Care Home

Bridell
Bridell
Cardigan
SA43 3DD

Date Inspection Completed

20/08/2019
Description of the service

Bridell Manor is located in Bridell, near Cardigan and is registered with Care Inspectorate Wales (CIW) to provide nursing and personal care for up to 37 people over 65 years of age living with dementia or mental infirmity.

Ashberry Healthcare Limited operates the service, there is a manager with day to day for the home and the Responsible Individual is Roz Spalding.

The home is currently subject to Welsh Governments Enforcement procedures due to issues raised by commissioners who contract with the home, namely Pembrokeshire County Council, Ceredigion County Council and Hywel Dda University Health Board.

Summary of our findings

1. Overall assessment
   
   People living in the care home benefit from positive relationships with staff, however, improvements are required to ensure people are achieving their personal outcomes. Opportunities to take part in activities have improved since the last inspection. Improvements are required to the quality of care and support in the home to reduce the current risk to people in terms of their health, welfare and wellbeing. Some improvements have been made to the environment, further improvements are required to ensure improved outcomes for people and unnecessary risks are eliminated. There are a lack of robust systems in place to monitor, review and improve the service and therefore we found significant, systemic failings in terms of the supervision, audit and accountability of the home. Since the last inspection concerns have been raised with Care Inspectorate Wales (CIW), some of which were referred to the local authority’s adult safeguarding team for further consideration.

2. Improvements
   
   This is the first inspection under the Regulation and Inspection of Social Care Act (RISCA) 2016. An activities coordinator has been employed and people have increased opportunities to take part in activities. Action has, and continues to be taken to comply with fire risk assessment advice.

3. Requirements and recommendations
   
   Section five of this report sets out areas where the registered person is not meeting the legal requirements and our recommendations to improve the service. These include:

   - personal plans;
   - care and support;
   - referrals to healthcare professionals;
   - pre-assessment documentation;
   - supervisions and appraisals and
   - statement of purpose.
The failure to meet legal requirements and make improvements has resulted in non compliance being issued and ongoing involvement by CIW.
1. Well-being

Our findings

People are mostly able to communicate in the language of their choice. We overheard care staff speaking in Welsh to people and relatives throughout the inspection. Unfortunately some care staff providing 1:1 support had no knowledge at all of the Welsh language. People’s language preferences were mainly recorded in their personal plans. We saw bi-lingual signs displayed. However, we consider further work is required to ensure that the service better meets and supports people to communicate in the language of their choice.

Improvements have been made to ensure a more balanced diet. We saw a mid-morning offer of fruit has been introduced. We saw people were offered a three week rolling menu, a full hot meal at lunch time, and lighter fare in the evening was offered. We spoke to one of the chefs who told us they had enjoyed the soft diet training. Whilst two choices are offered at lunch time, we noted these to be cheesy pasta or cheese on toast, with no alternative prepared for those who did not like cheese. Staff told us they would provide an alternative if asked. We observed one person being presented with three different lunches but was not asked at any time what they would like. No choice was offered for dessert. We saw that drinks were offered throughout the day and staff completed documentation in a timely manner to evidence fluid intake. We consider work is on-going to ensure people receive a good varied diet.

People’s physical, mental and emotional wellbeing is at risk. We observed during the inspection people were generally sitting in the main dining room or in the smaller lounge with the television on. We observed eight of the nine people in the dining room at 8.45 a.m. seated in the same position at 10.55 a.m., and continued to so throughout the lunch time period, staff confirmed they had not moved. This means people are at risk of skin integrity damage. Whilst we saw some new seating has been purchased, we observed air cushions to be dirty. Overall care staff whom we spoke with had the intention of providing good care and support. Staff interactions with people were polite and calm. However, staff had not completed in depth, detailed and informative dementia training, the training matrix evidenced staff had completed basic online dementia training. This meant staff do not have the competency to understand people’s complex needs. Staff we spoke with, told us they felt “uneasy” and,” they did not have an understanding of the dementia pathway.” We overheard and observed the use of complex language, mixed instructions given to people and the use of inappropriate phrases. This meant people became increasingly confused and displayed distress responses. We consider people’s well-being is not always supported or promoted.

People cannot be confident they will receive a service which protects them from harm and ensures they are receiving the right care and support to achieve the best possible outcomes for them. Although we found people’s preferences in terms of activities were
documented in the new documentation compiled by the activities coordinator, this was not reflected in people’s personal plans nor care staff advised to support the delivery of care and support. We did not observe staff providing care and support in line with people’s preferences during the inspection. Where one person’s pre admission documentation specifically detailed activities which the person found calming and beneficial, we found this information was not used during significant episodes of challenging behaviour. We noted and observed work undertaken by the activity coordinator to provide a variety activities. Unfortunately training received by other staff members (oomph) had not been relayed to the activity coordinator. The absence of the activity coordinator on the second day of our inspection meant that people did not have the opportunity to participate in activities, we observed two people being given children’s colouring books, however they were not supported to engage in the activity. We found from our observations and reviewing care documentation, that people were not receiving the right care and support to avoid unnecessary deterioration in their health, welfare and wellbeing, putting them at risk of harm and neglect. We found that people were not always referred to other healthcare professionals when required, and the provision of prescribed medication was not consistent. We found people were not always receiving care and support in line with their needs. Communication systems in place required improvement to ensure staff were aware of people’s up to date and current, individual needs. We saw no evidence that care staff had read changes to people’s care plan. We found that robust systems are not in place to ensure people are supported by a sufficient number of suitable trained, qualified, skilled and supported staff in line with the home’s statement of purpose. Although we noted the home was staffed by a number of both agency nursing staff and agency care staff, the home had no induction policy for these staff. Two agency carer’s we spoke with did not have specific dementia training nor introduction to the people they were to provide 1:1 support. Safeguarding referrals evidenced staff did not have an understanding of the skills and competency to undertake 1:1 care. We consider the safety and welfare of the people living in the home to be compromised.
2. Care and Support

Our findings

People cannot be confident the service will be able to meet their complex needs. This is because we saw the pre admission process requires significant improvement. We reviewed pre-assessment documentation and found that vital information regarding the care and support people required was not always documented on the pre-assessment documentation. For example, two people had no baseline weight recorded, one of whom weight was not recorded until three weeks after admission resulting in a dietician referral request. We found some people’s pre-assessment documentation had been completed mentioning potential risk areas requiring complex care, such as behavioural challenges and disorientation, however personal plan documentation had not been completed until some time after admission. The service was therefore unable to always evidence how care and support had been delivered to people after admission to the home. In one case personal plans, risk assessments and service delivery plans were not completed until two weeks after admission, and specific care plans regarding managing behaviours not until one month after admission. There was no evidence of how the information was shared with staff. Some pre admission documentation had been completed by non clinical staff, but updated the following day with information not recorded in the original documentation. There was no evidence as to how the additional information was obtained. Another person’s pre admission was completed by an inexperienced staff member and missed key information. The person was admitted the following day as an unplanned admission. We conclude people cannot be confident the service is able to meet their individual needs and support them to achieve their personal outcomes.

Personal plan documentation is not always reviewed in a meaningful way. Despite the recommendation to review care planning documentation made in the two previous inspections, this has not been completed. There was no evidence that people, or their representatives, were involved in the review of their personal plans to ensure the review process takes into account people’s personal outcomes. We spoke with three relatives of people using the service who confirmed the service had not maintained the improvements made in spring 2019. They told us, “it’s not the girls fault, they try hard but there is not enough of them, especially at weekends” and, “it’s not too bad.” We found that personal plan documentation was not always updated when people’s needs changed to reflect changes in their care and support needs, and therefore the service was unable to evidence people were receiving care and support in line with their current needs. For example, we found that one person’s daily care records noted a deterioration in their condition impacting upon other people and staff at Bridell. The person plan was not reviewed for two weeks and did not provide staff with strategies as to how to support the person. We were informed by the nurse on duty that such changes were communicated using the handover system, we were unable to access handover documentation relating to this period. When we spoke with care staff it was clear they did not access nursing care documentation. We recommend all
staff are made aware of information relevant to the provision of care and support. A healthcare professional we spoke with confirmed that, whilst things had improved for a short time, “they were now going backwards.” People cannot be confident the service has an up to date and accurate plan for how their care and support is to be provided. This is resulting in people not receiving the right care at the right time which puts their health, welfare and well-being at risk. We have issued a non-compliance notice in relation to care and support provided by the service.

People are not being provided with the quality of care and support they require. We reviewed people’s personal plan documentation and nursing diary entries and found that the service was not referring people on for specialist advice where required. For example, we found the service had highlighted three people required specialist intervention from a healthcare professional. The referral was only completed in one case. The service is experiencing difficulties with the Well-Pad system, and in the ordering of prescribed medication. We looked at procedures for managing and administering medication. We noted the correct logging details had not been implemented for a significant period of time. We received notification of a delay of 13 days in a person receiving prescribed medication, a recorded decline in their behaviour and well-being was noted. Whilst the last dose was recorded in the nursing diary no evidence was found to chase the prescription until this was highlighted by an external professional. We saw there were gaps in evidencing staff were complying with the home’s own medication policy. We saw gaps and inaccuracies in the completion of the controlled drugs administration book. We saw records for cleaning and recording of temperatures in the medication room were not fully completed. People are not supported to maintain their ongoing health, welfare and well-being which is resulting in avoidable deterioration in their health and wellbeing. We have issued a non-compliance notice in relation to the care and support provided by the service.
3. Environment

Our findings

People can be confident significant steps have been introduced to address shortfalls in the environment, in order to benefit their safety and well-being. However, this work is ongoing and clear oversight is required to ensure completion and supply of equipment. We saw works identified in the Fire Risk Assessment plan have been addressed and continue to be ongoing. For example a pump has been installed and the cellar is no longer flooded. We observed during our tour of the home work to fit new fire doors. Fire safety maintenance checks, drills and scenarios are completed. We noted that gas, appliances, hoists and fire extinguishers were regularly serviced and certified, and the water temperatures were tested to reduce the risk of Legionella. A maintenance log recording issues is in place and evidenced when completed. Staff reported to us the hoists did not always work. However, we addressed this with both the manager and maintenance person who both told us staff did not always check the battery packs were fully charged before using. We discussed ways to address this. The gardens and grounds are well presented, with seating areas. We saw photographs of people enjoying the sunshine and visits from an ice cream van and vintage cars. A project to refurbish the reception area had not been completed. Since our inspection we have been informed this work is now completed. Disappointingly work to replace an existing bathroom to a wet room, identified at previous inspections has not commenced. The radiator cover in the old style bathroom upstairs is broken. The service has received a four star food hygiene rating, staff we spoke with were uncertain as to why they had not received the top rating of five, nor were they aware of any plans to address the shortfall. Whilst new bed rail protectors have been purchased, housekeeping staff had yet to remove the old covers. The manager told us of plans to improve the dome area for the benefit of people living at the home. We consider work and plans are being made to ensure people can benefit from all the facilities the home can potentially provide, but clear oversight is required to ensure completion of all works.
4. Leadership and Management

Our findings

People benefit from a service which wants to improve and wants to provide a high quality of care. However, leadership and management of the service must improve to meet regulatory requirements. Staff are not always supported, trained or supervised to provide high quality care and support to people using the service. The service is heavily reliant upon agency staff as eight staff members of staff have left the service and two are on leave. Whilst the service has tried hard to maintain continuity of agency staff this has led to an over reliance on certain agency staff whose absence then impacts upon the provision of care for people living at Bridell. For example, an agency nurse with mental health training is providing significant support to lead and support greater understanding of complex health needs and the delivery of support for those with a diagnosis of dementia. Records, we saw, show in that persons absence care plans had not been reviewed, referrals completed or policies and procedures followed. Staff morale is low, staff told us they are not always aware of lines of accountability within the home nor of the ethos of the home. All staff whom we spoke with were complimentary about the manager, saying "she is good," "she is trying," and "I like her, she is approachable." The statement of purpose has yet to be reviewed to reflect the requirements of the new care legislation. Whilst there are systems in place to monitor whether the service is being run in accordance with its policies and procedures, as overseen by the responsible individual, there is little evidence to ensure any required improvements are implemented. This is because whilst we saw reports from the responsible individual and action plans provided to commissioners, we could not always evidence completion of points raised. Therefore, further work, support and oversight is required to secure a high quality service which enables people to achieve their personal outcomes.

During the inspection, we found there were insufficient staff to meet the individual needs of people in a timely manner and we found this was having a negative impact on the well-being and dignity of some people. For example, we found one person was shouting out for staff support as they required the toilet; we highlighted this to a member of staff who told us the person allocated to support the person was supporting someone else. This same person asked again on the second day of inspection, and was assisted to the toilet but left calling out when they had finished. No member of staff answered and the person walked in to a communal area not fully dressed. Whilst the service had identified people required increased 1:1 hours the requirements of social services to evidence this had not been completed. At the time of the inspection this meant other staff were necessarily providing that 1:1 support on an ad hoc basis, meaning other people did not have the required support they needed. Since our inspection CIW has been informed one person has received increased 1:1 support.
Staff were not receiving one to one management supervision at the required intervals. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for care workers. Actions to evidence competencies required in a performance management plan were not completed. Staff were not receiving an annual appraisal of their work. This means opportunities to address shortfalls, competencies and opportunities to develop are missed. We conclude people cannot be confident they receive care and support from staff who are supported in their role.
5. Improvements required and recommended following this inspection

5.1 Areas of non-compliance from previous inspections

None.

5.2 Recommendations for improvement

We have identified the following breaches of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 which the registered persons must address:

- Regulations 21 (1) in relation to failing to provide care and support in a way which protects, promotes and maintains the safety and well-being of individuals. This is a serious issue and we have issued a non-compliance notice to the registered persons.

- Regulations 34 (1) (2) (3) (4) in relation to the failure to ensure people are supported by appropriate numbers of staff who are suitably trained, skilled and supported. This is a serious issue and we have issued a non-compliance notice to the registered persons.

Non compliance notices have been issued.

In addition we recommend the following:

- To ensure the home fully complies with the “active offer” of the Welsh language as required under the Welsh Governments Strategy “More than just words 2016-2019”.

The service provider has been notified of the following:

- Regulation 36. In relation to staff supervision, staff supervision required quarterly (or more). All staff to have an annual appraisal.
- Regulation 14. To ensure the suitability of the service, to include the pre assessment process and to consider the risks to an individual and others using the service and staff.
- Regulation 15. In relation to the failure to produce accurate personal plans for individuals as to how their needs will be met.
- Regulation 58. To ensure safe systems for the administration and management of medication.
- Regulation 33. In relation to a failure to refer individuals in a timely manner to health care and allied health professionals.

Non compliance notices have not been issued at this inspection. These matters will be followed up at next inspection.
6. How we undertook this inspection

This was a full inspection brought forward as a result of a number of safeguarding referrals received. This inspection was carried out under the new regulations – Regulation and Inspection of Social Care (Wales) Act 2016. The unannounced inspection took place on the following dates: 15 August 2019 between the hours of 10.45 a.m. and 17:00 p.m. and on 20 August 2019 between the hours of 08:30 a.m. and 14:35 p.m.

The following methods were used:

- We reviewed documentation held on the system regarding the service before undertaking the inspection.

- We spoke with people living in the home, relatives, care workers, the manager and the responsible individual.

- We used the Short Observational Framework for Inspection (SOFI2). The SOFI2 tool enables inspectors to observe and record care to help us understand the experience of people who cannot communicate with us.

We looked at:

- Five care records of people living in the home;
- Three staff files;
- The statement of purpose.

In addition, we toured the property.

Further information about what we do can be found on our website: www.careinspectorate.wales
## About the service

<table>
<thead>
<tr>
<th>Type of care provided</th>
<th>Care Home Service</th>
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<tbody>
<tr>
<td>Service Provider</td>
<td>Ashberry Healthcare Limited</td>
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<tr>
<td>Registered maximum number of places</td>
<td>37</td>
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<tr>
<td>Date of previous Care Inspectorate Wales inspection</td>
<td>2 May 2019</td>
</tr>
<tr>
<td>Dates of this Inspection visit(s)</td>
<td>15 August 2019 and 20 August 2019</td>
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<td>Operating Language of the service</td>
<td>English</td>
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<tr>
<td>Does this service provide the Welsh Language active offer?</td>
<td>This is a service which is working towards the “Active Offer “</td>
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<tr>
<td>Additional Information:</td>
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**Date Published** 24/10/2019
Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Care Home Service

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on CSSIW’s website
www.careinspectorate.wales

Bridell Manor Care Home

Bridell
Bridell
Cardigan
SA43 3DD

Date of publication: Wednesday, 23 October 2019
<table>
<thead>
<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
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<tbody>
<tr>
<td>Regulations 21 (1) in relation to failing to provide care and support in a way which protects, promotes and maintains the safety and well-being of individuals.</td>
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**Evidence**

Person A - Had not received prescribed medication for 13 days. No record of service contacting GP in this time. Altered dose not logged to Wellpad medication administration system. Verbal handover of correct dose been provided by nursing staff. The impact for this person is they experienced increasing agitation in time period without medication. There is a risk the correct dose may not be administered. There is a risk to other individual's at the home, due to person A increased agitation.

Person B - Change in medication not provided at handover. Impact staff are not aware to observe and report changes in behaviour.

Two of Three requests for SALT referrals to be completed in June and July had not been actioned (20/8/19). The impact for the individuals concerned is a risk of malnutrition.

Person C - failure to complete personal plans, risk assessments and care records for over a week after admission. Care plans and risk assessment relating to behaviour and sexual disinhibition not completed until 1 month after admission. 1:1 support was not assessed as being required until 3 weeks after admission. Monthly observations, MUST assessment and dependency assessment were not completed in June. Impact - staff did not have access to information to support care for this individual, the person was at increased risk of disorientation and sexual behaviours towards other people and staff, insufficient staff to provide person with the support they required. Risk to safety of people at Bridell.

Two people requiring additional 1:1 support hours. Additional information required by commissioning authority not prioritised or completed. The impact for these two individuals is they are at risk of poor outcomes, falls, poor nutritional intake (two incidents observed SOFI 20/8/19). The impact upon other individuals living at the home is that staff are unable to support them to maintain their dignity and promote their well-being (observations 20/8/19).

Individuals are not always supported by appropriately trained staff who have sufficient language skills. For example not all staff have completed basic dementia awareness as well as a lack of mental health trained nursing staff. Staff providing 1:1 support do not always have any Welsh language ability. People's emotional, physical and mental well-being is at risk due to lack of understanding of dementia, a lack of information and an inability to communicate in
the language of their choice.
# Non-compliance identified at this inspection

<table>
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<th>Timescale for completion</th>
<th>04/11/19</th>
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## Description of non-compliance/Action to be taken

<table>
<thead>
<tr>
<th>Regulation number</th>
<th>Regulations 34 - failure to ensure people are supported by appropriate numbers of staff who are suitably trained, skilled and supported.</th>
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## Evidence

The registered person is not compliant with regulation 34 (1),(2),(3),(4).

This is because the provider has failed to ensure sufficient, skilled staff are employed to support and provide care for people with complex needs. Appraisals, supervisions and performance action plans have not completed. This means people are at risk as staff have not received guidance or support in order to deliver evidence based care. Nursing staff who have been assessed as not meeting the home’s required standards of practice are leading shifts. Bridell Manor is heavily reliant upon agency nurses and care staff. There is no policy in place regarding communication, induction, or handover for agency staff.

The evidence:
Discussion with agency carers - stated they had no specific training in dementia care, no induction to the role of 1:1, no handover of a person’s specific behavioural triggers and had not been made aware of any personal behaviour management plan. 1:1 care provided to a first language Welsh speaker by a carer who had no Welsh language knowledge or ability. The impact for people is they are at risk as staff do not have sufficient knowledge to support their complex needs. People are not able to communicate in the language of their choice and there is a risk of increased distress responses as a result. Safeguarding referrals have been made identifying staff lack of understanding of 1:1 role as a factor.

The provider has failed to ensure all staff have completed dementia awareness training. Dementia training completed is online based. Discussion with care staff did not evidence an understanding of people’s complex needs in relation to dementia. There was no evidence agency care staff had completed dementia training. A reliance upon one agency nurse with mental health training meant, in their absence, staff lacked guidance and support to undertake their roles. This meant a delay in completing care planning and risk assessments, a failure to request assessment for 1:1 support. One person had no care plans completed for one week after admission, and relevant care plans regarding behaviour for another week. We saw evidence of a nursing record completed for a person who was no longer living at Bridell. The impact for people living at Bridell is a decline in their mental health as staff are not provided with information as how to provide care and support. A risk to staff who do not have the understanding or skills to support people. Safeguarding referrals were upheld.
The provider has failed to ensure staff do not undertake roles they have not received training for or who have been assessed as competent to undertake the role. For example, a staff member who had not received training completed a pre admission assessment. The subsequent admission was not agreed before admission to Bridell. The admission document did not contain all the necessary information. A failure to record the person's weight on admission resulted in a failure to complete a referral for dietary advice in a timely manner. The referral was not completed. The impact for people living at Bridell is a potentially unsafe admission, where the service cannot evidence they are able to meet people's needs and the impact upon other people has not been considered. A failure to communicate with staff how a person's care needs will be met. We were told by a non clinical member of staff, they had been left a blank fax to complete to chase missing medication. This had not been completed. The impact was a person missed medication for 13 days, during which time a decline in their mental health was evidenced.
Leadership and Management

Our Ref: NONCO-00008241-YXWP

Non-compliance identified at this inspection

Timescale for completion | 04/11/19

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<tr>
<th>Description of non-compliance/Action to be taken</th>
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<tr>
<td>Suitability of the service 14.— (1) The service provider must not provide care and support for an individual unless the service provider has determined that the service is suitable to meet the individual’s care and support needs and to support the individual to achieve their personal outcomes.</td>
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Evidence

- The registered person is not compliant with regulation 14(1), 14,(3)(a)(b)(c)(d)(e)(f)(g)(h) and 14, (5) (a and b):
- This is because the service provider has failed to undertake accurate pre admission assessments by trained staff, consider risks to the individual's well-being and, any risks to the well-being of other individual's to whom care and support is provided. The service has failed to evidence how personal outcomes will be achieved. The service has failed to support a smooth transition for the individual to receive support at Bridell Care Home.

Person A - Pre admission undertaken 20/5/19 by non clinical manager, who noted "disorientated", and "think's everyone is his wife". Emailed brief admission details to clinical lead who completes the readmission document on admission (24/5/19). No risk assessment undertaken, no risk assessment undertaken to consider impact upon other individual's receiving care and support at Bridell nor staff. No care planning undertaken until 31.5.19, and 4.6.19. Impact upon the individual care staff did not have information to support individual. The service did not evidence how care and support needs would be met. No consideration was given to the risk to other vulnerable individuals. Safeguarding incident upheld.

Person B- Preadmission undertaken by a senior carer who had not received any training to undertake role, 20.5.19. No baseline weight recorded. Person admitted to home 21/5/19, preadmission documentation completed on admission. Person not weighed until 14.6.19. Impact - service did not evidence how individual's care and support needs were to be met. No agreed date for admission, no smooth transition to the home. No risk assessment undertaken regarding nutrition. No referral to SALT undertaken.