KR Care Homes Limited

Bankfield

Inspection report

Gigg Lane
Bury
Lancashire
BL9 9HQ

Tel: 01617648552

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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
Bankfield is a residential care home located in Bury, Greater Manchester. The home is registered with the Care Quality Commission (CQC) to accommodate a maximum of 47 people. 26 older adults, many of whom lived with dementia and memory problems, were accommodated at the time of this inspection.

People's experience of using this service and what we found
Whole-service risks, centred around unknown and unmet health and social care needs, were identified at this inspection. The provider had little understanding of people's baseline health and social care needs. Care records and associated risk assessments were either missing, or contained significant gaps meaning they were unreliable and not fit for purpose. Staff did not have enough underpinning knowledge or insight into people's needs. No meaningful action had been taken to reduce risks associated with falls management, pressure wound care and a risk of choking.

Infection prevention and control practices were inadequate and did not protect people from the risk of infection, in particular risks associated with COVID-19. Polymerase Chain Reaction (PCR) testing was not completed, instead, an inconsistent system of Lateral Flow Test (LFT) testing had been adopted as custom and practice. No effective system was in place to ensure COVID-19 checks were carried out on arrival at the care home. We were not assured staff had received the appropriate training in respect of 'donning and doffing' of personal protective equipment (PPE).

The management of medicines was poor. This included systems for ordering, storing, administration and disposal of medicines. Staff responsible for medicines administration had received training. However, records did not evidence these staff had their medicines competency checked and the home manager was unable to provide any assurances about this.

Systems to ensure people were protected from a risk of abuse were inconsistent and not operated effectively. We were not assured the provider and staff understand their individual and collective safeguarding responsibilities.

There was a significant failure in leadership and management. Systems for audit, quality assurance and questioning of practice were inadequate. There was an absence of meaningful overarching analysis of the already poor governance systems that were in place. There was a failure to identify themes, trends and newly emerging risks, which placed people at an increased risk of harm.

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 overall rating for this service at the last inspection was Requires Improvement, with a rating of Inadequate in the key question of Well-Led (published 04 August 2020). We took enforcement action by

serving a Warning Notice for failures of good governance, and we served three Requirement Notices for failures of person-centred care, safe care and treatment, and staffing. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, no tangible improvements had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the quality and safety of care, staffing levels - including unskilled and inexperienced staff, medicines administration, and poor leadership and management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. No new areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

We also 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.

Enforcement
We have identified new and continued breaches of regulations in relation to safe care and treatment, safeguarding, staffing and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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 six 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.

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.

Bankfield

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Bankfield 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 did not have a manager registered with CQC at the time of our inspection. Alongside the provider, a registered manager is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The 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 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. However, we did require the providers 'report of actions' that was sent to us after our last inspection. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people who lived at Bankfield about their experience of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four relatives by telephone.

We spoke with 10 members of staff including the provider, home manager, an external social care consultant (employed by the provider), the deputy manager, the administrator, senior carers, care assistants and the activities coordinator.

We reviewed a range of records. This included care plans and associated documentation, including medication records. A variety of records related to the management of the service were also reviewed.

After the inspection
In respect of the most serious concerns highlighted in this report, we raised individual safeguarding alerts with the local authority. In addition to this, the CQC took urgent steps to ensure the health, safety and wellbeing of everyone who used this service. CQC were supported in this action by system partners from across a variety of health and social care services in Bury.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection we identified failures around the management of risk. This was a breach of Regulation 12 (Safe care and treatment) At this inspection no improvement had been made and the service remains in breach of Regulation 12.

- We were not assured that risks to the health, safety and well-being of people were suitably assessed or appropriately monitored within the home. This was due to a number of factors including poor provider oversight and care records that were either were out of date or contained conflicting information.
- Where risks had been identified, action was not always taken to reduce the risk of harm to people. For example, three people had a recorded weight loss, but no meaningful action had been taken to ensure people were supported to gain and maintain weight. For one of three people, despite losing a significant amount of weight over a four-month period, no referral had been made to a dietician to ensure appropriate assessment and support could be provided.
- People who were at risk of dehydration were not properly monitored. Fluid input and output was not consistently recorded or totalled up each day. This meant staff had no reliable method of ensuring people were drinking enough.
- The management of witnessed falls and unwitnessed events was inconsistent. One person was considered a very high falls risk and had previously suffered a serious injury following a fall. This person's risk assessment and care plan lacked any falls prevention measures and guidance to assist staff in keeping this person safe.
- There was missing information in the care plans based on what people told us their health conditions and treatment were. The provider had failed to implement a risk assessment or written guidance to guide staff on how to reduce the risks to people. People who were at high risk of developing sore skin did not have detailed plans or risk assessments. This meant people were placed at increased risk of developing pressure wounds.
- Records relating to people's safety were not always up to date or accurate. This meant that staff were unable to follow guidance to help ensure people were consistently supported safely. This was of particular risk and concern because the home was regularly using agency staff.

The provider had not done all that is reasonably practical to mitigate risks to people. This exposed people to a risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Premises safety checks had been carried out. We saw evidence that demonstrated appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were undertaken on portable appliances and lifts to ensure people living at the home were safe
● Each person had a personal emergency evacuation plan (PEEP) which gave guidance on what support a person would need during an emergency. However, the file was not up to date and contained a PEEP record for five people who no longer lived at the home. In the event of an evacuation, this incorrect information may have placed rescuers at unnecessary risk of harm.
● Fire drills had been conducted once a year. We discussed with the management team possible improvements in this area to include, for example, a record of whether the drill went to plan and any lessons learned, and carrying out drills with both day and night staff to ensure all staff are clear about their role and responsibilities in the event of an emergency evacuation.

Using medicines safely

At the last inspection we identified failures around the safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) At this inspection no improvements had been made and the service remained in breach of Regulation 12.

● People's prescribed medicines were not safely managed.
● Written guidance for medicines prescribed 'when required' were not available to ensure they were given by staff consistently and at the right time.
● For people who were prescribed medicated skin patches, records had not always been completed when new patches were applied. Also, there was no system in place to ensure application of the patches on people's bodies were rotated appropriately to reduce the risks of skin effects.
● Medicines prescribed to be hidden in people's food or drink, often referred to as 'covert medicines', were not managed safely. This included not following recognised national guidance for covert medicines and not ensuring pharmacist instructions were available for staff to follow to ensure the medicines were suitable mixing with certain foods or drinks. Some medicines can become ineffective when mixed with certain foods or drinks. Altering the characteristics of the medicine may change a person's response to the medicine.
● Medicine administration records (MAR) were pre-printed or handwritten. For the handwritten records, the records of medicines, dosages and administration instructions were not duly signed by two care workers confirming the medicines were correct. Poor records are a potential cause of preventable medication errors.

● Staff responsible for administration of medicines had received training in medicines. However, we were not assured staff had their individual medicines competency checked. We were informed by the home manager that they had not yet had the opportunity to undertake these tasks. Providers and care home managers should ensure that staff responsible for medicines administration have an annual review of their knowledge, skills and competencies to ensure they are safe.

The provider failed to ensure that people's medicines were administered safely. This exposed people to a risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection we found the provider did not have a systemic approach to determine the number of staff and range of skills required to meet people's needs and to keep them safe. This was a breach of Regulation 18 (Staffing) At this inspection no improvement had been made and the service remained in

breach of Regulation 18.

● Staffing levels were inconsistent with no reliable systematic approach taken to ensure staffing levels were enough to meet people's needs. This was of particular concern because many people required the support of two care staff to meet their needs.
● Despite the majority of staff having worked in the care home for less than 12 months and/or having little to no previous experience in care, no meaningful consideration had been given to the skill mix and experience of staff. This caused a number of difficulties when less experienced staff worked with agency staff resulting in staff frequently calling the home manager out-of-hours for advice on how to manage people's needs.
● Staff were not organised, supervised and managed effectively. Care and support provided to people were task-and-time oriented with no meaningful opportunities for staff to engage with people other than when delivering care related tasks. Comments from people included, "There is nothing to do here, nothing at all."; "Sometimes I need the toilet but it's if I can find staff to take me."; and "Sometimes there is not enough staff."
●On the first day of our inspection visit, we observed one person sitting in the ground floor lounge become very distressed. However, we were unable to locate any care staff within the immediate vicinity and a member of the inspection team had to search the building in order to locate a member of staff.
● As a result of staff shortages, on the second day of inspection the home manager had to carry out direct care related duties. This took them away from their managerial duties for the whole of the shift. We spoke with the home manager about this and were told this happened frequently, which meant they were not afforded the opportunity to manage all other aspects of the care home. Comments included, "I'm simply firefighting on a daily basis."

The provider had failed to ensure sufficient numbers of skilled and experienced staff were deployed to meet people's needs. This was a repeated breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices had been followed. Pre-employment checks included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Preventing and controlling infection
● Infection prevention and control practices were inadequate and did not protect people from the risk of infection, particularly risks associated with COVID-19.
● Polymerase Chain Reaction (PCR) testing was not completed, instead, an inconsistent system of Lateral Flow Test (LFT) testing had been adopted as custom and practice.
● No effective system was in place to ensure COVID-19 checks were carried out on arrival at the care home. On both days of our inspection the member of staff who greeted us at the main entrance needed prompting to check our COVID-19 vaccine status and evidence of a recent LFT.
● We were not assured staff had received the appropriate training in respect of 'donning and doffing' of personal protective equipment (PPE). The newly recruited home manager did not know if such training had taken place, and no evidence of training was made available.
● One member of staff was on duty despite being unwell with an active infection. Their PPE was not sufficient to guard against aerosols being generated when coughing or in close proximity to people.

Systems were not in place to protect people from risks associated with COVID-19. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Systems to ensure people were protected from a risk of abuse were inconsistent and not operated effectively.

● We were not assured the provider and staff understand their individual and collective safeguarding responsibilities. There had been a failure to escalate new and emerging risks to the relevant safeguarding authority which exacerbated and prolonged concerns around poor quality care and prevented people from accessing the right care and support at the right time.

The provider had failed to establish and operate systems effectively to prevent abuse. This exposed people to a 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.

Learning lessons when things go wrong

● Nothing within the setup of the home lent itself to learning lessons. The provider lead by example in creating a poor learning culture, as evidenced by their failure to learn lessons from the last inspection and a failure to comply with a Warning Notice for safe care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection we identified issues around governance and oversight. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection no improvement had been made and the service remained in breach of Regulation 17.

● Following our last inspection, we took enforcement action against the provider by issuing a Warning Notice. At this inspection, no improvements had been made and the provider had failed to comply with the Warning Notice. This demonstrated a history of failing to respond to serious concerns raised by CQC and a failure to create a culture of continuous learning.
● Systems for audit, quality assurance and questioning of practice were inadequate. There was an absence of meaningful overarching analysis of the already poor governance systems that were in place.
● There was a failure to identify themes, trends and newly emerging risks, which placed people at an increased risk of harm.
● Care plans and associated records were inadequate and contained gaps and omissions, which meant records were not reflective of people's needs.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● It was not clear what systems and process had been established to ensure people, their relatives or lawful representatives were engaged and involved in daily life within the care home. This included the period of time when the home was without a manager for an extended period of time. Comments from relatives included, "I don't have a clue who is managing now. It's very confusing who is in charge."; "I would love to have more input (into [persons] care plans). I would love to be told, "Oh, Mum did this today." But that communication is not there.", and "We find the communication is very poor. I recently rang and left a voice message, and no one ever rang me back."

Working in partnership with others
● Since taking over the running of the care home, the provider had not actively sought opportunities to

engage and work in partnership with others. As previously mentioned in this report, this included when risks to quality and safety were obvious to the provider, but no action was taken to involve others from outside the home.

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 serious issues identified at this inspection fall within the duty of candour framework and we spoke at length with the provider about how this information should be shared with people in an open, honest and transparent way.

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

● The issues highlighted throughout this report demonstrates the culture and ethos within the care home was not person-centred and did not achieve good outcomes for people.

● The provider had little regard for the fundamental standards of quality of safety which placed people at risk of harm.