Golden Age Care Ltd

Breach House

Inspection report

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Tel: 01562730021

Date of inspection visit:
24 February 2022

Date of publication:
10 May 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Breach House is a residential care home providing personal and nursing care for up to 34 older people. At the time of our inspection visit there were 23 people living at the home.

Breach House accommodates people in one building over two floors. Around half of the people at the home had en-suite facilities in their bedrooms. Other people shared bathroom and shower facilities.

People's experience of using this service and what we found
The provider did not always manage risks to people's health and wellbeing. Procedures to maintain a high standard of cleanliness, and to ensure infection control risks were always managed were only somewhat effective.

The provider's systems and processes were not always used effectively to review and maintain oversight of the quality of the care people received. Governance procedures required improvement to ensure people always had accurate and up to date care records, that reflected their care needs.

Staff understood their responsibility to protect people from abuse and avoidable harm. People, staff and relatives told us there were enough staff to meet the needs of people using the service. Medicines were managed safely.

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.

The provider took some action immediately when we identified improvements at our inspection.

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

Rating at the last inspection
The last rating for this service was requires improvement (published 15 January 2020). The service remains rated requires improvement with a breach in Regulation 12 safe care and treatment, and a breach in Regulation 17 good governance.

Why we inspected
This was a focussed inspection. We inspected the service following anonymous concerns that had been raised with us. As a result, we undertook a focused inspection to review the key questions of Safe, Effective 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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed from Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to Regulation 12 safe care and treatment, as risks to people's health were not effectively managed. We have also identified a breach in Regulation 17 good governance, as the provider's systems and procedures were ineffective in identifying and driving forward improvements.

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 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

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 safe findings below.

Breach House

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 team comprised of two inspectors and an Expert by Experience who made phone calls to relatives and visitors of people who lived at Breach House. An Expert by Experience is someone who has experience of this type of service. On 24 February 2022, two inspectors visited the home.

Service and service type
Breach House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager registered with the Care Quality Commission. This means that they and the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because of COVID-19, we needed to be sure the service could accommodate our inspection team in a safe environment. Our inspection visit was on 24 February 2022.

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. Before our inspection we received feedback from a member of the public anonymously.

We requested information from the provider in the form of a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. The provider did not return this information to us. We have taken this into account during the inspection and asked the provider to send us all relevant information about their service. We used all of this information to plan our inspection.

During the inspection
We spoke with two three people who used the service, nine relatives, and two visitors, about their experience of the care provided. We spoke with nine members of staff including the provider, the registered manager, senior care workers, the compliance manager, care staff and facilities staff. We also received feedback from one member of staff via email. We also spoke with a visiting health professional.

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 reviewed a range of records. This included five people's care records in detail, six people's daily records and medicines records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

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 requires improvement. At this inspection the rating remains 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;

- Risk assessments and risk mitigation plans were not always followed, to ensure people were cared for safely. For example, one person was at high risk of skin damage. Risk mitigation plans stated the person should be moved every two hours to ensure their skin did not deteriorate. Records showed this instruction was not always followed by staff. This placed the person at increased risk of damage to their skin.
- One person was at high risk of falls. Staff were instructed to walk with the person to support them at specific times of the day, however, records showed the person had two falls in February 2022 where staff were not supporting them to walk safely.
- Risk assessments and risk mitigation plans were not always in place when risks had been identified, placing people at increased risk to their health and wellbeing. For example, one person who had a catheter and was prone to infection did not have a plan in place to instruct staff on how to manage their catheter care. This meant staff were not provided with information on how to spot the signs of the catheter becoming blocked or the symptoms of an infection. In addition, staff did not maintain an accurate record of the output from the catheter, to alert them to changes in the person's health.
- Risk assessments and risk mitigation plans were not always in place for people who had developed wounds to their skin. One person had a cut to their skin and was being treated by the district nursing team for the injury. However, the injury had not been recorded in a care plan, and staff were not provided with information on how to take action to manage the injury or help prevent this type of injury from re-occurring.
- The provider had missed opportunities to learn from incidents and accidents at the home. Some accidents and incidents were not recorded accurately or investigated when they occurred. This meant there was a lack of analysis of such events to identify areas that could be improved or where risks could be mitigated, helping to prevent the risk of re-occurrence.
- The provider had missed opportunities to learn from people and their relatives and gather feedback from them, to drive forward improvements. Whilst some relatives remembered being asked to complete a satisfaction questionnaire, another relative said, "I've had no questionnaires or been asked my views" another commented, "I used to get an annual survey but I haven't seen one for a long while."

The registered manager and provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider responded to feedback proactively. Following our inspection visit, putting into place a system to monitor trends and learn from accidents and incidents at the home. Wound care plans were also introduced.

Visiting in Care Homes

● The provider did not prevent visitors from coming into the home and visiting their friends and relatives. Visitors continued to visit their relatives with window visits, telephone calls and by using a designated visiting area at the home. Where people were receiving end of life care, or people who were unable to use the designated visiting area due to their mobility, their relatives continued to visit them in their bedrooms. However, some relatives told us they would like to be able to visit their relatives in their bedrooms rather than using designated visiting areas inside the home, without any restrictions being placed on them. Comments included, "I would like to sit with [name] in his room because it would be more personal", and, "I'm desperate to go into [name's] room and see what she needs. I've not been in there for 2 years."

Systems and processes to safeguard people from the risk of abuse

● People told us they thought their relatives were safe and trusted the staff at the home. One relative commented, "They've treated [Name] with dignity. It's the way they talk to her with kindness", another said, "Their [staff] vocabulary is as they would treat their own family. They use endearments - it makes you feel comfortable and not like an intruder."

● Staff told us they were confident identifying potential safeguarding concerns and knew how to report these to management. One staff member said, "I would feel more than comfortable going to the management team with any and all concerns that I may have. The management team are very accommodating and are able to listen to any concerns I have."

● Procedures were in place to report safeguarding incidents to the local authority safeguarding team and CQC. However, because accidents and incidents were not accurately recorded or investigated at the home, some incidents had not been reported to CQC or safeguarding for investigation.

Preventing and controlling infection

● People appeared clean and well presented. Staff understood their responsibilities regarding good infection control procedures. One relative told us, "[Name's] room is immaculate, it's like a 5* hotel. We see the chef cooking the dinners and the kitchen is always spotlessly clean." However, we received mixed feedback from relatives about whether their relation was always supported with good personal hygiene. One relative told us, "{Name's] finger nails are not always clean", another said, "Another relative said, "[Name] always looks as if her hair needs a wash so when I visit I take dry shampoo and do it myself."

● We were somewhat assured the provider was preventing visitors from catching and spreading infections. Some visitors told us they were not always prompted to wash their hands, on entry to the home.

● We were assured the provider was meeting shielding and social distancing rules.

● We were assured the provider was admitting people safely to the service.

● We were somewhat assured the provider was using PPE effectively and safely. We have asked the provider to improve the storage and accessibility of PPE items.

● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured the provider's infection prevention and control policy was up to date.

● We were assured the provider was accessing testing for people using the service and staff.

Staffing and recruitment;

● People, relatives and staff told us there were enough care staff to care for people safely.

● Records showed the provider's assessed numbers of care staff, based on the number of people at the home and their needs.

● The recruitment process ensured staff were suitable for their roles by conducting relevant pre-employment checks. These included COVID-19 vaccination as a condition of deployment checks and an enhanced Disclosure and Barring Service [DBS] check. The DBS helps employers make safer recruitment

decisions so only suitable people work with those who are vulnerable.

Using medicines safely;
● Staff were trained in how to administer medicines safely and their competency monitored.
● Medicines were ordered and stored safely and administered according to people's prescriptions.
● When staff had concerns about people's medicines or difficulties with administration, they shared this with their doctor for advice and review.
● There were protocols for 'as required' medicines. This is medicine administered occasionally to treat certain conditions or symptoms. Senior staff responsible for administering medicines could describe how they knew when to give people their medicine, but the protocols required further detail to ensure they were person centred. We fed this back to the registered manager and improved protocols were implemented shortly after our inspection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet;
● We received concerns that food monitoring records were not completely accurately, with some people documented as having eaten their meals when they hadn't. Some people had their nutritional intake monitored through food and fluid charts. However, there were unexplained gaps in records with meant there was little explanation about why people were not offered food or snacks. Records did not accurately record what people had eaten.
● We were unable to identify whether people had lost weight, as weight records were not taken and reviewed regularly. However, people we spoke to told us they ate well and enjoyed the food on offer. One relative told us, "[Name's] well-fed."

The registered manager and provider had failed to robustly assess the risks relating to the health, safety and welfare of people in supporting people to eat and drink enough. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● Assessments of need were not consistently carried out in a timely way to ensure everyone who lived at Breach House had relevant and up to date assessments and care plans, which accurately reflected their health and social care needs.
● People's preferences were gathered as part of assessment and care planning.

Staff support: induction, training, skills and experience
● Records showed staff had received training and staff felt supported in their roles. One member of staff told us, "I think the training is good enough. I feel supported." One staff member added, "When I am on shift the morale is high staff are interacting and communicating well with each and the residents."
● Staff were supported with regular meetings with their manager to identify training and development needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;
● People had regular access to their doctor through weekly visits to the home. When staff had concerns about people's health in between these visits they would request the doctor's support or the support of the district nursing team.
● District nurses visited the home daily to treat people's skin. However, guidance and advice from district

nurses to help monitor and mitigate the risks for further skin damage was not always incorporated into people's risk assessments and care plans.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Mental capacity assessments were carried out for those identified as needing them and were decision specific.
● Care records provided detail of the type of decisions people could make on a daily basis and when they required more support with complex decisions.
● When people's care and treatment indicated they were being deprived of their liberty, applications were made to the authorising body to ensure relevant DoLS were in place.
● We found some improvements could be made to assessments to evidence how each person was supported to take part in the decision-making process and steps taken to maximise their capacity, in line with the Code of Practice. One staff member told us, "The resident's needs, wishes and preferences are all met."

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 requires improvement. The rating for this key question has remained 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.

At our last inspection the provider's systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

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

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

- Risks relating to the care and support needs of people were not always identified, and staff were not always provided with information to guide them in managing risks effectively. Some risks to people were not being managed by staff, as directed in care plans. The provider had failed to identify staff were not always managing risks as directed.
- Your processes to monitor care records and ensure that an accurate, complete and contemporaneous record in respect of each service user had been maintained were ineffective. Where people had wounds and required support with identified health conditions, such as catheter care, there were not always plans in place to instruct staff on how they should support people effectively and safely.
- One person who had been admitted to the home in January 2022 did not have a risk assessment and care plan in place at the time of our inspection, which accurately showed the care the person received each day. Another person had a sight impairment. Care records were contradictory in how this was described to staff, and the support the person needed to maintain their safety.
- The provider had failed to operate effective systems to analyse accidents and incidents. This lack of oversight meant the provider had failed to learn from accidents and incidents, and opportunities to protect people from repeating accidents and incidents were missed. The provider implemented an accident and incident tracker following our inspection visit.
- Audits, monitoring systems and governance of the service were not always effective in driving forward improvements, as they had not identified the issues we found during our inspection visit.
- The provider understood their role in terms of regulatory requirements. For example, notifying CQC of events, such as safeguarding's and serious incidents as required by law. However, the provider had failed to respond to CQC's requests for information prior to our inspection visit, such as the provider information return.

Governance systems and processes had not been established to effectively monitor and mitigate risks and safety in the service. This placed people at increased risk of harm. This was a continued breach of regulation (17) of the Health and Social Care 2008 (Regulated Activities).

● The registered manager was supported by senior care workers and the provider.
● The provider was committed to making improvements at Breach House. Feedback from our inspection was welcomed and assurance was provided that action would be taken to address all of the areas which required improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed feedback from people's relatives about the communication and support they received from the management team at Breach House. Some people told us they felt the communication had improved since the new registered manager took up their position. Comments we received included, "Communication is fairly good, for example if I phone up, they will tell me what I ask", and "The manager is wonderful. He's kept me informed about everything that's going on." Other people said, "They [registered manager] don't contact me unless I ring up and ask how [name] is or to make an appointment to visit", and, "If the Doctor visits [name], sometimes they [staff] don't ring and tell us."
● People's relatives told us they were not always asked for their feedback about how the home and service could be improved.

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 provider understood their responsibility to be open and honest when things had gone wrong.
● The registered manager worked successfully with a wide range of stakeholders involved in people's care. These included occupational therapists and health professionals.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Most people and their relatives agreed the service was person-centred which achieved good outcomes for people.
● The registered manager and provider operated an 'open door' policy which enabled people, their relatives and staff to approach senior managers to discuss any concerns they had.
● The registered manager told us, and records confirmed, regular team meetings took place, to ensure staff were kept up to date with developments and changes at the service, and to provide an opportunity for staff to feedback their views.

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 You had failed to ensure individual risks to the health and safety of service users had been identified and mitigated.

The enforcement action we took:

We issued the provider and the registered manager with a warning notice, asking them to make improvements at the service within a specific time frame.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 2a &b. The provider had failed to ensure systems and processes were established and operated effectively to ensure compliance with the regulations. Procedures had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Procedures had failed to securely an accurate, complete and contemporaneous record in respect of each service user

The enforcement action we took:

We issued the provider and the registered manager with a warning notice, asking them to make improvements at the service within a specific time frame.