Bafford House Residential Care Home

Bafford House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Bafford House is a residential care home providing accommodation for up to 19 older people, some who live with dementia. At the time of the inspection 17 people were living in the home.

People are accommodated in one adapted building. Each person has their own furnished bedroom; eight have ensuite facilities and the remainder have a hand washbasin in the bedroom. A communal lounge and dining room is also available as are communal toilets and one adapted bathroom. There is a large garden for people to enjoy in good weather and limited car parking.

People's experience of using this service and what we found
Information of concern had been shared with us by the local health protection team (HPT) in relation to some staff members not following national self-isolation requirements following a positive COVID-19 test. This had put people at potential risk of exposure to COVID-19 infection. During the inspection we found people and staff were not protected from the risk of infection.

Systems and processes were not in place to assess and reduce the risks associated with Legionnaires Disease. People were at risk of injury if a fire was to occur as emergency evacuation training and evacuation arrangements were not up to date. Actions identified by a fire safety officer visit in October 2020 still needed to be completed.

We found some good practice in relation to the identification and management of Covid-19 related risks. However, improvement was needed to ensure that risks in relation to laundry, cleaning and the spread of infection during an outbreak was managed in accordance with national guidance.

Following the inspection, we asked the provider to forward to us an immediate action plan telling us what action would be taken, by when, to address the above areas of risk. The provider had taken some action to reduce risks to people and staff, although further action was needed to ensure people's safety. The provider has started work with external agencies to make the necessary improvements.

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 16 July 2019).

Why we inspected
We undertook this targeted inspection to follow up on information shared with us by the local health protection team. This related to risks associated with COVID-19 infection prevention and control. We also followed up progress made to address non-compliance with The Regulatory Reform (Fire Safety) Order 2005, identified during a visit by a fire safety officer in October 2020.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements. Please see the safe section of this report.

At this inspection we have identified a breach of safe care and treatment in relation to infection control and fire safety arrangements in the home.
You can see what action we have asked the provider to take at the end of this full report.

Some action was subsequently taken by the provider to address the more significant risks to people. Arrangements had been made to have a fire risk assessment completed and the fire safety officer was returning to follow up the provider's progress on the fire safety non-compliance in early May 2021. Action had been taken to reduce the risk of scalding associated with unregulated hot water. Cleaning schedules were given to staff to follow and arrangements put in place to monitor staff COVID-19 testing. The provider informed us they were making plans to continue to work with external agencies who could provide support to make further necessary improvements.

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

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

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 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?

Inspected but not rated

The service was not safe.

Details are in our safe findings below.

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Bafford 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.

This was a targeted inspection to check on specific concerns related to COVID-19 staff testing. As part of this inspection we looked at the infection prevention and control 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
Two inspectors completed this inspection.

Service and service type
Bafford 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.

There was not a registered manager in position. When in post 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. The partnership which the service is currently registered in has dissolved and the provider is taking action to adjust their registration.

Notice of inspection
This inspection was announced. We gave the provider one weeks' notice. This was to give the provider time to work with infection prevention and control (IPC) specialists to make urgent improvements to their COVID-19 IPC arrangements.

What we did before the inspection

We reviewed the information of concern which had been shared with us by the local health protection team in relation to COVID-19 staff testing. We sought feedback from the local authority and local infection, prevention and control (IPC) professionals, who had worked with the service to review and improve their COVID-19 arrangements. We reviewed two infection control audits and a visiting policy and procedures which the provider had forwarded to us on request. We used all of this information to plan our inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with a representative of the provider, the deputy manager, three care assistants, two members of the housekeeping team; one cleaner and one laundry assistant. We spoke with one agency member of staff. We spoke with one person who lived in the home.

We reviewed records related to staff COVID-19 testing, staff rosters, fire drills, weekly fire alarm testing and contractor service records related to the fire alarm and emergency lighting system. We toured the building and ran the hot water at a selection of hot water outlets to see how hot the water was running.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to receive confirmation on the actions they were taking since the inspection. We continued to liaise with professionals from the local authority and IPC specialists.

Inspected but not rated

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 Good. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Bafford House. We will assess all of the key question at the next inspection of the service.

Assessing risk, safety monitoring and management

- The service's Legionella policy and procedure had not been followed; a Legionella risk assessment had not been completed. Appropriate maintenance and checks on the water system and storage tanks had not been carried out, despite an audit in February 2021 identifying the need for this. This put people at risk of potential exposure to Legionella infection.
- Problems with the flow of hot water to some areas of the building had arisen due to a lack of maintenance and servicing of the water system and thermostatic mixer valves (TMVs). The provider had improved the flow of hot water to outlets around the home by removing the TMVs. Subsequently, in some areas, which people had access to, the hot water temperature was no longer regulated, putting people at risk of scalding.
- Fire safety had not been adequately addressed. In October 2020 the fire safety service issued a notice of non-compliance with several areas of fire safety requiring improvement. During this inspection we found action had not been taken to make those necessary improvements. Staff had also not been trained in fire evacuation techniques. This put people at risk in the event of a fire.
- People and staff who may be potentially more at risk of COVID-19 infection had not been formally identified and relevant and required risk assessments were not in place. This meant, in the event of a COVID-19 infection outbreak, those who were more vulnerable to the infection may not be adequately protected.

Preventing and controlling infection

- The provider had not completed a COVID-19 outbreak management plan. This put people and staff at increased risk because ways of working, required to reduce the spread of infection during a potential COVID-19 outbreak, had not been considered and planned. Staff had not been properly briefed on how cleaning, infected crockery and cutlery and soiled linen would be managed and were unclear how zoning and segregation may be organised to reduce risks to people. The provider was working with an infection control specialist to complete an outbreak plan.
- Staffs' COVID-19 testing arrangements were not sufficiently monitored. Although weekly PCR (Polymerase chain reaction) testing took place under the guidance of managers, the requirement for two additional weekly LFD (Lateral Flow Device) tests had been left to the staff to complete without monitoring. The provider was unaware that some staff had not been completing these as frequently as required. This put people and staff at risk of exposure to unidentified COVID-19 infection.
- Laundry soiled with body fluids was not managed safely and in line with current infection control and prevention guidance.

The provider had not taken action to protect people from potential avoidable harm or risk. They had not taken action to assess and maintain necessary safety systems. They had not ensured effective infection control and prevention arrangements were in place. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections. Relatives had been advised on how and when they could safely visit. Garden visits had been promoted when the weather permitted, with indoor visits taking place in a designated place, therefore reducing footfall throughout the building. Visiting was by prior appointment only, so staff could support COVID-19 screening prior to relatives entering the home. This included rapid testing of visitors. All visitors were required to follow national guidance in relation to social distancing, hand sanitising and the use of personal protective equipment (PPE).
● We were assured that the provider was admitting people safely to the service and in line with national guidance. The last person admitted to the home had only been accepted following a negative COVID-19 test. They had been supported to complete the necessary period of self-isolation post admission.
● Despite a lack of established cleaning schedules and records, we could see that housekeeping staff were completing cleaning tasks and the home looked clean.
● Following support from an IPC specialist, staff were using PPE correctly and it was accessible and stored safely. Improvements had also been made to how items ready for laundering were segregated and how clean laundry was stored.
● Agency care staff were used on a regular basis to ensure safe staffing numbers were maintained. Arrangements were in place to ensure, where possible, the same agency staff were block booked. This helped to reduce risks associated with consistently using different staff in a pandemic. Agency staff were LFD tested at the start of each shift and only worked if their test result was negative.

The provider responded to our feedback immediately after the inspection. This included removing the hot water risk and completing a Legionella water sampling test. They confirmed arrangements were being made for a specialist company to complete a fire risk assessment and staff were completing the required lateral flow device (LFD) testing. Cleaning schedules had been provided to the housekeeping staff and these were being followed. Alterations had been made to how soiled laundry was managed, therefore reducing the risk of infection spreading when handling this type of laundry.

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 People who used the service and others were not fully protected against risks which may impact on their health and safety. Not all which was reasonably practicable had been done to assess, address and mitigate risks. This related specifically to risks associated with infection prevention and control, including risks associated with Legionella bacteria, scalding from unregulated hot water, fire safety and fire evacuation processes. Regulation 12 (1) (2) (a) (b) (d) (h)