Handsale Limited

Handsale Limited - Bierley Court

Inspection report

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Bradford
West Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Handsale Limited – Bierley Court is a residential care home providing personal care for to up to 40 people. The service provides support to older people, some of who are living with dementia. Accommodation is provided over two floors in three separate units: Bronte on the ground floor and Hockney and Lowry upstairs. At the time of our inspection there were 37 people using the service.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. Some areas of the home were not clean and infection control was not well managed.

Medicines were not managed safely. People were not protected from the risk of harm as safeguarding incidents were not always recognised or addressed. People's nutritional needs were not always met.

There were not always enough staff to meet people's needs and keep them safe. Some staff had not received the training they needed for their roles. Recruitment processes required improvement. We have made a recommendation about the recruitment process.

People did not always receive person-centred care and care records did not fully reflect their needs. There were no activities taking place and there was little to occupy and interest people. People's dignity was not always maintained and they were not always treated with respect.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

People and relatives were generally positive about the service. Staff were described as kind and caring. People were supported to keep in touch with family and friends. People had access to healthcare services.

The provider took action during the inspection to address some of the issues we raised.

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 5 September 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We received concerns in relation to safe care and treatment and governance. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We inspected and found concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all five key questions.

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

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, safeguarding, consent, nutrition, privacy and dignity, person-centred care and good governance at this inspection.

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 following this report being published 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 6 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. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Handsale Limited - Bierley Court

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 3 inspectors.

Service and service type
Handsale Limited – Bierley Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Handsale Limited – Bierley Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 14 November 2022 and ended on 28 November 2022. We visited the location on 14 and 16 November 2022.

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 Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with 6 people who used the service and 2 relatives about their experience of the care provided. We spoke with 11 staff including the manager, senior managers, senior care workers, care workers and the cook. We also spoke with 3 visiting healthcare professionals.

We reviewed a range of records. This included 8 people's care records and 12 people's medicine records. We looked at 2 staff recruitment files. A variety of records relating to the management of the service were reviewed

Inadequate

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 has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- Risks to people were not assessed and managed safely placing people at risk of harm or injury.
- Risk assessments identified the risk level. However, there was no information in either the assessment or care plan to show how the risks were mitigated.
- Weight loss was not monitored or managed effectively. Records showed people had lost weight, however, it was not clear what action was being taken to address the loss.
- Environmental risks had not been managed safely. On 3 occasions people and staff had been stuck in the lift and twice had to be rescued by the fire brigade. The lift was still being used even though it was known to be faulty and could entrap people again. This was addressed on the second day of the inspection.
- People's sensor equipment was not always switched on when individuals were in their rooms. This meant if people fell staff would not be alerted.
- Accidents and incidents were not reported, recorded or acted upon to keep people safe. There was no information to show what action had been taken to protect people or prevent further occurrences.
- Learning from incidents and accidents was not actioned. One person was lying on a deflated pressure mattress placing them at risk of skin damage. It was unknown how long the mattress had been deflated. The manager said the person had switched the mattress off as they could reach the plug socket and had done this before. Despite this, no consideration had been given to repositioning the bed or preventing access to the plug.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They said action had and was being taken to address these issues.

Using medicines safely
- Medicines were not managed safely.
- People did not always receive their medicines as prescribed. One person was prescribed a medicine for diabetes to be given with food at breakfast, this had been given at teatime and staff were unable to explain why. Another person did not receive their weekly pain patch.
- There were gaps on medicine administration records (MARs) where staff had not signed and no reason was recorded for omission. Twenty-five people had no photograph on their MAR to help staff identify them.
- Medicines were not always stored safely and securely. Medicine trolleys were not secured in the treatment

room or when they were kept on the different floors. The medicine fridge was unlocked. Prescribed creams were stored in areas that could be accessed by people using the service.
● Systems for administering prescribed creams were not safe. There were no body maps or charts to show staff when, where or how often creams should be applied. Senior staff were signing the MAR when they had not applied the cream. Staff applied a cream to 1 person's broken skin, yet the MAR showed they were not prescribed any creams.
● A huge stock of medicines were stored in the treatment room waiting to be collected by the pharmacy. There was no record to show what medicines were being returned.
● There was no system in place to check that medicines people brought in when they were admitted from their own homes were correct.
● Not all staff who administered medicines, had completed medicines training and had their competency assessed.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. 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.

Preventing and controlling infection
● Government guidance on the prevention and control of infections was not always followed. On the first day staff were not wearing PPE correctly. We saw multiple occasions where staff were wearing masks below their noses and mouths and dropped masks down to talk to people. This had improved when we returned on the second day and staff were wearing masks correctly. However, external contractors working in areas where people were living did not wear masks.
● Cleaning schedules were in place, however, standards of cleanliness were poor. Floors and surfaces were sticky and dirty and there were malodours in some areas.
● There were not safe systems in place for staff to dispose of soiled items in bathrooms and toilets or to transfer them to the sluice room.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They said action had and was being taken to address these issues.

Visiting in care homes
● Relatives and friends were able to visit people in accordance with the current guidance. Relatives we spoke with said they were happy with the visiting arrangements and could visit when they wanted.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse or harm.
● We found numerous incidents had not been recognised or acted upon by staff. This included unexplained injuries such as bruising and skin tears and altercations between people who were emotionally distressed.
● These incidents had not been reported to the safeguarding team or notified to CQC. We made referrals to the local authority safeguarding team.

People were not protected from the risk of abuse as control measures were not implemented consistently. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They said action had and was being taken to address these issues.

Staffing and recruitment
● There were not always enough staff on duty to meet people's needs and keep them safe.
● The provider had a monthly dependency tool to calculate staffing levels.
● On the first day of inspection we observed communal areas were frequently left unattended. In 1 lounge people had no access to call bells. The manager advised staff carried out regular checks of the lounge but did not know how often or when the checks occurred. On the second day staffing had been increased by 1 staff member during the day.
● The manager confirmed 4 staff were required at night although rotas showed times when only 3 staff were on duty. Staff said they struggled when only 3 staff were on duty. Some people required 2 staff to assist them and other people walked around at night and were emotionally distressed requiring support from staff to keep them and others safe. Night staff also had a schedule of cleaning tasks to complete.

There were not enough staff deployed at all times to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes needed to improve.
● Criminal record checks and references had been obtained prior to employment. However, 1 staff member's interview form was not fully completed and was undated and unsigned. A reference for another staff member was from the last employer but had been completed by a colleague not the manager and had not been verified.

We recommend the provider reviews the recruitment process to ensure robust procedures are in place.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
- People's nutritional needs were not always met.
- People gave mixed feedback about the food. One person said, "No complaints about the food but timing could be better." Mealtimes were disorganised. We saw people waiting for up to 20 minutes for food to be served and some people were emotionally distressed and calling out.
- We observed some people struggled to eat their meals. Large amounts of food were put onto plates and we heard people saying it was too much. Other people had a baguette with toasted cheese which they found difficult to eat and most ended up picking off the cheese and leaving the bread. There was a lack of support from staff to assist people with eating and drinking.
- The cook told us snacks were offered with drinks in the morning and afternoon. We saw no snacks on the drinks trolley or being offered to people. One person asked staff for something to eat and was told to wait until lunchtime.
- There was no effective monitoring of food and fluid records to ensure people were receiving enough to eat and drink.

People's nutritional needs were not always met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- The service was not always acting within the legal framework for MCA. People's capacity to consent to their care and treatment was not always assessed.
- Where people's capacity to make a particular decision was uncertain, capacity assessments and best

interest decisions had not been completed.
● Some people had restrictions in place such as sensor mats and 1 person had bed rails. There were no consent forms, capacity or best interest assessments for these decisions.
● The manager confirmed there were no DoLS authorisations in place.

People did not have their care and support needs delivered in line with MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not receive the induction and training they required to meet people's needs.
● There was no evidence of induction for a staff member who had been employed in the last six months. The training matrix showed no staff had completed the Care Certificate and four staff were recorded as 'not started' the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● The training matrix showed staff training was not kept up to date. Forty staff were listed on the matrix but this did not include 5 staff members who were on the duty rotas. Nine staff were overdue fire evacuation training, 21 staff were overdue moving and handling practical training, 10 staff were overdue infection prevention and control training and 7 were overdue safeguarding training.

Staff had not received the training they required to carry out their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff said they had regular supervision and this was confirmed in the supervision matrix.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People's needs were not fully assessed by the provider before they moved into the service. There were social work assessments for 2 recent admissions. However, the manager confirmed they had not completed their own assessment to ensure they could meet the person's needs.
● The building was adapted to meet people's needs and parts of the environment were homely and comfortable.
● The environment did not promote independence for people living with dementia. Although bedroom doors were different colours, many had no name or photo to help people find their rooms. There were no pictorial signs to indicate bathrooms and toilets. Some lounges and dining areas were light and bright, in contrast other communal areas were dark with low lighting.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff supported people to access the healthcare support they needed.
● People's care records confirmed the involvement of other professionals in providing care such as the GP, district nurses and podiatrist.
● Two visiting health professionals said the service contacted them regularly when they had concerns about people's health and well-being. Another health professional told us staff were, "good at contacting us if they have any problems."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated with kindness and compassion by staff.
- Overall people and relatives spoke positively about the staff. One person said, "Staff are very kind, patient and caring." Another person said, "[Some staff] are not nice, don't treat people well. They don't bother me but do others." Relatives described staff as nice and caring.
- We found people's experiences varied. Some staff were patient and kind and took time to talk with people and made them smile. In contrast we saw other staff lacked warmth and empathy and did not interact with people.
- People were not always involved in decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always maintained and people were not always treated with respect by staff.
- Inspectors had to intervene to ensure people received they support they required. One person attempted to drink the tea they had been left by staff, spilling it on the bed as staff had not assisted them to sit up. The inspector alerted staff. Another person was struggling to eat beans on toast from a plate in their lap. Staff had left a table by the side of their chair. The inspector moved the table in front of the person and cut up the toast so the person could eat it.
- In contrast we saw one staff member assisting people with their breakfast. The staff member was gentle and calm and we saw the people responded positively to this approach.
- Two people were regularly sleeping in each other's bedrooms. Staff said they left them to it as both people were confused about which were their rooms.
- One person who was at risk of falls was walking round with no shoes or slippers on. The inspector alerted staff who brought some footwear 50 minutes later.

People were not always treated by staff with compassion, dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive person-centred care.
- People's care records contained some personalised information. However, care plans were not always up to date, fully reflective of people's needs or the support required from staff.
- Information about people's needs was recorded in communication books rather than on the electronic care system which staff used. Two staff told us they did not access care plans and relied on other staff to tell them about the care people needed.
- There was a lack of guidance for staff in how to support people who were emotionally distressed. Records described people being agitated or aggressive towards others but there was no detail in care plans about the support required to ensure a consistent approach.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communications needs were not always met.
- We saw staff struggled to communicate with a person who had a sensory loss and with some people who had dementia. Other people's first language was not English. There were no communication tools, pictures or objects of reference to help with communication.
- Staff said they used to have information in different languages and pictures for people to use, but they were unable to find these.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's social care needs were not met.
- There was no planned activity programme and no activity co-ordinator. There were no activities taking place when we inspected the service.
- We saw people spent time in their bedrooms or sat in the communal areas with very little stimulation. Some people walked frequently up and down the corridors. Care records showed scant evidence of activity. Three people's records over a 10 day period showed no activities other than watching television. One person said, "I can't go out but would like to."
- Staff said people used to go out for day trips but this no longer happened. They said occasionally people

went out for walks and trips to Asda or food shopping but not often.

People were not receiving person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
- The complaints procedure was displayed in the service.
- The complaints log showed actions taken in response to complaints raised.

End of life care and support
- The manager told us one person was receiving end of life care. There was no record to show the person's preferences and wishes for end of life care had been discussed and planned.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Continuous learning and improving care

- Significant shortfalls were identified at this inspection. There were breaches in relation to safe care and treatment, staffing, safeguarding, nutrition, person-centred care, consent and dignity and respect. These issues had not been identified or addressed through the provider's own governance systems.
- There was a lack of effective leadership and management. The manager had been in post since September 2022 and lacked the support they required to fulfil their role. There had previously been a deputy manager but this post was vacant and there was limited support from the senior management team.
- Quality assurance systems were not effective in identifying and addressing issues and risks we found at the inspection. Some quality audits were in place. However, where issues were identified, there was no action plan to show these had been addressed
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. Provider and senior management visits and quality audits had lapsed.
- Systems for managing risks to people's health and safety were ineffective. For example, accident, incident and falls audits were incorrect as they did not reflect all the events that had occurred. For example, the audit for October 2022 showed 5 incidents, we identified 6 other incidents that were not included. Environmental risks were not managed or addressed promptly. For example, the faulty lift continued to be used by people, a broken kitchen light was propped up with mop handle until we raised a concern and a bathroom that was out of use remained accessible to people.
- Communication systems were not always effective in ensuring staff were kept informed of any changes in people's needs. Care staff were not included in shift handovers where updates were provided. One staff member said, "The senior attends the handover and information that they feel is important is then passed onto the care staff on each unit. A handover sheet used to be in place on each unit, however this is no longer the case."
- Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay. During this inspection, we found the registered person did not ensure CQC was consistently notified of reportable events. This meant we could not check appropriate action had been taken to ensure people were safe at that time.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach

of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They said action had and was being taken to address these issues.

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

- People and relatives gave generally positive feedback about the service. We requested evidence of residents' meetings and surveys from the manager. None were provided.
- Staff surveys had been sent out in October 2022. Fifteen responses had been received which had been analysed. Most of the feedback was positive, however, there was no evidence to show there had been further exploration when staff had responded 'sometimes' to the questions asked.
- Staff meetings had been held in September and October 2022.

Working in partnership with others

- Professionals said communication was not always effective. We received feedback that staff did not always know what was happening at the service so important information about people was sometimes not available.