KR Care Homes Limited

Bankfield

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bankfield is a residential care home providing accommodation and personal care to up to 47 older people and people living with dementia. At the time of our inspection there were 22 people living at the home.

People's experience of using this service and what we found
People were not supported safely. Risks to people were not always robustly assessed and mitigated. Medicines were not safely managed. Accidents and incidents were not always recorded and analysed in a timely manner. An allegation of abuse had not been reported to the Care Quality Commission or the safeguarding team.

People were not supported in their best interests and staff were consenting to care and treatment on the behalf some people living at the home and without authorisation. A person new to the home did not have a thorough pre-assessment of their needs completed prior to admission. Care plans were not always reflective of people's current needs.

The providers governance processes did not highlight the concerns we found at this inspection. There was a high turnover of staff and staff had highlighted during supervision and feedback that staffing was poor.

People were not always treated with dignity and respect. We observed one person receiving a vaccination in the middle of a busy communal lounge. Another person was left asleep with their dessert on the dining table for a long period of time. People were not always involved in planning their care and reviews of their care. There were times, the communal areas were very loud and not always conducive for people living with dementia. The home was unclean in parts.

Improvements had been made to food and menu choices. Themed food nights were popular with people and the kitchen staff were aware of people who required a modified diet. Activities across the home had improved.

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 last rating for this service was inadequate. (Published 29 January 2022) and there were breaches of regulations. At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 29 January 2022. During this inspection, not enough improvement had been made and the service remained in special measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 have found evidence that the provider needs to make improvements.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to person centred-care, consent, safe care and treatment, safeguarding 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 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 remains 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 always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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 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 team consisted of two inspectors, a medicines inspector and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Bankfield 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. Bankfield 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. An application to register a manager had been submitted to the Commission prior to the inspection.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including notifications received from the provider. The provider submitted 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.

During the inspection
During the inspection, we reviewed multiple care plans and risk assessments, multiple medication records and staff recruitment records. We also looked at staff training, supervision and appraisal, audits to monitor and improve the service and home improvement plans. We spoke with the manager, the consultant, five staff members, two relatives and seven people who lived at the home.

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.

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 inadequate. At this inspection the rating has remained 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

At the last inspection, the provider had not done all that is reasonably practical to mitigate risks to people. This exposed people to risk of harm. At this inspection, not enough improvement had been made and the service remains in breach of Regulation 12.

- Risks to people were not always assessed and mitigated.
- Two people required fluid thickener to aid their swallowing and to reduce the risk of choking. Both care plans and risk assessments did not accurately reflect the directions for the use of thickener. We could not be assured people were receiving the correct amount of thickener as prescribed as the administration of thickener was not always being documented and the cup being used had not been correctly measured. Staff told us the cups they used were 280mls, but we measured them, and they were actually 320mls. Care plans and risk assessments were updated following our findings.
- One person who had fallen on three separate occasions did not have their risk assessment or care plan reviewed after each incident to assist in managing further falls
- The same person sustained a serious injury following a fall at the home, no medical intervention was sought for over 48 hours. Following the person's return to the home from hospital, care plans and risk assessments were not updated to reflect the support required.
- For one person, an incident report was not completed following a fall and for another person, an incident report was completed two days later.
- Accidents and incidents including falls were not analysed in a timely manner. The provider was unaware one incident had not been recorded and there had been no analysis of other incidents since March 2022.
- We had to intervene on two occasions during the inspection as one person was using a garden chair as a mobility aid to mobilise around the garden rather than their zimmer frame and risked falling. We also asked for staff to check on a person who was sat in the hot midday sun without sunscreen or shade

Risks to people were not robustly captured as part of care planning and risk assessing processes. The provider did not have thorough oversight of accidents and incidents. 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.

Using medicines safely

At the last inspection, the provider failed to ensure people's medicines were administered safely. This exposed people to a risk of harm. This was a breach of Regulation 12 (Safe care and treatment). At this

inspection not enough improvement had been made and the service remained in breach of Regulation 12.

● Medicines were not safely managed.
● Pain relief medicines such as Paracetamol were administered within less that the prescribed four hourly intervals on a number of occasions.
● A pain relief patch had not been applied according to the prescriber's instructions. The patch should have been applied every 72 hours but on some occasions, it was administered up to 24 hours later than it should have been.
● Stocks of medicines were not always correct, and some medicines were out of stock.
● Some creams were signed for as being administered but had not been opened.
● The temperature of the medication fridge was not correct as daily recordings suggested it was. We also found unlabelled urine samples, milk, chocolate and creams in the medication fridge.

The provider failed to ensure medicines were safely managed. 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.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, 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). At this inspection not enough improvement had been made and the service remained in breach of Regulation 13.

● People were not always protected from the risk of abuse.
● One person had made an allegation against a staff member and the manager had not referred the allegation to the adult safeguarding team or to the Care Quality Commission. The manager unsubstantiated the allegation without any impartial investigation. We referred this incident to the safeguarding team for further investigation.

The provider did not take action as soon as they were alerted to alleged abuse. 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

● Staff told us they felt confident to report any abusive practices and received training to underpin their knowledge.

Staffing and recruitment

At the last inspection, the provider failed to ensure sufficient numbers of skilled and experienced staff were deployed to meets people's needs. This was a breach of Regulation 18 (Staffing) At this inspection not enough improvement had been made and the service remained in breach of Regulation 18.

● The provider did not always deploy staff effectively.
● At the start of our inspection, the senior carer responsible for the safe administration of medication was required to leave her medication duties and answer the door or phone despite office staff being available to do so.
● The home had a high turnover of staff and also used agency staff to cover shifts. Eight staff members had

left the home in the month leading up to our inspection.
● People living at the home told us there wasn't always a stable and familiar staff team. Comments included, "We need permanent staff" and "They (staff) seem to be changing every two to three days" and "I'd get them (the provider) some more staff."
● Staff were recruited safely and pre-employment checks were in place prior to the employee commencing employment.

The provider did not effectively deploy staff to meet people's care needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection

At the last inspection, we found 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. At this inspection not enough improvement had been made and the service remained in breach of regulation 12.

● The cleanliness of the home needed further improvements in communal areas.
● On the morning of the first day of inspection, we found floors, skirting boards and sills to be dirty in communal areas.
● One person had been admitted to the home and there was no evidence the provider had checked the person's COVID-19 status or vaccination history before their arrival.

The provider did not ensure communal areas were clean. The provider did not have arrangements in place to monitor a person's COVID-19 status when transitioning between services. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulation Activities) 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visiting in care homes following the most up to date guidance.

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 in August 2021, we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider did not ensure care and treatment was provided with the consent of the relevant person. Staff did not understand what they must do to comply with the Mental Capacity Act 2005.
- During our inspection, we observed one person withdraw their consent for the COVID-19 vaccination and staff did not respect this decision and supported the vaccinator to carry out the injection. Staff did not clearly explain the process to the person or give them time to respond.
- On reviewing consent forms for the COVID-19 vaccination, we saw staff had signed them for some people on behalf of the person or their legal representative without the authorisation to do so or having any best interests' discussions.

The provider did not ensure consent was gained for care and treatment from the relevant person. The provider did not recognise consent could be withdrawn at any time and did not respect a person's decision to withdraw consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Where people did not have capacity, a referral was made to deprive the person of their liberty in relation consenting to care and treatment at the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People did not always receive a full assessment of their needs prior to moving into the home.
● One person had moved into the home since the last inspection and their pre-assessment consisted of a one-page handwritten page of paper. The assessment did not capture important information pertaining to the persons care needs, health and social history and risks.

The provider did not ensure assessments of people's care and treatment included all their health, personal, emotional, social, cultural, spiritual and religious needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 20028 (Regulated Activities) 2014

Staff support: induction, training, skills and experience
● Staff received an induction and training on commencing employment, although further training was required in the use of fluid thickeners. This was actioned following our inspection.
● Staff received training in health and social care related subjects to underpin their knowledge.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support
● People were supported by a range of external health and social care professionals.
● The GP surgery completed a weekly ward round to discuss any concerns and review medicines.
● Relatives were informed when their relation was unwell, but one relative told us, they had not always been informed promptly.
● The provider used preferred care agencies to fill staff vacancies.

Adapting service, design, decoration to meet people's needs
● The home had been adapted to meet the needs of people with changing mobility needs.
● Some parts of the home required refurbishment and we saw a large tear in the flooring on the first floor as people exited the lift. This posed a tripping hazard to people.
● People had personalised their rooms with their own personal possessions.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat a healthy and nutritious diet
● People told us they were given plenty of choice for their meals and themed nights had been introduced but were popular.
● The kitchen staff provided meals for people who were on a modified diet such as pureed.

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 in August 2021, we rated this key question requires improvement. At this inspection the rating has remained 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; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care.

At the last inspection in August 2021, The provider did not do everything reasonably practicable to make sure people received person-centred care which met their needs. This was a breach of Regulation 9 (Person-centred care). At this inspection not enough improvement had been made and the service remained in breach of Regulation 9.

- People were not always treated with dignity and respect, equality and diversity. People were not always involved in making decisions about their care.
- During the inspection, the communal lounge was very noisy. This included the TV being on, music being on and staff members shouting loudly or singing. Two people told us they did not go into the lounge area due to the level of noise.
- We observed staff members knocking on doors but not waiting to be invited into bedrooms.
- One person was left sleeping at the dining room table for over one hour with their dessert untouched. The person required staff support to eat and drink.
- People told us they hadn't been able to access a hairdresser for many months. The manager told us the deputy manager was cutting people's hair as they were a qualified hairdresser but had left the organisation. People told us they had previously had their hair attended to, weekly.
- The lack of continuity of permanent staff meant people were not familiar with the staff member who was caring for them.
- One person told us on talking about staff. "Some are better than others. Some talk to me like I have dementia."
- There was no evidence people were involved in care planning and care plan reviews.
- One person was not supported to see medical professionals in the privacy of their room. We observed staff members and a medical professional consulting with the person in the busy communal lounge area.
- On asking people if they felt listened to by staff, they told us, "The staff do listen, then it fizzled out. Things are said then it doesn't happen." and "Some staff are pretty forgetful".
- On asking people about their support with personal care, one person told us, "I am offered a bath when the staff feel like it. They tell me when I can have one."

The provider did not do everything reasonably practical to make sure people who used the service, received

person-centre care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection in August 2021, we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

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

At the last inspection in August 2021 the provider did not maintain an accurate, complete and contemporaneous record in respect of people living in the home, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 (Good Governance) At this inspection not enough improvement had been made and the service remained in breach of Regulation 17.

- Care plans were not always up to date and reflective of people's current needs.
- One person's mobility had changed considerably following a fall and injury. The care plans or risk assessments had not been updated to reflect this.
- Care plans for two people were not descriptive of the choking risk they presented and what action staff should take to safely support both persons.
- Care records were not updated in a timely manner and information was recorded in retrospect including information about accidents and incidents, falls and medical information. One person's support with continence had changed and this was not reflected in the care plan.
- We were not assured staff and agency staff were supporting people in line with their current needs and care plans were not always reflecting these needs.
- Care plans were being reviewed by a number of staff including the office manager. We were not assured of the competency, training and knowledge of the office manager to complete these reviews. There was no evidence people or relatives were involved in care plan reviews.

The provider did not maintain an accurate, complete and contemporaneous record in respect of people living in the home, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2088 (regulated Activities) 2014.

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

At the last inspection in August 2021, the provider did not ensure people's social, cultural, religious and spiritual needs were met. This was a breach of Regulation 9 (Person-centred care). At this inspection, enough improvement had been made and the provider was no longer in breach of Regulation 9 in relation to ensuring these needs were met.

● Activities for people had improved for most people.
● The activities co-ordinator showed us photos of parties for birthdays and the Queen's Jubilee. Singers and Irish dancers had visited the home and the majority of people spoke positively of these improvements.
● Two people told us they didn't always like the louder activities. One person told us they would prefer to have access to a computer. Another person told us there was nothing for them to do but watch TV.

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.

● Some signage was used around the home to orientate people to their rooms or bathrooms.
● There had been improvements to the displays of menus and pictorial images were used to assist people in making their preferred choice.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place.
● There had been no complaints received since the last inspection.
● People told us, if they wished to complain, they would tell their family or a staff member.

End of life care and support
● People could be supported at the care home, at the end of their life, if that was their wish.
● Care plans were reflective of people's end of life wishes and choices.

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 inadequate. At this inspection the rating 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

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 not enough improvement had been made and the service remained in breach of Regulation 17.

- The provider was not clear about their role and did not understand how to effectively use quality performance as a tool for improving the service. The provider did not promote a person-centred culture for all people.
- A health and social care consultant had been employed to support the home to embed improvements and a number of audits and performance reports had been implemented but these did not capture our concerning findings in relation to risk management, care planning and medicines.
- The provider did not follow their safeguarding policy when concerns were raised and did not follow their falls protocol for people who were regularly falling.
- The manager was not open and transparent when discussing recruitment and retention of staff and failed to disclose eight staff had recently resigned from working at the home.
- The provider did not have processes in place for ensuring staff were regularly given supervision and appraisal. Some supervisions were completed for staff by the office manager and we were not assured of their competence and skills to do so.
- Some feedback had been gained from staff with themes of lack of communication, lack of staff and lack of teamwork. We were not assured, the provider had taken any action following this feedback.
- The provider had implemented daily walk around and team huddles, however we found these were not occurring daily.
- The provider had failed to improve following three consecutive inspections.

The provider did not operate effective systems and processes to make sure they assessed, monitored and improved the service. The provider did not ensure effective communication systems were in place to notify external partners or relatives any information about the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

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 provider was not always honest and open when something went wrong.
● We saw one example when relatives had not been informed in a timely manner, their relative had fallen and received an injury.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had requested feedback from people, their families and staff to seek their views on the service.
● One positive response had been received from a family member. Seven responses had been received from people living at the home which were positive although some people said their bed wasn't changed often enough.
● The staff responses contained comments about lack of staff, lack of teamwork and poor staffing levels. There had been no analysis of the feedback at the time of the inspection.

Working in partnership with others
● The provider had been supported by the local authority and other partners to improve the service following the last inspection.
● Although some improvements had been made, it was clear, they had not been sustained once the support from partners had reduced.