Miss Tina Boswell

Banbridge House

Inspection report

Banbridge House
3 The Esplanade
Minehead
Somerset
TA24 5QS

Tel: 01643702275
Website: www.banbridge-house.co.uk

Date of inspection visit:
03 March 2017

Date of publication:
21 April 2017

Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Banbridge House is a care home which is registered to provide care to up to 19 people. The home specialises in the care of older people. At the time of this inspection there were six people living at the home.

The registered provider, who also managed the home on a day to day basis, died unexpectedly in December 2016. Since this time their personal representative has taken responsibility for the home and an acting manager has been put in place to oversee the day to day running of the service. This is in accordance with Regulation 21 Care Quality Commission (Registration) Regulations 2009.

This inspection was an unannounced focussed inspection carried out by an inspection manager and one inspector.

Commissioners of the service and other health and social care professionals had expressed concerns about the standards of care people were receiving. The inspection was undertaken to check whether people were receiving safe and effective care and support. It also looked at how the home was being led and managed since the death of the provider.

The last inspection of the home was carried out in June 2016. At that inspection the service was rated as Requires Improvement and two requirement notices were issued. At that inspection we found the provider had not taken adequate action to ensure all areas of the home were clean and properly maintained. We also found the provider did not have adequate systems in place to assess, monitor and improve the quality and safety of the service provided. At this inspection we found some minor improvements had been made in standards of cleanliness and maintenance but there were still no systems to monitor quality.

At this inspection we found further concerns;

The service was not following safe recruitment procedures to make sure people were protected from being cared for by unsuitable staff. This could place people at risk of abuse.

People's medicines were not always stored, administered and recorded in a way that made sure they received the correct medicines at the correct time. One person had been given the wrong medicine on three occasions and we found a quantity of out of date medicines which had not been returned to the pharmacy.

People were not being supported by staff who had up to date training to enable them to effectively support people. Staff had not received training in health and safety issues, such as fire safety or moving and handling for a number of years. This meant staff did not have up to date knowledge about how to promote people's safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected against the risks of abuse because recruitment practices were not robust.

Improvements were needed to make sure people received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive care and support from staff who had the skills and training to meet their needs.

Improvements were needed to make sure people had access to healthcare specialists when they needed it.

Is the service well-led?

Inadequate

The service was not well led.

People could not be confident that systems were in place to assess, monitor and improve the quality and safety of the service provided

The acting provider and manager were not up to date with current good practice or legislation which placed people at risk of receiving inappropriate care.

Banbridge House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 March 2017and was unannounced. It was carried out by an inspection manager and an adult social care inspector.

Before the inspection we looked at information we held about the service which included notifications of significant events and previous inspection reports. We also spoke with commissioners of the service and professionals who have been supporting the home since the death of the provider.

During the inspection we met with all six people who lived at the home. Some people were unable to fully express their views and we therefore observed care practices and spoke with three members of staff about the care provided to people. We also looked at three staff personnel files and two care plans. The acting manager was available throughout the inspection.

Inadequate

Is the service safe?

Our findings

People were not always receiving safe care.

At the last inspection in June 2016 we found that improvements were needed to make sure people lived in a clean and well maintained environment. We identified that toilet frames and commodes were not always adequately cleaned which could place people at risk of the spread of infection. We found that furnishings within the home were tired and worn and many carpets required deep cleaning. We also found that the mechanical hoist in use at the home had not been serviced for 12 months although the 'Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) state a thorough examination of mobile hoists should be carried out at least every six months. We therefore issued a requirement notice for a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Premises and Equipment. The provider sent an action plan which stated they would put in place a new cleaning rota and essential maintenance would be carried out.

At this inspection we found some action had been taken to address the issues identified at the last inspection but further action was needed. A cleaning rota had been put in place and was displayed in the kitchen area. We found some improvements had been made in the cleanliness of the home but some areas required further attention. The cleaning rota was required to be signed by staff once they had completed tasks. We asked one member of staff about the cleaning rota and if they had to sign to say when they had completed cleaning tasks. They seemed unaware of the rota and said "No" when referring to signing. A new mechanical hoist had been supplied by the local healthcare trust and staff had been instructed in its safe use. Progress was being made to upgrade areas of the home and some communal rooms had been decorated. Chairs in the dining room had been re upholstered and were now clean and comfortable.

At this inspection we found the acting provider and manager had not followed safe recruitment procedures to make sure people were protected from the risks of abuse. One new member of staff had been appointed. Although this staff member had a wealth of experience and had provided the service with a CV (Curriculum Vitae) the information on this had not been checked by the acting provider or manager. The staff member informed us they had a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people. However the acting manager told us they had not sought confirmation of this. Neither had they sought personal or professional references in respect of this person.

People were at risk of receiving care and support from staff who were not suitable to work with vulnerable people. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to make sure people received their medicines safely. People were at risk because medicines were not always administered in accordance with their prescriptions. Running records in one person's care plan showed that on three occasions the person had received medicines which were not prescribed for them. This had been highlighted to the acting manager by a visiting healthcare professional

and we were informed an investigation was being carried out by the acting manager. However there were no records of this investigation and therefore no records of action being taken to make sure this did not reoccur.

People were at risk of not receiving their medicines at the correct time. We identified there was a printing error on the medication administration records which had not been noticed by staff at the home. The times printed on the records showed medicines should be given at 08.30, 13.00, 19.00 and 21.30. This meant for people receiving pain relief which required a gap of four hours between doses they were at risk receiving these at the incorrect time. We were told the normal time for administering medicines were 08.30, 13.00, 17.30 and 21.00. This meant there may still not be a four hour gap between the administration of pain relief.

Some medicines were out of date or unlabelled which placed people at risk of receiving unsafe or un-prescribed medicines. The medicines trolley contained an inhaler which had no label showing who it had been prescribed for. The inhaler was not recorded on the medication administration records for anyone who lived at the home. One person had a medicine spray which had expired in December 2016. The senior carer on duty informed us that the person no longer used this medicine. However there was no record in the person's care plan to state that they did, or did not use it. This medicine was not recorded on the medication administration record.

There was a high quantity of out of date prescribed pain relief. We were told by a senior carer that these were waiting to be returned to the pharmacy. They said it had been a difficult time and they hadn't sorted out the returns.

Medicines were not securely stored. We found that the medicines trolley was not secured to the wall and the keys for this were in an unlocked drawer in the treatment room which was also unlocked. This meant anyone at the home could gain access to the home's supply of medicines.

There were no audits of medicines or safe administration which would have identified these shortfalls. The acting manager informed us they had requested a full audit of medicines in the home from the dispensing pharmacy and this had been arranged for the week following the inspection.

The lack of proper and safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A fire officer recently visited the home and found areas that required improvement to minimise risks to people. They found there was no up to date fire risk assessment in place and no records of tests of fire detecting equipment. At this inspection we found no up to date fire risk assessment but there were records which showed the fire detecting system had been regularly tested in house and the system had been regularly tested by outside contractors. The last full service of the system was in October 2016.

Requires Improvement

Is the service effective?

Our findings

People did not always receive effective care and support because staff did not always have the skills and knowledge required to effectively and safely care for them.

The newest member of staff told us they had received a basic induction to the home but there were no records of this. There were no training records which showed when staff had received training in health and safety or subjects relevant to the needs of people who lived at the home.

People were not being supported by staff who had up to date training to enable them to effectively support people. One member of staff told us they had not had training for "Some time." We looked at a sample of staff files and found certificates for training which showed some training required up dating to make sure staff were aware of up to date good practice. Two staff files showed their fire safety certificate had expired in November 2016. They also showed they had not received training in manual handling since 2012 and they did not have up to date first aid certificates. The lack of up to date training could potentially place people at risk of not receiving the most effective care to meet their needs. The acting manager was unclear about what training staff had received and told us they therefore planned to make sure all staff received up to date training in essential health and safety.

The lack of appropriate support, training and supervision for staff employed at the home is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to access healthcare professionals according to their needs. Healthcare professionals highlighted to us some instances where staff had not responded appropriately when people required professional support. For example in December 2016 running records showed that one person had banged their head but no GP or ambulance was called. In another instance in December 2016 the running records for a person showed staff suspected the person had an infection and staff had written in the care plan "Will call GP in morning." There was no further information and no records to show that a GP was ever consulted. Records for another person showed they were at times unsettled and disorientated. There was no record that the person had been referred to mental health services. The lack of referrals to healthcare professionals meant that people did not always receive the support they required to alleviate discomfort. However on the day of the inspection one person appeared unwell and the acting manager had arranged for a GP to visit them that day.

People generally received the support they needed to meet their personal care needs. One person was being cared for in bed and they appeared warm and comfortable. Districts nurses visited the person regularly and the required pressure relieving equipment was in place to maintain their comfort and protect their skin. There were charts which showed that staff assisted the person to change position regularly to minimise the risks of pressure damage. Although this person required assistance with all mobility they had no pressure damage which showed the actions staff were taking were effective. Another person chose to spend their day sat in their wheelchair and needed assistance with all mobility. We saw they had a pressure relieving cushion in their chair to minimise risks of pressure damage. They told us "Two of them [staff]

always help me with getting in and out of bed and dressing and such."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Some staff had received training in the use of the MCA but this had been some time ago. One staff file showed their training had not been up dated since 2014.

Staff informed us that most people who lived at the home were able to make decisions for themselves. Staff said they always asked people if they were happy to be assisted. Due to the small number of people living at the home there were only two staff on duty at any one time. There were a number of occasions when both staff were male. This meant people did not always have a choice about the gender of the staff who supported them with intimate personal care. There were no records in care plans showing people had been asked about their preferences in this area.

People can only be deprived of their liberty to receive care and treatment which is in their best interest and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS authorisations had been made where people required this level of protection to keep them safe.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the provider did not have adequate systems in place to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good Governance. A requirement notice was issued. Although an action plan was received stating the provider would put measures in place no improvements in this area had been made. At this inspection we found there were still no systems to assess and monitor standards of care.

The acting provider and manager had co-operated fully with quality improvement meetings held with the Local Authority and Care Quality Commission. Their style of management had been reactive and they had tried to address any issues raised.

People could not be confident that the home was well led in line with current good practice guidelines or legislation. The acting provider and manager had not attended any relevant training to enhance their knowledge or skills in providing care in accordance with current good practice, legislation or expected standards. Following the death of the provider the acting provider had sought advice from an appropriate local organisation regarding the management of the home. However we found that systems and practices suggested by the organisation had not been put into practice. There were no effective systems to ensure the safety of people or to plan and maintain improvements. For example as previously mentioned the acting provider and manager had not ensured that recruitment practices minimised the risks of abuse to people.

The acting manager had a plan to up-date all care plans to make sure they were person centred and outcome focussed. There was no information about how this would be achieved or what systems would be put in place to make sure any improvements were maintained.

Whilst we acknowledge some improvements had been made to the environment these were not significant in improving the facilities available to people. There were no regular audits or action plans to state how improvements would be made to the fabric of the building. There were no routine audits of practice, such as medicines management, which would have highlighted the shortfalls we found at this inspection.

Staff told us they were not receiving formal supervisions or appraisals. This would have highlighted staff strengths, weaknesses and training needs and helped to promote safe and effective care for people.

People were not able to influence changes in the home because there was no formal system to seek and record their views. There were no meetings for people who lived at the home which would enable them to make suggestions or share their views. No quality assurance questionnaires had been sent to people or their representatives to enable the acting provider to gain feedback on people's perception of the quality of the service they received.

The lack of systems to monitor and improve the service and ensure people's safety is a continued breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Medicines were not safely managed. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems in place to assess, monitor and improve the quality and safety of the service provided to people or to mitigate risks. Regulation 17 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to make sure people were protected from the risks of abuse. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive the appropriate support, training or supervision as necessary to carry out the duties they were employed to perform. Regulation 18 (2) (a)