Mr Manmohun Ramnial

Bafford House

Inspection report

Bafford House
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bafford House is a residential care home providing care for up to 19 people. The service provides support to people who live with conditions associated with older age and some people also live with dementia and mental health needs. At the time of our inspection there were 17 people using the service.

People lived in one adapted building, each with their own bedroom, some bedrooms included use a personal toilet and washing facilities and others a sink in the bedroom. People had access to a lounge and other areas to sit on the ground-floor and access to a dining room on the lower ground floor via a lift.

People's experience of using this service and what we found
There remained ineffective arrangements in place for identifying and managing risks which may impact on people's health, safety and wellbeing. Safety checks and actions which could help reduce and mitigate these risks were not always completed. In this respect the provider did not always follow their own policies, procedures and risk assessments.

People's medicines were not managed safely, and people had been put at significant risk from the impact of medicine errors. Infection, prevention and control guidance had not been consistently followed.

There remained insufficient staff to support the routine work of the service. This was impacting on the standard of cleanliness, staffs' availability to support people with meaningful and therapeutic activities and the managers abilities to fulfil their management responsibilities.

The provider did not operate safe staff recruitment practices and they did not have arrangements in place to ensure staff completed necessary training which included training in communication with people who lived with a learning disability.

People were provided with support to eat and drink enough and people's food preferences were met however, people had limited opportunities to make mealtime choices.

There were inadequate arrangements in place to keep the environment suitably maintained.

The provider continued to operate ineffective quality monitoring systems and process which meant they did not assess, monitor and manage shortfalls in the quality and safety of the services provided. This meant people were placed at risk without suitable action being taken to reduce of mitigate risks. Shortfalls in record keeping remained and action had not been taken to address this.

Lessons had not been learnt from previous inspection findings, for example, in staff recruitment practices and there were no mechanisms in place to drive service improvement. The provider did not have a formal process in place to seek the views of people, their relatives, staff or visiting professionals to help plan future

service improvement .

People had access to medical support and review by a GP or emergency services when needed. There were arrangements in place to support people's ongoing health needs such as chiropody. Staff worked with community health care professionals to ensure people's health needs were met. Relatives gave positive feedback regarding how people's care needs were met.

People were supported in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There were arrangements in place to acknowledge and address complaints and concerns although the provider told us they had not received any. Relatives told us they had not had cause to complain.

There were no formalised meetings with relatives or staff, but relatives and staff spoken with confirmed there were other arrangements in place for information to be shared. Relatives felt involved, supported and communicated with.

Managers of the service worked alongside health and social care professionals to ensure people could access the service as required.

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 requires improvement (published 6 July 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations and previously issued enforcement action had remained unmet.

At our last inspection we recommended that the provider review relevant oral health guidance and implement an oral health assessment. At this inspection we found this recommendation had not been met, although people received support to maintain their oral hygiene.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 22 November 2021 and breaches of legal requirements were found. Enforcement action was taken in relation to good governance and safe care and treatment and the provider was informed what action they must take by when to meet legal requirements. The provider also completed an action plan to show what they would do and by when to improve need for consent.

We completed an unannounced focused inspection on 30 May 2022 to check they had followed their action plan and to confirm they had met legal requirements. The provider had met legal requirements in respect of need for consent but had not fully met legal requirements in respect of good governance and safe care and treatment. We also found a new breach in relation to staffing.

This report only covers our findings in relation to the Key Questions Safe, Effective, Responsive and Well-Led which contain those requirements.

This inspection was prompted in part due to concerns received about staffing, staff training, medicines administration, cleanliness and some aspects of how people's care was delivered. A decision was made for us to inspect and examine those risks and to check if legal requirements in respect of good governance and safe care and treatment had been met.

We have found evidence that the provider needs to make improvements and we found legal requirements remained unmet. Please see the safe, effective, responsive and well-led sections of this full report.

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.

For those key questions not inspected, we used the ratings awarded at the last time these were inspected to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

We have identified breaches in relation to the assessment and management of risks, management of medicines, infection, prevention and control, staff training, staff recruitment, record keeping and the governance of the service 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 always effective. Details are in our effective 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**

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 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
Three inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Bafford House 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. Bafford House is a care home without] nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 October 2022 and ended on 17 October 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 professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We looked around the care home to review the environment and facilities available for people. We reviewed infection prevention and control arrangements and observed staff interactions.

We spoke with six people who used the service and six relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 10 members of staff including the provider, the deputy manager, three care staff, four agency staff and the cook. We received feedback from one healthcare professional and one adult social care professional.

We looked at a range of documentation including care files and daily records for six people and medication administration records for seven people. We looked at four staff recruitment files and reviewed documentation relating to the management and running of the service, such as training records and audits. We looked at a range of documentation related to the health and safety of the environment and a selection policies and procedures.

After the inspection
We reviewed the information provided to us by the provider in response to concerns identified regarding the management of medicines. We spoke with the local authority to share some of our findings under safeguarding processes and we made a referral to the fire and rescue service and the local environmental health office.

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; Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people were not safely managed. Risks were not adequately assessed, and the provider was not doing all that was reasonably practical to mitigate risk. This included risk relating to fire, infection and the care people received.
- Fire safety risks had not been appropriately mitigated as the provider had not robustly implemented their fire risk assessment. Required checks had not been completed for fire alarms, emergency lighting, fire extinguishers or fire resisting doors to ensure these remained effective. All staff had not completed fire awareness training to enable them to maintain people's safety in the event of a fire.
- People were not adequately protected from the risk of infection, this included the risk of exposure to the flu and COVID -19 viruses, the environment and legionella bacteria. Not all staff consistently wore face masks in accordance with government guidance to help reduce the risk to people of infection. Risks related to legionella bacteria had been identified but action not taken to fully reduce these in accordance with the provider's legionella risk assessment dated 11 July 2022. This stated there were two shower heads in constant use which required to be cleaned, disinfected and descaled 6 monthly. The records showed this had not been completed since June 2021. Some equipment and parts of the environment, in need of maintenance and repair, could not be sufficiently cleaned to ensure people were not exposed to infection risks. This included detached sealant around the bath exposing mould, mould on the bath mat and a rusty bath chair hoist.
- Not all areas of the care home were clean. We observed dust and debris under people's beds and chairs and carpets were stained. Cleaning records showed inconsistent and inadequate levels of cleaning. Waste was not always managed safely. During the inspection we observed a waste bin which was full and its waste, which included personal, protective equipment (PPE), had spilled onto the floor.
- Some cleaning products used by staff required additional controls to reduce the potential of people being harmed by the exposure to these products. All hazardous products in use had not been risk assessed. Products such as bleach and a heavy-duty degreaser were not stored securely to ensure people could not access these.

● Risks to people's health, safety and wellbeing were not appropriately monitored or managed. This included the risk of choking, falls and injury resulting from falls. During the inspection one person, at risk of choking, did not receive their food prepared in the way a speech and language therapist had instructed. This placed this person at increased risk of choking. The person's choking risk assessment had not been reviewed since January 2022 to determine if the actions to prevent choking were still in place and remained appropriate. Staff had not all received first aid training to ensure they would know what action to take if people were to choke.
● One person's falls risk assessment had been reviewed following a fall and they had been assessed as at continued high risk of falls. There was no care plan in place for staff guidance on what support the person required to reduce the likelihood of them falling. Environmental shortfalls had not been addressed such as the broken lock on the stairgate and a hole in the floor covering of the lift; both posed potential falls risks. Staff were not clear about the actions they should take when a person fell in the home. This increased the risk of people's injuries not being suitably identified so timely medical support could be sought.
● Learning had not been taken from previous shortfalls in the above areas and people remained potentially at risk of harm because of this.

Systems had not been maintained to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The ground floor provided ample space for people to sit but most people either chose to sit in the front lounge or staff placed people there. Further thought needed to be given to how the available space could be used to support more effective social distancing. This would be particularly important in the coming winter months when there was less ventilation and an increased risk of flu and respiratory infections.
● Following our visit to the care home the provider informed us they had refurbished the bath hoist and replaced the bath hoist chair and had organised a deep clean of the care home.

Using medicines safely
● The electronic Medicines Administration Record (eMAR) system was not always safe. Time specific medicines were recorded as being given at the wrong time for three people. For one person, four-hour time intervals between paracetamol doses had not been maintained on eight occasions. Managers said medicines had been given correctly, and the time recorded was when the eMAR system had reconnected to the Wi-Fi. This meant inaccurate records were kept of when people's medicines were administered. This put people at increased risk of harm as staff could not be sure when previous doses of a medicine had been administered.
● Medicines were not always given as prescribed. We found courses of people's antibiotics had not always been completed as per GP instructions.
● An emergency medicine for one person had expired. Staff were unaware of the presence of this medicine in the cupboard. They were also unclear why it had been prescribed. They were not sure if the person suffered from the conditions this medicine may be used for. There was no care plan in place with guidance on its use. It had not been added into the eMAR system for use, in the event of it being needed. Managers confirmed it could not be used by staff in the home anyway as staff had not been trained in the administration of this type of medicine. Action had not been taken to ensure this medicine could be used safely and effective. This put this person at potential risk of not receiving safe care and treatment.
● Staff did not record where a medicine patch had been applied and therefore there was no assurance that the patch was rotated correctly. This increased the risk of the person suffering side effects.
● Records for four people receiving their medicines covertly (hidden) showed that the provider had not

taken steps to ensure that these medicines were administered safely.
● We found concerns with the storage of medicines. Medicines to be returned to the pharmacy were not stored in accordance with national guidance. Expired medicines had not been returned to the pharmacy and were still stored in the care home's controlled medicines cupboard.

Systems were not in place to ensure the proper and safe management of people's medicines. This put people at risk from the impact of medicines errors. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection there were insufficient suitably qualified, competent and skilled staff to ensure people's needs were met and to cover the routine work of the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Due to a continuing lack of housekeeping staff the deputy manager consistently needed to complete cleaning and laundry tasks and, some care staff were also redeployed to support in these areas. This meant the deputy manager did not have time to fully complete other tasks for which they were responsible. This included reviewing people's care plans and carrying out quality monitoring checks. This resulted in regulatory requirements continuing to be unmet.
● The service remained heavily dependent on agency care staff and there was a lack of suitably competent senior staff to support and direct staff. This was evident when we asked the provider about their staffing and management arrangements.
● All staff were working in a task orientated way making sure people's basic care needs were met and supporting areas where staff could not be recruited to. The impact of this was people received little support with meaningful and therapeutic activities.

There continues to be insufficient suitably qualified, competent and skilled staff deployed to fully meet people's needs and to cover the routine work of the service. This was impacting managers abilities to meet regulatory requirements. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A relative said, "When we have personally been to visit there are plenty of staff."

● Staff were not safely recruited. The required pre-employment checks had not always been fully undertaken to ensure staff were sufficiently vetted before working with people. Reference checks were not always sought to gather assurances about staff conduct in previous roles. A full employment history was not available for all staff and the provider did not keep interview records to show how they had determined the suitability of each candidate.
● One staff member during their recruitment had been unable to provide certificates of training they said they had previously completed. The provider had not attempted to obtain the training certificates to seek assurances about these trainings. In the absence of these also had not ensured the staff member had completed all necessary training to ensure they could perform their role safely. Although the provider told us about the gaps in their recruitment process, they had not completed an assessment to show how the risks associated with these had been considered and mitigated.

Safe recruitment practices had not been followed. This placed people at risk of harm. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DBS checks had been completed for all staff. Staff Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer.

Systems and processes to safeguard people from the risk of abuse
● Staff could tell us how abuse may present itself and who they would report concerns to within their own organisation, although their knowledge of who to report to outside of their organisation was limited. Staff had not all received safeguarding training.
● The provider and deputy manager were aware of the local authority's safeguarding arrangements and how to share relevant safeguarding information.
● There were no visiting restrictions in place and people's representatives, family members and friends could visit as they wished. Family members spoken with confirmed this to be the case.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to adequately review staffs' training needs and competencies. Staff had not been provided with adequate training to ensure they could support people safely. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- The home supported people who lived with dementia and anxiety related behaviour, people who required support to move safely, which included the use of a hoist and sling, people who required support to take their medicines and people who lived with a learning disability. Staff had not been provided with enough training to ensure staff could fully meet these people's needs safely.
- At our last inspection on 30 May 2022 we identified that staff required safe moving and handling training at this inspection this training was still to be organised.
- Records showed that staff who prepared food had either not completed food hygiene training or their training had expired. Staff had not received specific training in how to support communication with a person who lives with a learning disability. Staff employed by the provider had not received First Aid training. Evidence was lacking to show all staff responsible for administering medicines had received relevant training. Not all staff had received training in fire safety, dementia awareness and coping with aggression in the workplace. This placed people at risk of staff not having the skills and knowledge required to keep them, and others, safe from harm.
- The deputy manager told us they checked staffs' competencies in various care tasks although these checks were not recorded. Two staff, yet to complete induction training, were working independently without direct supervision , both were experienced care staff but as competency checks were not recorded and induction training was yet to be completed, we were not assured a robust process was in place to check if staff were fully competent to work unsupervised.
- Staff appraisals had not been carried out and although the deputy manager told us they had completed individual and group supervisions with staff, these were not comprehensively recorded. The supervision matrix only noted the day the supervision took place and the topic covered. There were no records kept of the conversations held during individual staff supervision sessions. Therefore, the provider could not determine what areas of training and support was needed to support staffs' learning needs and development

The provider has failed to ensure staff are provided with appropriate training and supervision in line with their own policies. This puts people and staff at risk from the potential impact of a lack of appropriate training and support. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● A pre-admission assessment for one person recently admitted could not be found. The provider told us they had completed an assessment of the person's needs prior to their admission but had not recorded this. They told us they considered the information provided by the local authority when making their decision to admit the person.

● People were treated equally, and their needs supported whilst considering their protected characteristics and their physical and mental frailty.

● As the service did not employ nurses, when people had nursing/health needs, which required attention, such as their skin required assessment or they had a wound which required monitoring and dressing, managers worked within set agreements and protocols and ensured people were appropriately referred to the community nursing team.

Adapting service, design, decoration to meet people's needs

● Relatives we spoke with commented on the environment. Comments included "Bafford is not the most salubrious home" and "It's generally a bit tired" but all were positive about the support provided to their relative which they prioritised over the environment.

Supporting people to eat and drink enough to maintain a balanced diet

● There was only one main meal option cooked at lunch time, so people were not provided with a choice. We observed one person, push their plate away when their meal was served, in a way which indicated they did not want what had been provided. Although staff acknowledged the person's rejection, they did not provide the person with an opportunity to choose an alternative. The person went without their main course but ate their pudding.

●The food provided was well presented including foods which were pureed. One relative said, "When (name) was poorly we and the staff fed (name) and everything was individually pureed for example, the potatoes were pureed, the carrots were pureed and the fish was pureed and it was well presented, not just one mush."

● People's food preferences were known to the staff and on both days of the inspection, one person who did not like meat was provided with their preference. Another person liked to source some of their own food and staff supported the storage of these food items in the person's own fridge in their bedroom which the person preferred.

● People were provided with hot and cold drink in-between meals and people who remained in their bedrooms had drinks near to hand or were supported to drink enough by the staff. We observed staff supporting people to eat in a caring and dignified way.

● People's weights were monitored by the deputy manager who referred people to the GP if they were concerned about these. People who required support to maintain their weight were provided with food which was fortified with cream and butter to increase the person's calorie intake.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was limited evidence to show there were arrangements in place to support people to take part in regular exercise, even if this was armchair exercises. One relative told us they had been there when there had been a 'Dancing with Dementia' session taking place but said this was some time ago. One person's daily

notes recorded they were supported to take a walk in the garden.
● Staff supported people's access to emergency services when required which included the ambulance service and the NHS Rapid response service.
● People were reviewed by a GP if poorly and managers had access to advice and support from the GP's surgery as needed. A GP confirmed they were kept appropriately informed about falls and changes in people's health. A relative told us they were in discussion with their relative's GP about their diet as they had lost some weight.
● People had access to regular chiropody and reviews by a community optical service. A member of staff told us dental support would be organised when required. There was no link to NHS dental services for routine NHS dental reviews.
● Staff worked with people's representatives to ensure they could attend medical appointments. Where leaving the care home to attend a medical appointment might cause distress, managers tried to get these to take place at the care home.

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 had maintained the completion of DoLS applications to the local authority since the last inspection. They had one to complete for a person admitted a few months prior to the inspection and they confirmed this would be completed following the inspection.
● Care was provided when people provided verbal or implied consent. People were not forced by staff to receive care when they could not agree to it. This sometimes-meant staff returned at another time to provide people's care.
● Where people lacked mental capacity to consent to aspects of personal care, including the administration of their medicines, records showed decisions to provide this support were made in people bests interests. In the case of decisions to administer medicines covertly (hidden), best interest decision making had involved appropriate health professionals, such as the person's GP, the person's representative and staff caring for them.
● During the inspection a DoLS assessor visited the care home to assess a person who's authorised DoLS had expired, to see if these safeguards were still required.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection where this key question was assessed it was rated as good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

● The provider did not employ an activities co-ordinator to support the provision of activities and there was limited evidence to show how people, less physically and mentally able, were supported with meaningful and therapeutic activities. One member of staff told us staff tried to provide these when they can, and another said staff had little time to do this.

●People's care records showed how people, more able, had been engaging in some activities. One person enjoyed a walk in the garden, and another had been shopping. A relative told us how they maintained family relationships with their relative. They said, "We can have (name) out on the lawn when we want, and the family have been to see him when they want.''

● During the inspection we did not observe any group activities or one to one activity taking place. We did observe staff interacting with people when they provided care.

● There was no plan of activities and no activity records recording what activities may have taken place.

● One person's relative told us they were not aware of their relative taking any part in activities, or if activities provided to them were appropriate. We reviewed this person's daily care notes and they had one documented activity in the month prior to our inspection. We reviewed a further four people's daily care records which were also limited in information about how they had been supported in this way.

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

● We were shown a bath rota and people able to and wanting to bathe were allocated a day a week for a bath. However, when we reviewed three people's daily records a weekly bath was not always recorded. Where there was no weekly bath recorded there was also no reason recorded as to why the person had not had a bath. This made it difficult for us to be assured that people were consistently being supported to have a bath or if they had been offered one and refused. When the daily records about the care and support people are provided with are either inconsistent or lack detail it can make auditing the care people are receiving difficult. It can also then be difficult for health and adult social care professionals when they visit to complete a review of care or an assessment, to get a true picture of the care being provided.

● People's care plans had not always been regularly reviewed and some required more detail to help staff know how to support their needs. One person's care plan stated they needed supervision and prompting with personal hygiene, but also stated they remained reluctant to do any of this. The care plan did not go on to provide guidance to staff on how they should manage these situations, so the risk of self-neglect was reduced. During the inspection an adult social care assessor visited to complete an assessment and found the person's care plans had not been reviewed since February 2022 making it difficult for them to be sure of the person's current needs and abilities.

● In some cases the information in various care records did not match making it potentially confusing for new staff and visiting professionals to know what support was current. One person's falls risk assessment

revised last in July 2022 referred to the person's walking frame and staff to assist with all transfers and mobility. However, the falls support plan created in April 2021 (with no obvious date of review since) referred to the person as now being immobile. The person's mobility care plan referred to the use of a hoist and sling and a crash mat to be used "when necessary".

People's care records were not always accurate and well maintained. This potentially puts people at risk of not having their needs met in an individualised way. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Information about people's needs and how to meet these was handed down verbally between staff. Staff employed by the provider and longer standing agency care staff knew people well and ensured staff who were less familiar with people were supported to know how people's care needed to be provided. One member of staff said, "Information about care is handed over by the deputy manager who updates us if someone is not well or has fallen." Daily staff handover meetings were also used to update staff about people's care needs. The deputy manager also worked alongside care staff most days and provided practical guidance.
● Relatives comments about how their relative's care needs were met were positive. Comments included, "I know the difficulties they face, and they manage (name) incredibly well. When I first entered Bafford House, oh my god, I was really despondent, as I walked into the hallway, its old and tired but actually since (name) has been there the care that (name) receives supersedes your first impressions of Bafford House", "I know they do get agency staff to cover, but the staff do know my (relative) well" and "They have done a great job, (name) seems happier in there than when (name) was living on her own. They have done a great with (name) mobility. In hospital (name) nearly died."

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 communication care plans provided some guidance for staff on how to communicate with them and what their abilities were to be able to engage. One relative told us staff engaged well with their relative when they cared for them despite their relative not being able to engage fully back because they lived with dementia.
● During the inspection we spoke with a relative and social worker about the arrangements in place to support their relative's hearing needs. The social worker was going to review if the person had been referred for a new hearing assessment to ensure they were getting the support they needed to be able to effectively communicate and engage with those around them.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy with procedures in place, the provider informed us they had not received any complaints.
● People's relatives confirmed they knew how to make a complaint but had had no reason to complain. One relative said, "I can honestly say I haven't had any problems" and another said, "No problems, we haven't had any issues to complain about."

End of life care and support

● At the time of our inspection no-one was receiving end of life care.
● The deputy manager remained aware of people's frailty levels and reviewed these with the attending GP when they felt these were altering.
● A GP told us the deputy manager was good at letting them know when people's health deteriorated. They told us the staff at Bafford House always aimed to look after people until their death rather than people having to move to alternative care.

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 requires improvement. 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; Continuous learning and improving care

At our last inspection the provider had failed to operate and maintain effective systems and processes to help them identify shortfalls in their service, drive improvement and remain compliant with the necessary regulations. Systems also remained ineffective in maintaining accurate records. This put people at risk. This was continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider's quality monitoring processes had not improved since our last inspection. There was still a lack of effective systems and processes in place for the provider to be able to assess, monitor and mitigate risks to people, and to ensure compliance with the regulations. This was the third consecutive inspection in which we found regulations had not been met and the provider had failed to improve the service in response to our inspection findings.
- The provider's policies, procedures and relevant risk assessments were not always followed. This was seen in relation to fire and Legionella risk management, infection, prevention and control and the use of personal protective equipment (PPE), Control of Substances Hazardous to Health (COSHH), staff training, staff supervision and staff recruitment. The provider's quality monitoring processes had not identified shortfalls in these areas.
- We found significant shortfalls with the provider's electronic medicines administration records system which had not been identified by the provider, placing people at risk of not receiving their medicines as prescribed. We found ongoing shortfalls in the maintenance of people's care records which included pre-admission assessments.
- The provider had not monitored health and safety checks to ensure they would be completed as required to reduce risks related to the environment which could harm people.
- There was still no system in place to ensure staff were recruited in accordance with the provider's recruitment policy and all necessary checks were completed before they worked with people. No action had been taken to make improvements to the staff recruitment process which put people at potential risk.
- Staff training, supervision and developments needs were not effectively monitored and prompt action had not been taken to ensure staff had the required training to meet people's needs safely.

● The provider explained they get feedback from relatives as they and the deputy manager are in frequent communication with most relatives. However, there remained no process in place to formally gather the views of people, their relatives, staff and visiting professionals to help drive improvement in the service.
● During the inspection we signposted the provider to their website which told people the service was no longer registered with the CQC which was incorrect at the time of the inspection. The website provided out of date information about the service (the statement of purpose) and did not provide information or a link to the last inspection rating. The provider was unaware of these shortfalls and told us they would address these.

There remained ineffective systems and processes in place to monitor the quality and safety of the service and to ensure records were properly and accurately maintained. The provider had not taken action to make necessary improvements to the service. This placed people at risk of harm. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider and deputy manager promoted a person-centred approach to care, but the challenges the service faced meant this did not always result in good outcomes for people. This was seen for example, in the lack of meaningful activities for people, lack of choices at mealtimes and lack of individualised and holistic care planning.
● Relative's comments described a caring and inclusive culture which supported good outcomes for people. One relative said, "(Staff names) have given me the reassurance and are brilliant at keeping me in the picture and involving me, so I do not worry" and another relative said, "(Staff name) and (staff name) are very good at keeping me in the picture, I have a very good relationship with them… and the staff are extremely good, and I always get a call from (staff name) to ask me if it is alright for (name) to go on (name of tablets) and things like that. I am kept completely updated."

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 and deputy manager understood their legal responsibility regarding duty of candour.
● The provider ensured appropriate agencies were informed of things which had gone wrong and which had impacted on people.
● Relatives told us they felt confident the provider or deputy manager would inform them of events which had not gone to plan, and which impacted on their relative.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Both the provider and deputy manager engaged well with relatives. Relatives comments included "I can honestly say I have not had any problems at all, Bafford House is always very accommodating and they listen to us" and "The home is being great, and we are getting a lot of support."
● There were no formalised meetings with relatives or staff meetings, but information was imparted on an informal and individual basis, to relatives when they visited or by phone and email. Ad-hoc meetings took place with staff and daily handover meetings kept staff updated with care matters and matters relating to the service.

Working in partnership with others
● Managers' worked closely with local authority commissioners to support people's access to care where this was required. There was evidence to show that the service continued to provide support to people when

situations arose, which had previously caused care placements to breakdown.

● The provider had followed the advice and requirements issued by an Environmental Health Officer (EHO) following their last inspection where the food safety rating was lowered from five (very good) to one (major improvements are needed). On a recent follow up visit the EHO had been satisfied with the improvement actions taken by the provider.