Four Seasons (No 10) Limited

Bamford Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bamford Grange Care Home is a care home providing personal and nursing care to 60 people aged 65 and over at the time of the inspection. The service can support up to 79 people.

Bamford Grange Care Home provides care across separate five units. Units specialise in dementia care, general nursing and mental ill health.

People's experience of using this service and what we found
People did not always receive care which met their needs. Care plans did not always reflect people's current needs. End of life wishes were not always captured. Monitoring records were inconsistent. The provider had failed again to demonstrate the required standard of governance. This is a breach of Regulation 17 (Good Governance) and Regulation 9 (Person-Centred Care).

Staff were not appropriately deployed to ensure that meant people's care needs were met. This is a breach of Regulation 18 (Staffing).

Activities were taking place in parts of the building, but people cared for in bed were at risk of social isolation. We made a recommendation about activities.

There was a clear policy and system to manage infection control particularly in terms of the prevention of Covid-19. The inspector completed an infection control questionnaire on site. We made a recommendation about infection control.

The provider followed their complaints policy when dealing with complaints. One complaint had been escalated to the Local Government and Social Care Ombudsman who investigate complaints about adult social care settings.

Staff expressed a commitment to their caring roles. Most relatives told us they were happy with the care their loved ones received. Relatives told us that communication between themselves and their loved ones could be better supported by staff at the home. We made a recommendation about communication.

There had been some changes to the management team at Bamford Grange Care Home and new systems were being implemented to improve people's experience of care.

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 5 February 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough

improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of people's care needs, staffing and infection control. A decision was made for us to inspect and examine those risks.

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 coronavirus and other infection outbreaks effectively.

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

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bamford Grange Care Home 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to staffing, person-centred care and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bamford Grange Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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
This inspection was carried out by three inspectors, a specialist nurse advisor 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.

Service and service type
Bamford Grange Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a new manager who had started to register with the Care Quality Commission. This means that when registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also gathered information that the local authority and Healthwatch held about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection-
We spoke with or observed the care of 12 people who used the service and we spoke with 15 relatives. We spoke with 20 staff members including the area manager, the manager, the activity coordinator, two nurses, the chef, the maintenance officer, a domestic and 12 care staff.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At our last inspection the provider had failed to ensure that sufficient staff were available to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection. Therefore, the provider was still in breach of Regulation 18.

● People's needs were not always met. Staff were not always available when people needed them. For example, people had not had the opportunity to have regular baths or showers.
● Staff told us they were regularly moved to work in different units where they did not always know people's needs.
● Staffing levels were determined by a dependency tool. The manager told us that the service was not short of staff. However, we found that people were not receiving appropriate support with personal care which indicated that staffing levels were insufficient or that staff were not deployed appropriately. For example, bathing charts did not indicate that people had been bathed frequently and hardened toothbrushes demonstrated that they had not been used to clean teeth."

The provider had failed to ensure that sufficient staff were available to meet people's needs. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were not always monitored. Systems had not picked up shortfalls in monitoring and records.
● There were inconsistencies in the monitoring and recording of fluid intake for people at risk of dehydration and for the use of air flow mattresses for people at risk of developing pressure wounds.

The provider did not have effective systems in place to ensure the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safety checks relating to the building and environments were carried out to a high standard by the maintenance team.
● Care plans and risk assessments were reviewed following an accident or incident.

Preventing and controlling infection
● We were assured that the provider's infection prevention and control policy was up to date.
● 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 admitting people safely to the service.
● 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 not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Mattresses had not been cleaned in line with the service's policy.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Limited attempts to cohort staff to individual units had been made.

We recommend the provider refers to the current good practice guidance relating to reducing traffic throughout the premises to prevent the spread of infection.

Using medicines safely

At our last inspection the provider had failed to ensure that staff were managing people's medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● People's medicines were managed safely. Nurses who administered medicines were competent for this role and supported people in a caring and patient way. Records showed that people received their medicines in the way prescribed.
● Medicines were stored safely and at the right temperature. Medicines that are controlled drugs (subject to stricter control because of the risk of misuse) were handled in a safe way.
● Protocols describing when to administer any medicines prescribed 'when required' were kept with people's medication administration records (MARs). Protocols were up to date. Medicines prescribed 'when required' to relieve pain or agitation were used appropriately.

Systems and processes to safeguard people from the risk of abuse
● The inspection team raised one safeguarding alert during the inspection. The local authority was investigating this at the time this report was written.
● The manager showed us examples of two safeguarding investigations that had been carried out since the last inspection. These had been managed in line with the provider's safeguarding policy.
● Staff had received training in safeguarding adults from abuse and knew how to report any concerns that people were being harmed. Staff understood their responsibility to blow the whistle if their concerns were not reported to the appropriate authority in order to keep people safe.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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; End of life care and support

At the last inspection we made a recommendation that the service ensured people's end of life care needs and preferences are sought and documented. We also found the provider had failed to ensure staff provided people with individualised care which met their needs. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection. Therefore, the provider was still in breach of Regulation 9

● People's personal care needs were not always met. Records did not show that topical creams and ointments had been applied as directed. People were not supported with oral healthcare or regular bathing. We saw that people's nails were over long which meant they could damage their skin.
● People's end of life needs and wishes were not always captured in their care plans. This meant staff may not be able to offer personalised care.
● Staff had not completed training in end of life care.

The provider had failed to ensure staff provided people with individualised care which met their needs. This placed people at risk of harm. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans were reviewed regularly and were still in the process of being updated. One care plan we reviewed had not been rewritten since 2015 although it had recently been reviewed by care staff.

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 the provider had failed to ensure staff supported people to follow their interests and take part in activities. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a modest improvement had been made at this inspection and the provider was no longer in breach of regulation 9 relating to activities.

● Some people had access to individualised activities. One relative told us, "During the lockdown the home has organised a home book library especially for our relative who is a prolific reader and we are really grateful for that as it keeps them going."
● Most relatives were happy with the care at Bamford Grange Care Home. Some relatives told us they were supported to keep in touch with their loved ones virtually. Others said that communication was inconsistent. One relative told us, "We provide resources such as audio books. We talk to our relative every day."
● People cared for in bed did not always have access to activities and records showed they had limited interaction with staff. Staff told us they had limited time to spend with people due to low staffing levels. A relative told us, "My relative is isolated and has withdrawn into themselves. There are no activities not or any interaction."
● The manager told us that they planned to offer an increased number of hours for activities from November 2020.

We recommend that the provider refers to current best practice to prioritise meaningful interaction for people cared for in bed.

Improving care quality in response to complaints or concerns
● Systems were in place for any concerns, complaints, or compliments to be acknowledged and investigated. The provider had a policy which detailed how any complaints would be investigated and responded to.
● The provider was investigating two complaints at the time of the inspection. These related to communication between the service and relatives, end of life provision and visiting. One complaint had not been dealt with to the satisfaction of the complainant and was being investigated by the Local Government and Social Care Ombudsman.
● One relative had made an informal complaint. They told us, "The Manager was helpful and investigated the matter. They called me back in a couple of days to apologise and to assure me that it won't happen again and as far as I know it hasn't [recurred]."

Requires Improvement

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 the last inspection this key question was rated as requires improvement. At this inspection this key question 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

At the last inspection the provider did not have effective systems in place to ensure 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) Regulations 2014.

Not enough improvement had been made at this inspection. Therefore, the provider was still in breach of Regulation 17

● The home had two managers in the previous 12 months. They did not have a manager currently registered with CQC and the last registered manager had de-registered in August 2019. At the time of our inspection, the existing manager had been in post two months and was in the process of applying to become the registered manager of the home. They were supported by a deputy manager and one of the area managers, who was also relatively new in post.
● Authorisation to deprive a person of their liberty (The Deprivation of Liberty Safeguards) had not always been requested from the authorising body in a timely way. We were made aware that authorisation for one person had lapsed, and further authorisation not requested until three months later. This meant the person may have been unlawfully deprived of their liberty.
● Management and senior staff completed a variety of regular checks and audits of the service; however, these were not effective in ensuring appropriate levels of quality and safety were being maintained at the home. For example, systems did not provide oversight of people's personal care needs. The systems in place for checking on the quality and safety of the service were not always effective. They failed to identify where people's needs were not being met or identify and mitigate risks associated with people's safety and personal care.

The provider did not have effective systems in place to ensure the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) 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
● Staff told us that management instability had impacted on staff morale and they had been presented with

inconsistent leadership. The area manager told us they planned to send out a questionnaire for staff to share concerns.

● The provider had completed some of the actions from the plan they submitted to us after the last inspection. For example, a 'resident of the day' initiative had been set up to improve person centred care at the service. However, a keyworker system had not yet been actioned and so positive outcomes for people were limited.

● Most relatives felt more positive about the current management team. Comments included, "The high turnover of staff and managers has been unsettling so this is good news if the new manager stays" and "This new manager seems to know what they are talking about."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The manager understood their responsibilities in terms of quality performance, risks and regulatory requirements and took immediate steps to improve personal care provision. However, the management team did not accept that there were staffing issues at the home so we were not assured that changes would be made.

● The provider had submitted legally required notifications to CQC as required, with one anomaly. When we spoke to the manager about this they told us this was a systems error and they would resubmit the notification.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Relatives said they knew who the manager was. One relative said, "The new manager did an open meeting by 'zoom' to introduce themselves which was a good idea." However, formal feedback from relatives had not been invited since the last inspection.

● Relatives told us that communication between themselves and their relatives could be improved during lockdown. The onus was on relatives to initiate contact. One relative told us, "It is often difficult to get through on the telephone." Another said, "We have managed to get facetime set up, so we have been able to talk to our relative."

We recommend that the provider considers how they can best support communication between the service and people's relatives.

●Staff had attended several team meetings over the lockdown period. Staff views were mixed. Some staff had a positive view of the management team. Other staff said that they did not feel listened to.

● Provider engagement with commissioners, the local authority's quality support team and safeguarding teams was limited. The local authority quality support team told us they were keen to work with the home to improve quality standards.

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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient staff were available to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure staff provided people with individualised care which met their needs.

The enforcement action we took:

We issued a warning notice to the Provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure the quality and safety of the service.

The enforcement action we took:

We issued a warning notice to the Provider.