KR Care Homes Limited

Bankfield

Inspection report

Gigg Lane
Bury
Lancashire
BL9 9HQ

Tel: 01617648552

Date of inspection visit:
10 October 2022

Date of publication:
13 December 2022

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

About the service
Bankfield is a residential care home providing accommodation and personal care to up to 47 older people and people living with dementia. At the time of our inspection there were 20 people living at the home.

People's experience of using this service and what we found
Staff were not always administering medicines safely. Some medicines were being administered too closely together and audits had not identified this. The recording of medicines was not always robust.

Recruitment checks of new staff members were not always safe. Agency staff were regularly used and did not receive an induction to the home. Night staffing levels required reviewing to ensure people's needs are met safety, by trained and competent staff.

Risks to people were not always clearly documented. A safety check on the passenger lift had not been carried out in a timely manner. This was actioned following our inspection. Staff were not following COVID-19 guidance for personal protective equipment.

On commencing the inspection, the care manager denied the inspectors access to the electronic care planning system. Following speaking to the nominated individual, they confirmed they had made the decision to deny inspectors access. We did review electronic care records following a discussion with the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

People were supported to have maximum choice and control of their lives and staff did support them in the least restrictive way possible and in their best interests; the policies and systems in the service did support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was inadequate. (Published 16 August 2022) and there were breaches of regulations. At this inspection we found the provider remained in breach of regulations. This service has been in Special Measures since 29 January 2022. During this inspection, not enough improvement had been made and the service remained in special measures.

Why we inspected
We received concerns in relation to staffing and risks to people. As a result, we undertook a focused inspection to review the key questions of safe only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe sections of this

full report.

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 Bankfield on our website at www.cqc.org.uk.

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

We have identified breaches in relation to safe care and treatment, staffing and fit and proper persons employed at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore remains' in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Bankfield

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection team consisted of two inspectors.

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

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with the registered manager, the care manager, the nominated individual, a senior care worker, two care workers and two people who live at the home. We reviewed recruitment and staffing records, risk management arrangements and health and safety. We look at multiple medication records and infection control arrangements. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection, the provider failed to ensure medicines were safely managed. This exposed people to a risk of harm. This was a breach of regulation 12. At this inspection not enough improvement had been made and the service remained in breach of regulation 12.

- Medicines were not safely managed.
- Two people received pain relief medication in less than the required four hourly intervals with one person receiving too much of the medicine, too closely together on more than 16 occasions within one month.
- It was not always clear if staff were following the prescriber's instructions for applying pain relief patches to people as application charts were not always completed appropriately.
- Night staffing levels required reviewing to ensure people's needs are met safety, by trained and competent staff.
- An audit had been completed by the care manager on the previous week's medication administration records. The audit showed a number of missed signatures but did not highlight where pain relief was being administered too close together. The care manager, on the day of inspection, told us the senior care worker responsible for the mistakes was being retrained in medicines management, however, they returned to administering medicines the following day without receiving the necessary training.

The provider did not ensure medicines were being managed safely. This was a continued breach of regulation 12 (1)(safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
At our last inspection, the provider did not effectively deploy staff to meet people's care needs. This was a breach of regulation 18. At this inspection not enough improvement had been made and the service remained in breach of regulation 18.

- Staff were not always recruited safety. Agency staff were regularly used by the provider and they did not receive an induction to the home or the providers processes.
- Agency workers were regularly covering up to 100 hours per week of care shifts and there was no record of induction to the home. A staff member told us they were responsible for telling agency staff what to do, but there was no time, specifically when agency staff don't know how to work the electronic care planning system.
- One person told us they regularly have to get up early due to staffing levels. A staff member told us, those staff who work at night struggle as they can be in a bedroom with a person who requires the support of two staff members which means there is no one having oversight of communal areas.

The provider did not effectively deploy staff to meet people's needs. The provider did not have an induction programme which prepared agency staff for their role. This was a continued breach of regulation 18 (1) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Application forms for new staff members contained gaps and a full employment history was not always obtained.
● References were not always from the last employer and some were from the applicant's friends.
● Where references only confirmed the dates of employment, no further action was taken to assure the provider of the applicant's good character.
● The provider had not sought references or viewed a Disclosure and Barring Service check (DBS) for the care manager who had recently commenced employment at the home. A DBS helps providers make safer recruitment decisions.

The provider did not assess whether the applicant was of good character and make every effort to gather all available information to confirm the person is of good character. This was a breach of regulation 19 (1) (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection, risks to people were not robustly captured as part of care planning and risk assessing processes. The provider did not have thorough oversight of accidents and incidents. This was a breach of regulation 12. At this inspection not enough improvement had been made and the service remained in breach of regulation 12.

● Risks to people were not always fully reflected in care records.
● There was differing information contained in care records to support a person who had swallowing difficulties. Despite this being raised at the last inspection, the information in care records was still not correct. This put the person at risk of unsafe care. Fluid intake and the use of fluid thickeners were not always recorded for this person.
● The moving and handling information for one person stated they were able to weight bare using a zimmer frame, but the person now required mobilising with staff support due to an injury and the risk assessment had not been updated.
● The last Examination of Thorough Lifting for the passenger lift was completed in December 2021 and was due again in June 2022. We raised this as part of the inspection and the examination was completed the following day.

The provider did not ensure risks to people were robustly captured as part of care planning and risk assessing processes. There were no processes in place to ensure the passenger lift received timely examinations to ensure its safety. This was a breach of regulation 12 (1) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Improvements had been made to the recording of accidents and incidents and these were being audited more often for patterns and trends.

Preventing and controlling infection
At the last inspection, the provider did not ensure communal areas were clean. The provider did not have arrangements in place to monitor a person's COVID-19 status when transitioning between services. This was a breach of Regulation 12. Although some improvements have been made to the management of infection

control, further improvements are required, and the provider remains in breach of regulation 12.

●Staff were not always following the correct guidance for the wearing of face masks in the care home.
● On our arrival, a senior staff member opened the door and was not wearing a face mask while they spoke with ourselves and other professionals.
● Another senior care work was wearing a mask under their chin whilst administering medicines to people.

COVID-19 guidance for the use of personal protective equipment was not being followed by the provider. This was a continued breach of regulation 12 (1) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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

Systems and processes to safeguard people from the risk of abuse
At our last inspection, the provider did not take action as soon as they were alerted to alleged abuse. This was a breach of regulation 13. At this inspection, improvements had been made and the provider is no longer in breach of regulation 13.

●Safeguarding concerns had been reported to the local authority for further investigation.
● Staff received training in safeguarding, and we received mixed feedback on raising concerns. One staff member felt they could raise concerns and they would be acted upon while two other staff members felt if they did raise concerns, they would not feel listened to.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.