Vitalbalance Limited

Bank Close House

Inspection report

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09 November 2020
17 November 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bank Close House is a residential care home providing personal care to 20 people at the time of the inspection, some of whom were living with dementia. The service can support up to 27 people across two floors in buildings connected by a glass walkway. The accommodation also contains two communal seating areas as well as two dining areas. There are several bathrooms and toilets throughout the building and bedrooms are spaced on the upper floor of the main building.

People's experience of using this service and what we found
People living in the service were not safe and were placed at risk of harm. The service was inspected during the COVID-19 pandemic. Risk management, poor infection control processes and reduced staffing levels put people at increased risk. Records relating to people's care did not always contain sufficient information or guidance to enable staff to provide the safe care and support people required .

The registered manager was not present on our first inspection, however they were present for the following two inspection days. Leadership and governance arrangements were not fully effective, impacting on staff morale and team work. Systems and processes were in place to monitor the quality and safety of the service, but these had not identified the issues highlighted at this inspection. At the second and third inspection we saw some improvements had been made following involvement of external professionals advice and the providers action plan.

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

Rating at last inspection
The last rating for this service was Good (published 10 April 2019).

Why we inspected
The inspection was prompted in part, due to concerns we received about infection control practices and staffing at the home. As a result, we undertook a review of Infection Prevention and Control (IPC) practices to assess whether the service was compliant with IPC measures. This took place on 04 November and was unannounced.

During the targeted inspection a number of concerns were found around infection control and governance and this prompted a further unannounced focused inspection which took place on 09 November 2020 and 17 November 2020. The overall rating for the service has now changed from good to inadequate.

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

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 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to infection control, risk management, staffing, leadership and oversight 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Special Measures
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The Service was not well-led.

Details are in our well-led findings below.

Bank Close House

Detailed findings

Background to this inspection

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
The inspection was carried out by two inspectors and an assistant inspector. The site visits were carried out over three days and telephone calls were also made to relatives to seek their feedback and to staff off site.

Service and service type
Bank Close House 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 manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We did announce our arrival immediately before entering the premises as we needed to check the current COVID-19 status for people in the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and information

received in statutory notifications. A statutory notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. 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 also sought feedback from the local authority. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We completed an initial visit on 04 November 2020 to look at the infection control and prevention measures in place and spoke with staff on duty. Following this visit we sent a letter outlining the concerns we had found which the operations director responded to with details of their action to ensure people's safety. The response did not fully mitigate the risks we had found which prompted a focused inspection to take place on 09 and 17 November.

On 09 November 2020 we revisited Bank Close House and spoke with two people who used the service about their experience of care provided, and we also observed staff interacting with people. We spoke with members of staff on the inspection including the registered manager, operations manager, senior carer, carers and domestic staff. We reviewed a range of records including multiple medication records and asked for other care plan records and quality assurance records to be forwarded to the inspector for review after the inspection visit.

We carried out a further visit on 17 November 2020 which was conducted with an external IPC healthcare professional.

After the inspection
We made phone calls to five relatives to ask about their experience of the service. We made phone calls to five further staff. We continued to seek clarification from the provider to validate evidence found. We looked at care records and quality assurance records.

Inadequate

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- The home had an outbreak of COVID-19 and had been supported by a range of health care professionals to review their infection control practices. All the areas reviewed fell short of the required standards.
- The provider was not ensuring staff were using personal protective equipment (PPE) effectively and safely. On our first visit there were no identified PPE stations, we observed staff did not follow national guidance in changing their PPE after supporting people who had tested positive for COVID-19 or ensuring the correct disposal of the PPE. This placed people who were not COVID-19 positive at risk of contracting the virus.
- The provider was not promoting safe hygiene practices for the premises. On several occasions, the rota's indicated insufficient domestic support within the home. The cleaning schedules were not detailed or monitored effectively, and we saw products used for cleaning and disinfection did not meet current recommendations. This meant some areas and equipment for the home were not cleaned regularly and risked the further spread of infection.
- The provider was not making sure infection outbreaks could be effectively prevented or managed. We saw there was no signage to identify or alert staff to the COVID-19 status of people in their bedrooms, this placed an increased risk when agency or professional staff did not know people as well as regular staff. Several staff we spoke with told us they had either not had training, or not received updated advice following the recent outbreak. A lack of understanding and implementation of current guidance and training in relation to COVID-19, meant additional measures were not in place to control the outbreak.
- The provider was not following the most recent guidance to ensure any visitors were not at risk from catching or spreading infection. There were no procedures in place for visitors to the home to be identified, screened and their details recorded in line with current guidance. By our third day of inspection the guidance for dealing with external visitors was completed effectively.
- The provider was not meeting shielding and social distancing rules. People who were both COVID-19 positive and negative were seen to share a communal space and measures, such as altering the environment layout had not been put in place to encourage social distancing.
- The provider's infection prevention and control policy was not up to date with current guidance and we therefore found the required guidance was not being followed. For example, the laundry area was not managed in line with best practice. We saw dirty and clean laundry was placed in the same area and procedures had not been followed in using specialist bags for potentially infectious laundry. This placed additional risk of the transmission of the virus.

The provider failed to ensure that people received care and treatment in a safe way and failed to ensure systems in place were robust enough to protect them from risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been some improvements to elements of the service, however we still had continued concerns for the consistent use of PPE. We have also signposted the provider to additional resources to develop their approach. The provider has since increased their resources to make improvements following our visits.

● The provider was accessing testing for people using the service, however staff had not received the required training and this could impact on the validity of the testing. The provider told us they would be accessing further training in this area.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

● People's risks were not fully assessed, mitigated or managed effectively in order to keep people safe. For example, risk assessments had not been completed in relation to government guidance when isolating people with the symptoms of COVID-19. Another person required equipment in order to transfer safely and a detailed moving and handling plan had not been completed for staff to follow. This meant people were at risk of their needs not being met or placing them at risk of harm.

● Since the start of the pandemic, the possible impact of isolating on people had not been fully considered. For example, regular refreshments were not being consistently provided due to the shortage of staff and people being isolated in their rooms having less opportunity to access any drinks independently. This placed people at risk of dehydration or receiving the required nutritional needs.

Using medicines safely

● Prescribed medicines were not always managed safely. We found opened creams for people in an open container adjacent to the medicine trolley and in the bathroom cupboard. Some of these creams were for COVID-19 positive people which demonstrated the provider had not recognised the risks around cross contamination from creams being stored in a communal space.

● Medicines records were not always accurately maintained. Medicine use was not always monitored and checked following administration, as we saw a number of missed signatures. This meant people were at risk of not having their medicine as prescribed, a possible repeated dose or in not managing their medical condition appropriately.

Learning lessons when things go wrong

● The provider did not have an effective system in place to effectively monitor and learn from accidents and incidents. Where concerns had been recorded, investigations were limited with no learning outcomes detailed and record of followed up action.

● Lessons had not been learnt when people's needs changed. For example, when one person had a fall, their risk assessment was not reviewed, additional measures had not been considered to reduce the risk of the person falling again.

● Environmental risks were not managed adequately to ensure the safety of people. We saw communal areas were dusty and soft furnishings which were dirty or had sustained damage had not been replaced. Some people's rooms had not been cleaned for over a week and areas of one room had peeling paint which could have impacted on the person's health and wellbeing.

The provider failed to ensure that people received care and treatment in a safe way and failed to ensure systems in place were robust enough to protect them from risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels were not managed safely. There was not enough staff to support the number of people

living at the home. Staff told us they were concerned about staffing levels since the start of the pandemic, one staff member said, "There is not enough staff and I often feel like I am rushing people."

● We reviewed the providers dependency tool and found on several occasions there was not the required number of staff as identified to meet people's current needs. For example, when there was no cook the food had to be brought in from a local baker, this then had to be distributed through the home by staff along with people's drinks. When there was no domestic on duty, staff told us they were expected to do cleaning and laundry at night which they often could not do, as these shifts were also short staffed. This meant people were at risk of not receiving their nutritional needs and the hygiene standards not being maintained within the home, to reduce the risk of further transferring the infection.

● Agency staff were employed for the first time over the weekend between our visits. These staff did not receive an induction, to introduce them to the home's layout or routine and the handover information was limited with regards to people's needs. Although agency staff had access to the handheld devices which contained care plans, these were not all up to date.

● Staff did not always have the required training or competencies, skills and experience to provide care safely. Staff had not received training in infection control or updates in the use of PPE. For example, we found when the food was distributed, the staff did not follow PPE guidance in relation to changing PPE or in the management of collecting dirty crockery and risked further transmission of the virus. The training matrix provided confirmed not all staff had completed appropriate infection control training.

● Any training which had been received had not been checked to ensure staffs understanding or to consider if any further training was required. One staff told us they had not seen the Public Health England guidance video for health and social care for donning and doffing of PPE and said, "We have not had any training for a while, we need more training." Another said, "We have not had any training on COVID-19 or PPE only what we pick up from each other."

Suitably competent and experienced staff were insufficiently deployed to provide safe care. Staff did not receive the appropriate support, training or appraisals to enable them to carry out their duties. This was a breach of Regulation 18 (1) and (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated 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

- The registered manager was not present on our first inspection, however they were present for the following two inspection days. After our first inspection visit the provider sent us an action plan, however this did not provide us with ongoing assurances. We found measures agreed by the provider to be completed immediately, were not found to have been actioned, this placed people at continued health and safety risk.
- Daily records and care plans were not always accurate or updated from the paper record to the handheld electronic devices to reflect whether people's assessed needs were met. This meant people were at risk of their needs not being met and reflects a lack of oversight with the quality monitoring systems.
- Communication system failures within the staff team at handover meant information was not always shared with all care staff. We saw handover sheets with no information detailed on them. Where responsibilities such as recording fluid intake were delegated, there was poor recording and oversight meaning people were placed at risk of not eating and drinking enough.
- There was no provider oversight of the home, which meant they were unaware of the risks, concerns and issues we identified. Quality monitoring audits were limited and inconsistent. Where improvement actions had been identified some were found to not be completed.
- The provider had a health and safety policy, this had not been updated to include managing a COVID-19 outbreak and there was no evidence any other guidance had been shared with staff to support them in managing within the pandemic.
- The registered manager had not established clear supervision, direction or management of the home, during the pandemic. One of the staff on our first visit told us, "I don't know what to do."
- At our last inspection we identified monitoring improvements were required, we found these had not been implemented to ensure a robust approach to maintaining standards. This meant the required action had not been taken or monitored by the provider or registered manager to provide the assurances we need to reflect the home has good governance arrangements in place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not ensured a person-centred approach to care. Consideration had not been made for individual needs whilst they isolated. People were not supported to have hand hygiene prior to eating their

meals. People were left in their rooms with no television, radio or means of stimulation. Two relatives told us they had not been involved in the care planning about their relative's care needs.

● Five of the families we contacted told us they had not had any information or communication about COVID-19 and the measures they were taking to reduce the impact on their relative. People were not supported to keep in contact with their loved one. There was no offer of using electronic systems to engage in face to face contact or promote contact. Some people had their own mobile phones; however, these had not been regularly charged up to enable free flow contact. This meant we could not be assured that the communication methods in place promoted an inclusive and open culture

● The culture within the service was not consistently positive. Staff we spoke with told us about low morale and lack of adequate staffing as the main concerns. Not all staff felt supported or assured that when concerns were raised these would be acted upon. One staff told us, "We have not had a staff meeting for over a year, we're not listened to and any concerns that are raised are not dealt with."

● The providers recent auditing of medicines noted errors in the counting of controlled drugs. We found continued counting errors, this meant this area of concern had not been addressed.

● The IPC audit identified a mattress was ripped, this was not changed until several weeks later when identified as part of our inspection. Other areas of this audit had also not been addressed and areas in the home which were at risk had not been reflected on. This meant we could not be assured by the methods in place were sufficient to review safety and ongoing improvement measures.

The provider failed to ensure that their systems and processes operated effectively to improve the quality and safety of the service they provided to people. Audits were not always been used effectively to drive improvements and the support available was not always consistent to support staff, so their rights and wellbeing was protected. All of the above evidence was a breach of regulation 17 of the Health and Social Care Act 20008 (Regulated Activities) Regulation 2014.

● Statutory notifications had been submitted as required to enable monitoring of the service and the previous rating was on display.

Working in partnership with others

● Partnerships had been established with others such as health and social care professionals who had provided some guidance to the staff in how to meet people's needs. However, this information had not always been effectively communicated to staff and resulted in some staff feeling unconfident in some care delivery. Information provided by external professionals was not always updated from admission or reflected in care plans.