Mrs Safia Bano Hussain

# Bankfield Manor Care Home

**Inspection report**

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## Ratings

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|---|---|
| **Overall rating for this service** | **Inadequate** |
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires improvement** |
| Is the service caring? | **Requires improvement** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Inadequate** |

## Overall summary

This inspection took place on 2 and 24 September 2015 and both visits were unannounced. At the last inspection on 12 January 2015 we found four breaches in regulations which related to safe care and treatment, need for consent, receiving and acting upon complaints and good governance. The provider sent us an action plan for the breaches which told us improvements would be made by 30 May 2015.

At this inspection we found continued breaches of regulations which related to safe care and treatment, receiving and acting upon complaints, good governance and further breaches in relation to dignity and respect, safeguarding service users from abuse and improper treatment and staffing.

Bankfield Manor is a residential care home situated in the Boothtown area of Halifax. The service provides accommodation, personal care and support for up to 25 older people and people living with dementia. Accommodation at the home is provider over two floors, which can be accessed using a passenger lift in the main

# Summary of findings

building and a stair lift in the extension. At the time of our visit there were 10 people living there as the provider had agreed a voluntary suspension on admissions with the local authority until improvements had been made.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were areas of the home which were not clean or safe. Some of the furniture was not suitable for the people using the service and some equipment did not have the necessary safety certificates in place.

The medication system was not well managed and there was no assurance people were receiving all of their medication as prescribed by their doctor.

People told us they felt safe and staff understood how to report any concerns about people's care and support.

We found staff were being recruited safely, however, we found there were not enough always enough staff to make sure people's needs were met or to keep the home clean. Although the staff training matrix showed staff training was mostly up to date, staff understanding of infection prevention procedures, for example, was poor in practice. Formal supervisions and appraisals were not up to date.

The registered manager, who was cooking on both days of our visit, had a good understanding of people's food preferences and we saw good stocks of branded food items in the fridges, freezer and stock cupboards. People told us the meals were good.

We found staff were not always following the advice they had been given by health care professionals, which meant people were not receiving support in the safest way. Care plans were in place but had not always been updated to reflect people's current needs. Some of the interactions we saw between staff and people using the service were not respectful.

Concerns and complaints were not always being recognised and dealt with effectively. One person identified a number of things they were not happy with and these had not been addressed either through the care planning process or through the complaints procedure.

Information about people using the service was not stored securely, which meant they were not assured information about them would be kept confidential.

When we inspected the service in September 2014 and January 2015 we found breaches of regulations. The provider assured us they would make the required improvements following both visits, however, again on this inspection we identified continued breaches of regulations. The service lacked leadership and the quality systems in place were not effective in identifying areas for improvement or driving up the standards in the service. The office was chaotic and records were difficult to find or did not exist. On the second day of our inspection the provider and registered manager told us the manager would be 'standing down' as the registered manager and taking on the catering.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of

# Summary of findings

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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 in any of the five key questions it will no longer be in special measures.

# Summary of findings

## 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.

There were not always enough staff on duty to provide care and support or to keep the home clean.

There were areas of the premises which were unsafe and furniture which was not suitable to meet people's needs.

People's medicines were not always handled and managed safely.

**Inadequate**

**Is the service effective?**
The service was not always effective.

Induction training for new staff was poor and although staff had received training, in practice some basic principles were not being applied. Some staff supervisions had taken place but were not consistent across the staff team.

People told us meals were good and we saw people were offered choice and variety.

**Requires improvement**

**Is the service caring?**
The service was not always caring.

The care records for people using the service were not kept securely which meant people's right to confidentiality was not being maintained.

People's views about the staff were mixed; some people told us some staff were nice. Some issues with the premises and some interactions between staff and people using the service showed a lack of respect.

**Requires improvement**

**Is the service responsive?**
The service was not always responsive.

Staff were not always following the advice from healthcare professionals, which left people at risk of receiving unsafe care and support.

Some activities were on offer to keep people occupied.

People's concerns and complaints were not always being recognised and dealt with effectively.

**Requires improvement**

**Is the service well-led?**
The service was not well led.

The office was disorganised and chaotic. Records were difficult to find or could not be produced.

**Inadequate**

# Summary of findings

People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. This was evidenced by issues identified at this inspection.

# Bankfield Manor Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 2 and 24 September 2015 and both visits were unannounced.

On the first day the inspection team consisted of one adult social care inspector, an inspection manager and an expert by experience in dementia care. On the second day the inspection team consisted of one adult social care inspector and another expert by experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Over the two days of our inspection we spoke with eight people who lived at Bankfield Manor, two visitors, the owner, the registered manager, two night care workers and four care workers.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included five people's care records, five staff recruitment records and records relating to the management of the service.

On this occasion we did not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all information we held about the provider.

Inadequate

# Is the service safe?

## Our findings

When we inspected the service in January 2015 we found the provider did not have suitable arrangements in place to make sure medicines were managed safely. We asked them to send us an action plan telling what action they were going to take. In the action plan we received dated 4 May 2015 the provider told us they would be compliant with regulation 12 by 30 May 2015.

When we arrived at the service at 7am on 2 September 2015 we saw the keys to the medication trolley, along with other keys, had been left on top of the trolley. We saw throughout our visit the keys were either left on top of the trolley or on one of the dining tables. We looked at the medication policy which stated, 'The keys to the medication storage area will be controlled by the designated person on each shift. The keys will be kept on the person at all times and handed to the next person in a formal handover procedure. Medication storage keys must be kept separate from any other keys.' Staff were not following the procedure and anyone could have opened the medicines trolley and accessed its contents.

On the second day of the inspection we noted the keys to the medication cabinet were still on a bunch of keys, which were passed between various members of staff. This meant there were a number of people who could access medicines in the home who were not authorised to do so.

We looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We observed the morning medicines being administered and saw the senior care worker stayed with people until they had taken their medicines. However, no explanation was given about what the medicines were for.

We looked at the medication administration records (MAR) we saw two people were taking medication which needed to be taken 30-60 minutes before food in the mornings. We saw this was not being done and all of the breakfast time medicines were given at the same time. We spoke to the senior care worker about this. They told us they knew another medicine needed to be given before breakfast but they were not aware about the instructions for the medicine we identified, even though it was clearly specified on the MAR.

We saw people had been prescribed various creams and lotions. There were no details or body maps to show staff where these needed to be applied and staff were not completing the MAR to show these had been applied as prescribed.

We saw on the MAR staff were not always booking in the amounts of medication received. This meant a clear audit trail of medicines could not be maintained.

We looked at some MAR's with the provider. We saw one person had been supplied with 21 antibiotics 22 had been signed for as being given. The same person had been prescribed Paracetamol. We checked the stock balance and found there were two tablets missing.

This meant medicines were not being stored safely and there was no assurance people were receiving their medication as prescribed by their doctor.

**This breached Regulation 12 (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Since our inspection in January 2015 the provider had purchased a new cabinet for the storage of controlled drugs. We checked the balances of medicines held and found they balanced with the amounts documented in the controlled drugs register.

The accommodation at Bankfield Manor was arranged over two floors there was a passenger lift in the older part of the home and a stair lift in the other part of the building. The lounges and dining area were all on the ground floor.

We looked around the building and found areas which were unsafe. In one en-suite toilet we saw the door to the electric fuse box was open. We asked a care worker about this and they told us they had noticed this the previous day. We asked them to get the handy person to secure the door whilst we were in the room and this was done. In the same bedroom we saw the emergency call bell was at the opposite side of the room from the bed. This meant the person occupying this room did not have access to the call bell. We saw there was a sensor mat in place which set the emergency alarm off to alert staff if the person was getting out of bed, so they could respond quickly and try and prevent the person falling. However, when we tested this we found it only worked if you stepped on one end of the mat. This meant it may not have been effective in alerting staff if the person got up.

Inadequate

# Is the service safe?

We saw the easy chairs and sofas were all very low. We saw one person, who was tall, sit on one sofa and then was unable to get up without assistance from staff. This was because the sofa was too low for them.

There were no locks on the ground floor bathroom door or the adjacent toilet door. We also found the lock on the toilet door on the first floor did not work. This meant people could not use these facilities and be assured of their privacy.

On the first floor corridor we found the cupboard which housed the hot water tank was unlocked. This meant if someone opened the door and touched the tank there was a risk of them being hurt.

The standards in bedrooms was variable, some were very personal and others were very bare. The lighting levels in some rooms was poor. People living with dementia or deteriorating eye sight need good lighting levels, poorly illuminated areas could increase the risk of people falling.

On the second day of the inspection the expert by experience sat on a dining room chair, the arm came off and the exposed screw ripped the expert's trousers. This piece of furniture was unsafe and could have cause someone using the service an injury.

There was no 'master key' system to allow care workers to access people's bedrooms quickly. We saw it took staff some considerable time to access some of the bedrooms. If someone using the service chose to have their door locked and then needed assistance in an emergency the issue with the keys could mean a delay in staff responding.

In one toilet we saw the freestanding over toilet frame was unstable as one of the legs was shorter than the other three. This meant if any one had sat on the frame it would not have been stable and could have posed a risk of them falling off the seat. When we spoke to the provider and senior carer about this, the senior carer told us they had been cleaning that morning and had taken the frame out of use.

We asked to see the electrical installation certificate, gas safety certificate, small electrical appliance test records and the safety reports for the hoists, lift and stair lift. None of these could be located on the first day of our visit. Following the first day of the inspection the provider sent us copies of some of the certificates. They told us the registered manager could not find the safety reports for the hoist, lift and stair lift and they were going to ask the company who provided the servicing for duplicate copies. When we returned to complete the inspection on 24 September 2015 these certificates were still not available. This meant there was no assurance the lift, stair lift and hoists were in safe working order. We asked the provider about this and they made arrangements the same day for the equipment to be tested and sent us the up to date certificates the following day.

**This breached Regulation 12 (d) & (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

On the first day of the inspection we found there were no designated cleaning staff; care workers were cleaning in between delivering personal care. We found areas of the home which were not clean. The toilet on the ground floor had faeces in the toilet pan, on the skirting board, wall and light pull cord. There was dust on top of the paper towel dispenser and the 'push down' taps did not stay on long enough to allow people to wash their hands effectively. In the shower room the shower chair was dirty and the soap holder was rusty.

The expert by experience sat on a chair in the lounge which was wet with urine and we found other chairs which smelt of stale urine.

In one bedroom we found the mattress smelt of stale urine, there was faeces in the toilet and a lot of dust on top of the wardrobe. On the second day of the inspection we noted two mattresses smelt of stale urine. The provider told us they had completed a mattress audit the previous day, however, agreed they would not sleep in one of the beds we showed them.

We saw there was a notice on the kitchen wall which stated; 'Anyone entering the kitchen must wear a disposable apron, wash their hands and wear disposable gloves.' We saw both members of night staff go into the kitchen and they did not wear an apron or gloves. We saw one of them wash their hands but there were no paper towels in the dispensor, so they had to go and get more.

On the second day of the inspection we saw three clinical waste bins were in use. In all three we saw incontinence products had been disposed of without being put into a bag first. These bins smelt heavily of stale urine. We looked at the infection control policy and saw there was no guidance for staff regarding disposal of incontinence

products. We asked the provider and registered manager how staff should be disposing of these and both told us they should put the soiled product into a bag prior to disposal. When we told the registered manager what we had found they said, “I wondered why the stocks of bags in the cellar were not going down.” This meant infection prevention procedures were not being followed.

We looked at the infection control policy which clearly stated staff should only wear a wedding ring and should have their hair tied back. We saw staff were wearing rings with stones in and with loose hair. This meant staff were not adhering to the policy and potentially increasing the risk of spreading infection.

On the second day of inspection we found a domestic had been recruited and there had been some improvements in the cleanliness of the home, however, we found the metal rails on one bed were dusty, mirrors and windows which were smeared and toilets which were dirty.

**This breached Regulation 12 (h) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Before our inspection we had received concerns from the local authority about staffing levels at the service. The provider had met with the local authority contracts staff on 1 September 2015 and agreed to increase the staffing levels. On the morning of our visit we met two night care workers. They explained prior to the 1 September 2015 there had been one waking member of night staff and another who slept at the service, who could be woken up to give assistance to people using the service if needed. The registered manager told us the night staffing cover had been reduced on 20 August 2015 from two waking night staff to one waking and one sleeping because of the reduced numbers of people living at the home.

People using the service told us, "There isn't always someone around to help." Another person said, "There'd be enough of them if they concentrated on what they're supposed to do. They've no time to talk to you - it's as if you're not there. You can't get hold of anyone at night time and weekends vary, it depends who's on." A third person said, "There's always someone to help if needed. You've got to be patient though. It depends on how busy they are but I've not noticed if there are particular times when you wait longer."

One staff member told us the service would not pass ‘the mum test’ (would I let my relative live here?) due to staffing levels on days and nights and the lack of kitchen and domestic staff as this had an impact on the experience of people who used the service.

We looked at the duty rota’s from 30 July 2015 to 1 September 2015 and saw during this period there was no cook or domestic staff on duty. The registered manager and care workers had been undertaking the cooking which only left two care workers on duty throughout the day to care for people and do the cleaning. We saw on two occasions there were only two staff on duty to deliver personal care and support, cook and clean for all 10 people using the service. Given the number of people and the design and layout of the building two members of staff were not enough to ensure people’s safety.

On the first day of our visit the registered manager was cooking breakfast and lunch, there was a senior care worker on duty and two care staff. Staff told us it was unusual to have so many staff on duty. We saw staff were given no clear direction about what they should be doing. For example, one was asked to go and wash up after lunch but someone else was already doing it.

One person using the service told us, “I would like to get around a bit more but there are not enough staff to push me in my wheelchair and if I do manage to go to the lounge in my chair they leave me too long and I am uncomfortable.” One relative told us, “The staff can cope with an emergency but there is not enough staff most of the time.”

We saw there were times during our visit when no staff were available in the communal areas to offer people guidance and support. For example, on the first day of our visit the expert by experience was talking with a relative in the lounge. One person who used the service was walking around the lounge. The expert by experience noticed they looked unwell and became unsteady. The expert supported them until care workers responded to the emergency call bell. Without the expert by experiences intervention the person would have fallen to the floor. There were no staff supervising the lounge or providing support to this person.

On the second day of our visit we arrived at 8am and the registered manager was on duty with a member of night staff, who had started work at 8pm the previous evening

and was working until 10am, a 14 hour shift. An agency member of care staff had been booked but was late, the agency care worker arrived as did two other care workers. The registered manager was once again cooking.

We saw between our two visits a cook had been recruited and started work and left after approximately a week.

We looked at the duty rotas from our last visit on 2 September 2015 to 23 September 2015. The rota's showed shifts where the registered manager and/or senior care worker had been on shift with only one or two other care workers and no cook. We asked the provider about this who told us there had been no shortage of staff since our last visit. However, this could not be confirmed by the rota.

The provider told us and us the duty rota's were not accurately reflecting which staff had been on duty or in what capacity. This meant the provider could not demonstrate adequate staffing arrangements were in place.

**This breached Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We checked recruitment procedures for five staff. We saw a recruitment checklist had been completed for one member of staff. The files we looked at contained evidence that pre-employment checks had been completed. This included disclosure and barring checks, references and checks of identity; however, there was no record of interviews in two of the five files. This meant it was not possible to see what had been discussed and how the decision to appoint the individuals had been made.

People who used the service told us they felt safe. One person said, "Yes, I feel safe here. There are one or two who can be noisy or screaming but they can't help it. I've been one of them." A another person told us, "I like living here and I do feel safe. I've never seen anything worrying or frightening." A third person said, "You're safe here. There's been one or two (people) who you're careful of but it can't be helped, you just watch it."

Staff we spoke with told us they had not seen any abusive practice but knew how to report any concerns. We saw from the training matrix staff had completed safeguarding training. We had received notifications from the registered manager when they have made referrals to the safeguarding team, for their consideration. This meant staff understood how to keep people safe and how to report any concerns to outside agencies to ensure people's safety.

Requires improvement

# Is the service effective?

## Our findings

We spoke with a newer care worker who confirmed they did not have any induction training when they started working at the service. They started on day shifts and were shown policies and procedures regarding fire and confidentiality. They worked three shifts on days before changing to nights. This meant the registered manager had not made sure they were fully equipped to undertake the role as a night care worker.

The provider told us the training matrix was not up to date and updated this record during our visit. Prior to our inspection the local authority had shared concerns that staff who were preparing food in the absence of a cook did not have up to date food hygiene training. The provider told us staff had completed training since this had been identified as a need by the local authority.

One care worker told us they had supervision, "In the first few days" but had not received any formal supervision or attended a staff meeting since. This meant they had not had opportunity to review their performance or learning needs.

We saw from records that one member of staff had an appraisal where they had raised concerns regarding a lack of support from other staff. They had also requested additional training in relation to dementia awareness and catheter care.

The registered manager had commenced supervision for some staff. Where this had taken place we saw the supervision included an observation of the staff member's practice. This allowed the registered manager to review work practices with staff in order to identify any learning or satisfy themselves staff were working to the required standards.

In the records of one staff member's interview notes we noted the staff member had stated they had felt under trained in their previous role. We spoke with the staff member who confirmed they had a limited induction consisting of policies and procedures. They told us they had completed Social Care TV on COSHH and food hygiene since commencing in post. Although they told us they had recent training in the Mental Capacity Act and dementia awareness in their previous role they had not been asked to provide evidence of this.

We saw one member of staff was recorded as completing eight training courses on Social Care TV in one day. This raised questions about the depth and effectiveness of the training completed.

We saw from the training matrix staff had undertaken infection control training, however, as we found issues around infection prevention it was questionable how effective this training was if staff did not understand the need to 'double bag' incontinence products or to wear protective aprons in the kitchen.

**This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

When we inspected the service in January 2015 we found the provider did not have suitable arrangements in place for acting in accordance with the Mental Capacity Act 2005. We asked them to send us an action plan telling what action they were going to take. In the action plan we received the provider told us they would be compliant with regulation 11 by 30 May 2015.

On this inspection we found where people lacked capacity to make decisions there were best interest decisions recorded in their care records in relation to their care plan. However, we found in one person's records the assessment had another person's name recorded that had been crossed out and the person's name added. This raised doubts regarding the process being followed fully with the person.

We saw there was a coded lock on the front door and people's bedroom doors were kept locked. This meant for a number of people they were dependent upon staff to open their bedroom doors for them and could not access their bedrooms without a staff member.

We spoke with staff about how they would support a person who was resistive to personal care. One staff member told us they would explain to the person that they needed support with personal care. If they refused they would seek support from another member of staff. They told us if the person continued to refuse they would explain it was in their best interest and deliver the personal care.

We noted one person refused to follow medical advice regarding their diet. A risk assessment was in place to help staff manage this and support the person to make an unwise choice.

Requires improvement

# Is the service effective?

Where people's liberty was restricted in order to keep them safe action had not always been taken to manage this lawfully. We saw an copy of an urgent Deprivation of Liberty Safeguards (DoLS) authorisation for one person had lapsed but could not find evidence a standard authorisation request had been submitted to the local authority.

We saw one person had a DNACPR. This recorded the decision had been made with the person who had capacity to make the decision.

**This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager told us there was always enough food for people. As there was no cook the manager completed the cooking on both days of the inspection at all mealtimes. We saw fresh fruit and vegetables were included in the menus with fruit offered with morning drinks.

The registered manager explained the service used a three week menu but this did not change to reflect seasonal changes or people's preferences. The registered manager told us, "I haven't had any input in these menus and I think they need reviewing." The registered manager told us they thought food was a great source of pleasure for people and they did home baking for special occasions. However, we found the majority of food such as savoury pies and cakes was shop bought. On the first day of the inspection the manager did not cook the food that was on the menu. This meant the provider could not assure themselves people were receiving a planned balanced diet that offered the appropriate nutrition to people.

One visitor told us, "When my relative first came in here they put a lot of weight on because they were given too much carbohydrates and not enough fruit and vegetables so I told the manager and now their diet is much better". Another relative said, "Snacks are available all the time."

The registered manager told us about people's dietary needs related to their health and advised there was nobody who needed a menu that reflected their religious needs or lifestyle choices. The registered manager told us they routinely enriched the food to support people to maintain their weight; they also explained the support they provided to one person who lost their appetite when they became anxious, explaining the alternatives they offered to entice the person to eat.

We found some food items in the pantry were out of date; this included tea cakes, malt loaf and scones.

During the morning we saw staff asking people what they would like for their lunch. No menu was on display and they were no pictures of meals available to assist people living with dementia to make an informed choice.

We observed the lunchtime meal. The dining room was not prepared for lunch in advance to provide people living with dementia with visual cues that a mealtime was approaching. Tables were set at the point of meal service with tablecloths and cutlery but people were not provided with cruet sets or condiments to help themselves. Although we saw some people were provided with dementia friendly cutlery and crockery we found they were not always supported appropriately to eat their food. We saw one person was using their fork to dip into their orange juice and were then sprinkling this on their food. When the staff member who was sitting adjacent to the person noticed this they removed their fork and asked another member of staff to provide a new one. During the time the person waited for a new fork they attempted to eat their meal with a knife. Again this was not observed by staff.

We saw from daily records that where changes in people's conditions were noted medical assistance was sought. We noted the involvement of GPs, District Nurses, dentists, opticians, chiropodists and QUEST matrons. We saw the person who had been unwell on the first day of our inspection had been seen subsequently by the GP and district nurse.

Requires improvement

# Is the service caring?

## Our findings

On arrival on the first day of our inspection we found a metal cupboard in the bottom lounge unlocked and all client records were accessible. This continued throughout the course of the inspection. The cupboard remained accessible to anybody. We saw records about people using the service were left on one of the dining tables and heard the registered manager discussing people in front of people who used the service when they were getting handover information. On the second day of the inspection the same cupboard was unlocked and again records about people using the service had been left on one of the dining tables. This meant people's right to confidentiality was not being maintained.

On reviewing people's care records we found gaps in assessments and care plans related to social history and relationships and emotional well-being. These aspects of a person's life are crucial to staff understanding the person's values and preferences, particularly where a person is living with dementia and requires support to maintain their preferred lifestyle choices and relationships.

**This breached Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We noted three toilets that did not have a lockable door. This meant people could not be assured of their privacy when using the toilet. We also found the toilets were soiled both inside and outside the bowl and were not pleasant to use. This compromised people's dignity.

During the course of the afternoon, on the first day of the inspection, it became apparent that one person was unwell. We asked staff to intervene as we were concerned for their welfare. We asked a staff member of they could be supported to bed and were told the person was not allowed to go to bed during the day as they would not sleep at night. The person was subsequently supported to their room.

On the second day of the inspection when we arrived we saw one person sitting in a very uncomfortable position, with their arm hanging down the side of the armchair. We brought this to the attention of the registered manager, who was in the dining room at the time. They came over and spoke about the person to us in an inappropriate and childish way. We also noted they used the same inappropriate language with another person using the service.

When one of the experts by experience was talking with people the registered manager stepped in to fill in the "blanks" that they felt people had forgotten in some of the discussions. Although the registered manager was trying to be helpful, this again was inappropriate and showed a lack of respect for people.

**This breached Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

When discussing staff one person we spoke with told us, "They are all good." Another person said, "Some (staff) are nice." A third person said, "They're OK, I'm alright with them and they're alright with me." And a fourth said, "They don't seem to want to bother. They're no good for people who can't move themselves. One or two are good but the rest - there's no difference between agency and regular staff. It's no good ringing bells, no one comes."

On both days of the inspection we saw some very positive interactions between people using the service and care workers. For example, we heard one care worker talking to someone about their family. They gave the person plenty of time to answer the questions and clearly knew a lot about them. One care worker we spoke with was able to tell us about people's life histories and told us how they used the information to engage people in conversation. We saw staff spending time with each person trying to engage them in an activity or in conversation.

People told us their relatives and friends could visit at any time.

Requires improvement

# Is the service responsive?

## Our findings

Care records did not always accurately reflect people's needs or the advice of professionals. We saw the care records for one person who required the support of two staff following an accident contained a risk assessment completed by the registered manager dated 21 August 2015 that showed the person should be supported on a one to one basis. This contradicted the written advice of a QUEST Matron from the same date that stated they needed the support of two staff. We raised this with the manager and provider who told us the registered manager had become confused regarding the person's needs.

On the second day of the inspection we saw this person sitting on a sofa on a pressure relieving cushion, the sofa seat cushion had been removed. We saw the person struggled to stand with the assistance of two care workers. We asked the deputy manager about this who told us the individual had been see by the physiotherapist and should be sat in an armchair. Before lunch we saw this person sitting in an armchair with a seat cushion and a pressure relieving cushion. We noted when they needed to stand this was much easier for them. In the afternoon we saw staff were going to sit them in an armchair minus the seat cushion. This would have meant the chair would have been too low for them to stand with minimal assistance. The inspector intervened and the seat cushion was put in place. We looked in their care plan and saw the advice from the physiotherapist but there had been no clear plan put in place for staff to follow to make sure the person was using the correct seating.

In another person's records we saw their continence care plan referred to them having a urinary catheter in situ and included guidance on supporting the person with this. The care plan had not been amended despite the person no longer using a catheter and requiring support with an alternative continence aid.

**This breached Regulation 12 (a) & (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

When we inspected the service in January 2015 we found the provider did not have an effective system in place for identifying, receiving, handling and responding to complaints. We asked them to send us an action plan telling what action they were going to take. In the action plan we received dated 4 May 2015 the provider told us they were already complaint with regulation 16.

We spoke with people who used the service and they were not aware of a process to make complaints. One person told us, "I don't know about complaining but I can't complain about the staff." Another said, "I don't know about anything formal but I don't take anything (from anyone) - I get up and tell 'em." A third person said, "No information is given out. I've asked how to make a complaint for theft. Nobody does anything."

We asked to see the complaints log, which could not be produced. On the second day of the inspection the registered manager gave us details of one complaint they had received about the heating system. This showed what action they had taken to resolve the complaint. We asked the registered manager if they were recording low level concerns so they could identify if there were any common themes or trends. They told us low level concerns tended to be dealt with straight away and were not recorded.

We spoke with one person who used the service who identified a number of things they were not happy about. None of these concerns had been logged or dealt with through the care planning process to show how staff were addressing the areas they were unhappy about. For example, they told us they would like to go out, but there were not enough staff to facilitate this. This meant staff were not recognising and dealing effectively with people's concerns and complaints.

**This breached Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

On reviewing daily records for eight people from 24 August – 2 September 2015 (a period of nine days) we found two people had not had a bath or a shower recorded.

Staff we spoke with told us day staff completed showers on an evening and decided who needed to be showered based on the last recorded dates. This meant people were not supported to bathe or shower in accordance with their preferences.

Requires improvement

# Is the service responsive?

We asked people using the service if they had been involved in developing and reviewing their care plan. No-one had heard of a care plan and no ne could recall being asked for their opinion or views about living in the home.

Care staff told us they did not have any input in creating or reviewing care plans as this was done by the manager and deputy manager. This meant staff were not knowledgeable about care plans and relied on daily notes and handovers.

In one person's care records we saw reference to their religious practice. Their assessment stated "[Name of person] used to go to church but she does not go any more as she said it is a long way to go. [Name] would like to see a priest if she ever became terminally ill." Staff we spoke with told us there was no provision at the service for visiting clergy. This meant that efforts had not been made to support people to meet their religious and spiritual needs.

The environment did not support the cognition and promote the independence of people living with dementia. A notice board in the dining room remained blank throughout our visit. Bedroom doors were numbered but did not have people's names or visual aids to support people to recognise their own bedroom. There was no signage to prompt people to find their way to the toilet or other areas of the service.

On the first day of our visit a care worker was doing a jigsaw with someone who used the service but the jigsaw was too hard for the person and the member of staff. On the second day of our visit the jigsaw was produced again, but quickly put away as it was not appropriate.

On the second day of our visit, there was a much more relaxed atmosphere and we saw staff spending time with each individual person talking with them or engaging them with books or a variety of objects. In the afternoon the registered manager was engaging people in a reminiscence session, which people enjoyed. However, we did see the TV was put on with no reference to people using the service. No one was asked if they wanted it on or what they might like to watch.

Inadequate

# Is the service well-led?

## Our findings

When we inspected the service in January 2015 we found the provider did not have suitable arrangements in place to regularly assess and monitor the quality of the service provided and to identify, assess and manage risks. We asked the provider to send us an action plan telling us what action they were going to take. In the action plan we received dated 4 May 2015 the provider told us they had already taken action and were now compliant with regulation 17 good governance.

On this inspection we found policies and procedures were out of date, there were no effective systems in place to monitor the service or to identify improvements which needed to be made. Records we asked for were not readily available or did not exist and the office was disorganised and chaotic. We saw from the providers report dated 5 August 2015 they had noted the office was in a 'big mess' and had asked the registered manager to ensure it was tidied up in the next few days. This had not happened.

There was a lack of leadership in the service. When we inspected the service in January 2015 the registered manager had only just started working at the service. Since then they have registered with the CQC. The registered manager was cooking on the first morning of the inspection staff had been given no clear direction about what was expected of them and this added to the overall chaotic and disorganised atmosphere. One member of staff told us, "There is no professionalism by the management, no one knows what they are doing. Everyone is trying too hard today because CQC are here. The senior staff speak down to you, the owner knows what they are doing but they are not here much."

The provider told us they had reviewed the management support at the home the previous day and would be spending one day a week at Bankfield Manor with immediate effect. They told us they were doing this as they had identified shortfalls at the service and felt they were under scrutiny from the local authority.

On the second day of the inspection the provider told us the registered manager would be 'standing down' and was going to take over the catering. The registered manager confirmed this and said they would be de-registering with CQC. The provider told us the deputy manager would be applying for registration as the manager.

We looked at the quality assurance policy which stated, "Auditing plays a very important role in achieving and maintain quality standards." We saw the range of audits the provider had introduced in January 2015 were being used, however, we found they were not effective in picking up a range of issues. These were some examples:

An environmental audit had been completed in July 2015, but this had failed to pick up three toilet doors could not be locked. As doors could not be locked this compromised people's dignity. It also failed to identify the one bedroom door that could be locked from the inside preventing any staff access in an emergency.

We looked at the accidents and incidents analysis. We saw the registered manager was listing all of the accidents each month, however, no analysis was taking place to try and identify and themes or trends. We saw there had been three un-witnessed falls and one un-witnessed injury over a three week period in June/July 2015. The registered manager had not looked at these to see what measures they could put in place to mitigate these risks.

We saw from the care records one person had broken their leg and arm but could find no accident form or investigation into the incident. The registered manager told us they were on holiday at the time. The provider told us they did not think an accident form had been completed but they had referred the incident to safeguarding. This meant nothing had been put in place to try and find out how these injuries happened or measures put in place to stop the same thing happening again.

We saw from the provider's report dated 5 August 2015 a medication audit had only been carried out for one person and they had asked the registered manager to carry out audits for everyone. This had not been done, therefore, there was no mechanism to pick up the issues we identified about medicines being given at the wrong time and medication records not being maintained in line with the services policy.

We looked at the statement of purpose for the service. This is a document the provider produces which sets out the philosophy of the service and what it would provide. We saw it stated staff meetings would be held every two months. Staff told us there were no staff meetings. We asked for the staff meeting minutes and saw the last meeting had taken place in April 2015. This meeting had been for the night staff and six people attended, of these

Inadequate

# Is the service well-led?

only three remained working at the service. This meeting had been mostly about cleaning and working practices. When we spoke with staff we found, individually, some had good ideas about how the service could be improved, however, there was no sense of the same vision and values of the service being shared by everyone.

We saw in April 2014 people using the service had been asked for their views about the activities on offer and in August 2015 they had been asked for their views about meals. The expert by experience spoke with people about the activities they had identified on the surveys. No one responded with the same things which were on the survey. For example, one person had been identified as loving singing said, "Singing - I can't sing. I like Bingo. I think we did it once." This meant the surveys were not accurately reflecting people's interests.

**This breached Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Service users were not provided with care and treatment in a safe way as the management of medicines was not safe and proper; premises were not safe, equipment in use was not always safe and the risks in relation to the spread of infection were not assessed, prevented, detected or controlled. Regulation 12 (2) (a) (b) (d) (e) (g) & (h). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>Systems for identifying, receiving, investigating, recording, handling and responding to complaints were not effective.<br><br>Regulation 16 (1) (2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems and processes were not established or operated effectively to assess, monitor and improve the quality of |

This section is primarily information for the provider

# Enforcement actions

the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.

The provider did not act on the feedback they received from relevant persons.

Regulation 17 (1) (2) (a) (b) (c) (e).

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>Service users were not always treated with dignity and respect.<br><br>Regulation 10 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Service users were not protected from being deprived of their liberty.<br><br>Regulation 13 (5) |