Esteem Care Ltd

Banksfield Nursing Home

Inspection report

20 Banksfield Avenue
Fulwood
Preston
Lancashire
PR2 3RN

Tel: 01772733001
Website: www.banksfieldnursing.co.uk

Date of inspection visit:
25 September 2018
28 September 2018

Date of publication:
26 March 2019

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 25 and 28 September 2018. The first day of the inspection was unannounced. We informed the registered manager that we would be returning on the second day of the inspection. 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.

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

Banksfield Nursing Home is a detached, two storey, purpose built care home registered to provide Nursing and Residential Care to a maximum of 42 service users. The service consists of a 20-bedded unit on the ground floor, providing general nursing and residential care to male and female service users. On the first floor, nursing and personal care is provided to a maximum of 22 people who live with dementia.

There were 39 people who lived at the service at the time of the inspection.

During this inspection we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safeguarding service users from abuse and improper treatment, safe care and treatment, staffing, need for consent, meeting nutritional and hydration needs, person centred care and good governance. We also found one breach of the Care Quality Commission (Registration) Regulations 2009, in relation to notification of other incidents.

Our last inspection of Banksfield Nursing Home was carried out on 8 December 2015. At that time we rated the service as overall 'good' with the effective domain being 'requires improvement'. There were no breaches of the regulations at that time. At this inspection the rating had deteriorated to overall 'requires improvement'.

This is the first time the service has been rated Requires Improvement.

You can see what action we told the provider to take at the back of the full version of the report.

The service had procedures in place for dealing with allegations of abuse and showed us the guidelines they followed from Lancashire County Council when they make a judgement in relation to raising a safeguarding alert. However, we found two incidents that had not been referred to the local authority in line with the providers policy for safeguarding.
We observed staff undertake unsafe practice in relation to dealing with behaviours that challenge and when we looked at the staff training matrix we saw that staff had not received suitable training to ensure that they

could meet the needs of people who lived with dementia.

Staff told us that they felt confident to whistle-blow and we observed the management team engage with staff, people who lived at the service and visitors across both days of the inspection.

We looked at people's care records and found inconsistencies in how the service managed individuals' risk. For example, people at risk of choking were not always suitably risk assessed and this meant that people's personal safety was compromised.

We looked at the care records for a person who lived on the dementia care unit and found they had not been suitably assessed and care plans had not been completed to show the support they required. This placed the person at risk of receiving inadequate and unsafe care. We found that the providers admission procedure was not always fully carried out, one person had not been suitably risk assessed and care plans had not been formulated to reflect what care and support they required 13 days after they were admitted.

We found that medicine management was good in relation to stock control and recording when a person had been administered their medicines. We observed safe medicine administration. However, we found shortfalls in the way the service maintained records for 'as and when required' medicines and topical treatments.

We made a recommendation about how the service calculates its staffing levels in relation to people's dependency assessments.

We found four bedrooms on the dementia care unit were particularly cool and the heating system was not turned on. Some people who lived on the dementia care unit appeared cold and had not been provided with duvets, we found them in bed with a thin sheet or thin fleece blanket. At 8.00am we informed the deputy manager who took immediate action to provide all people with suitable bedding. Maintenance checks were undertaken during the first day of the inspection to turn on radiators. We found that this issue was isolated to the dementia care unit.

We found that maintenance work around the service had not been always been planned or completed. For example: there were holes in two bedroom walls, a toilet in a locked store cupboard that had not been disconnected and this meant that it collected stagnant water, we found a sharp screw in a person's bedroom furniture that meant the person was at risk of injury and several fire doors that did not fully close. The registered manager took immediate steps to rectify the issues we found.

We analysed training statistics for the service and found gaps in compliance for training courses the provider stipulated should be mandatory. For example, only two employed nurses [one being the registered manager] had undertaken first aid training in the previous 12 months and no other staff members had undertaken first aid training. This meant that staff had not received adequate training to ensure that people were provided safe and correct care in the event of an accident/injury.

During the course of our inspection we looked at the personnel records for three members of staff. We found that staff were safely recruited and checks were undertaken before they started to work at the service. Staff were inducted inline with the providers induction policy.

At this inspection we found staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not sufficient and this had lead to inappropriate restrictive practices. For example, we found that one person used restrictive seating (a bean bag) and this had not been considered in line with

the MCA. The same person was given covert medicines and again the service had failed to assess the person to ensure that their rights were not infringed upon.
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice

We undertook a Short Observation Framework For Inspection [SOFI] during lunch time meal service on the dementia care unit, this allowed us to observe the care provided and to help us understand the experience of people who used the service who could not talk with us. We found that people were not always assisted in a person-centred way and this meant that they did not always receive a nutritious meal because of the lack of assistance. We received positive feedback from people who lived at the service about the meals provided and observed a better standard of dining on the general nursing unit.

People were assessed on an individual basis against the risk of malnutrition and nutrition care planning was undertaken, however we found significant shortfalls in the accuracy of nutrition planning.

People were supported to access external health care professionals. We found evidence within care records that showed people had been reviewed by multi-agency health care professionals including dentist, optician, mental health teams and podiatry. Staff told us that they understood referral pathways for external health agencies such as tissue viability and dietetic.

We found that the environment on the dementia care unit was not 'dementia friendly'. The registered manager told us that refurbishment throughout the unit had been planned.

We have made a recommendation about adaptation of the dementia care unit.

People who lived at the service and their representatives told us that they felt involved in their care and had been provided with the opportunity to read their care plans.

We found that staff approach to people who lived at the service was not consistent. We observed some positive interactions and also some instances when people's needs were not responded to.

We have made a recommendation about staff training in relation to providing specialist dementia care.

We looked at minutes for 'resident and relative' meetings and found that the registered manager held meetings on a regular basis.

We found a significant difference in the standard of care plan writing and risk management when we compared records from the general nursing unit and dementia care unit. Across the two care files we looked at on the general nursing unit we found a good standard of person centred care planning, with the exception of nutritional assessment. People's needs and preferences had been assessed thoroughly prior to admission and detailed admission assessments had been undertaken when the person arrived at the service. We also found that people's life stories, hobbies and interests had been recorded and staff understood the holistic needs of the people we pathway tracked from the general nursing unit.

When we looked at care records on the dementia care unit, we found a significant difference in the quality of care planning and saw that care plans were not always reflective of the person's current needs.

We observed people on the general nursing unit to be dressed in clean and personalised clothing. People

appeared to have been supported to maintain good personal hygiene. We found that this standard of personalised care was not always provided for people that lived on the dementia care unit, across both days of the inspection we observed people to have stained clothing, men appeared unshaven and their hair unkempt and we noticed after meal times people were not supported to maintain a good standard of personal hygiene including hand washing and face cleaning. We saw that people on the dementia care unit had unclean and long finger nails, we looked in people's care plans and they did not identify their needs and or preferences in relation to personal grooming.

We found that the service was not providing a consistent approach to providing stimulating activities, however the registered manager was aware of this and had started to request feedback from people who lived at the service to improve ways in which they provided activities.

We looked at complaints management and found that the registered manager dealt with complaints in a timely manner and maintained records.

At this inspection we found that there was a lack of consistent quality auditing and governance processes. Whilst the provider had multiple auditing systems including audits of; infection control, care planning, environment, dining experience, accidents and incidents and medicines management the systems had not picked up on the failings found at this inspection.

As part of our inspection planning we looked at routine notifications that the provider had submitted to the Commission. We found one notification had been submitted in the last 12 months in relation to serious injury. We discussed this with the registered manager and provided further information about their legal obligation to inform the Commission without delay of incidents that are reportable under Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

We looked at minutes from staff meetings and found that the registered manager organised meetings on a regular basis. We observed positive morale throughout the staff team.

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

People were exposed to abuse and improper treatment because robust systems had not been implemented to identify and address areas of risk.

Medicines management systems were not robust.

Some areas of the environment were unclean and maintenance work was immediately required to ensure people were safe and comfortable.

Staffing levels and deployment of staff appeared sufficient to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Training was not sufficient to ensure that people were cared for by trained and skilled staff.

Staff were inducted and supervised on a regular basis.

We found gaps in providers compliance with fundamentals of the Mental Capacity Act 2005 this meant that consent to care and treatment was not always appropriately obtained.

Is the service caring?

Requires Improvement

The service was not always caring.

People's representatives told us that they were provided with the opportunity to be involved in the care planning process and people were encouraged to make choices in relation to their care and support.

People's dignity was not consistently respected.

People's confidential information was stored in a secure area.

People using the service and or their representatives were invited to attend meetings with the registered manager and provider.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found some inconsistencies across the service in relation to the delivery of person centred care and planning.

Recreational activities were not always available, the manager explained how they intended to improve this part of the service.

Complaints were recorded and the manager maintained transparency with all involved.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of robust quality monitoring and auditing systems did not identify failing found at this inspection.

The registered manager and senior management team were responsive to our concerns and showed transparency throughout the inspection.

Staff felt supported in their role and were proud to work at Banksfield Nursing Home.

Statutory notifications were not always submitted in relation to notification of other incidents.

Banksfield Nursing 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 checked 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 25 and 28 September 2018 and the first day was unannounced. On the second day the service was aware we would be returning.

On the first day the inspection team consisted of two adult social care inspectors, one specialist mental health nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, the expert-by-experience had personal experience in caring for loved ones with advanced medical illness and dementia.

We used information the provider sent us in the Provider Information Return. This is the information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we received information of concerns from an anonymous source. Their concerns were in relation to staffing levels, restrictive practices, infringement on person centred care and unsafe moving and handling practices at the service. We also reviewed the information we held about the service such as notifications, complaints and safeguarding information. We obtained the views of safeguarding and contract monitoring teams and the local health and social care commissioners.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived at the service. We carried out observations in the communal areas of the service and undertook a Short Observational Framework for Inspection [SOFI] during the lunch time period on the second day of the inspection. A SOFI is a specific way of observing care to help us understand the experience of people who used the service who could not talk with us.

We carried out a pathway tracking exercise. This involved us examining the care records of people who lived

at the service closely to assess how well their needs and any risks to their safety and wellbeing were addressed. We carried out this exercise for five people who lived at the service. We also looked at a further three peoples' care records in relation to personal risk assessment.

We spoke with eight people who lived at the service and seven relatives. We received written feedback from four external professionals and reviewed the enter and view report published by Healthwatch Lancashire 01 May 2018. We also spoke with the registered manager, deputy manager, head of compliance, procurement and compliance manager, another compliance manager, five health care assistants and three registered nurses.

We looked at a sample of records including three staff files, staff rotas, training and supervision records, minutes from meetings, complaints and compliments records, medication records, maintenance records and certificates, policies and procedures and quality assurance audits.

Inadequate

Is the service safe?

Our findings

We spoke with people who lived at the service and asked them if they felt safe and they told us, "I do feel safe here." "I am very safe here." And "Yes, I can get around very easily in my wheelchair." We also asked peoples' representatives if they felt their loved ones received safe care and treatment and they told us, "Yes, it is 24-hour care and much safer environment than at home." "I am reassured to know that there are qualified staff here." And "They're safe, because it is a secure unit and if they were at home they would get out and roam."

The service had procedures in place for dealing with allegations of abuse and showed us the guidelines they followed from Lancashire County Council when they make a judgement in relation to raising a safeguarding alert. However, we found two incidents of abuse, physical altercations between people who lived at the service, that had not been referred to the local safeguarding authority and care records for the people involved had not been updated to reflect risk management and prevention plans despite physical injury being caused.

On the first day of the inspection we pathway tracked the care of a person whom resided on the dementia care unit, we saw that the person was sitting in a large bean bag and this restricted their ability to move freely. The registered manager told us that the person was at risk of falling and the bean bag had been provided to prevent falls. However, risk assessments and care planning had not been completed to show how the provider ensured that this type of restrictive seating did not deprive the person of their liberty to move freely around the service. The provider had not completed a Deprivation of Liberty Safeguards application in relation to the person being seated in the bean bag. On the second day of the inspection we saw the provider had removed the bean bags, however a risk assessment and care plan in relation to maintaining the person's safety had not been updated to reflect effective risk management and mitigation.

On the second day of the inspection we observed two people who lived on the dementia care unit have a physical altercation, we saw that staff who intervened did not follow safe and correct behaviour management techniques and this meant that one of the people were physically restrained before any other less restrictive practices were considered. We asked the registered manager to refer the incident to the local safeguarding authority because it was evident that the incident was not dealt with in a safe way due to a lack of staff understanding in relation to behaviour management.

We looked at staff training records and found 70% of staff had undertaken training in safeguarding, 24% of staff had undertaken training in physical restraint and none of the staff had been trained in dealing with behaviours that challenge. This meant the provider did not ensure that staff were suitably trained to protect people who used the service from abuse and improper treatment.

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

We asked staff if they felt confident in making safeguarding alerts and if they understood the importance of

whistle-blowing. Staff told us, "I would not hesitate to report it if I felt someone was being abused." "I would feel confident to use the whistle-blowing policy. I make sure the care staff know how to raise a safeguarding concern." And "I am aware of the whistle-blowing procedure."

People's needs were not always risk assessed against avoidable harm and injury. Care records showed general risk assessments were completed, however person-centred risk assessment had not always been undertaken. For example, when a person was at risk of choking, skin break down and falls. This placed people at significant risk of harm.

We found four people were at risk of choking due to not being provided foods that were safe and inline with the recorded guidelines issued by external speech and language professionals (health professionals responsible for assessing a person's ability to swallow). For example, care records showed one person was being provided foods such as fish fingers and chips despite their hospital discharge record specifying that the person was at risk of choking and therefore required a puree consistency diet and thickened fluids. The person did not receive thickened fluids and this placed them at risk of aspiration. The registered manager assured us that immediate action would be taken to mitigate such risks on the first day of inspection and agreed to raise a safeguarding alert for people identified to have been given foods that placed them at risk of choking, however on the second day of the inspection we found that despite choking risk assessments being completed people were still receiving foods that placed them at risk.

We looked at care records for a second person that resided on the dementia care unit and found that risk assessments had been completed however did not reflect the persons' actual needs. For example, the person was seated in a bean bag for long periods of time and their moving/handling and skin integrity risk assessment did not reflect the potential impact of restrictive seating. The same person was being given medication in a covert manner and despite the provider having protocols in place for the safe assessment and administration of covert medicines this was not followed. This placed the person at significant risk of harm.

We found that a person had been admitted to the dementia care unit 13 days before our inspection and their needs had not been fully assessed. This meant that the provider could not evidence how they would provide the person with appropriate and safe care. A body map had been completed on admission and showed significant bruising to the persons' arms and this had not been risk assessed, care planned or reviewed. The person had also fallen and no care planning had been undertaken to show how the service would prevent further falls and potential injury.

We looked at staff training records in relation to clinical competency and how registered nurses were provided clinical training to maintain their skills and knowledge to provide safe care and treatment. Training records showed low compliance statistics for example, 0% catheterisation, 40% venepuncture, 48% pressure area care, 10% first aid and 33% nutrition.

On the second day of the inspection we looked at medicines management. We found that day to day completion of the medication administration records [MARs] we looked at had been completed without error, however not all medicine recording systems were robust. For example, some people were prescribed topical medicines to be applied to the skin, creams and ointments. Topical MARs and body maps were not always in place to guide staff when and how to apply these creams. We also found several creams in the treatment room with expired usage dates.

We looked at the information available for as and when required medicines (PRN) and found a lack of detail for people who were not able to reliably communicate. For example, one person was prescribed a sedative

and the PRN record showed 'for agitation'. No further detail was available and this would not facilitate a safe, correct and consistent way for the administration of such medicine. Another person was prescribed PRN pain relief, the PRN record showed 'for pain' with no further detail or pain assessment prior to administration.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found other areas of medicine management showed a good level of compliance in relation to meeting the service policies and procedures. The registered manager maintained records of errors and lessons learned and weekly auditing was undertaken. Medicines we looked at were in stock and stored in a safe way. Each unit had a designated treatment room and room temperatures were taken to ensure that medicines were stored at a safe temperature. We checked how controlled medicines were stored and monitored. We found accurate recording and safe procedures in relation to the storage and administration of controlled medicines. We observed the administration of medicines across both days of inspection and saw that registered nurses maintained safe and hygienic administration techniques.

We found that staff recruitment was safe and staff were supported throughout their induction process. We asked people who lived at the service and, or their representatives if they were happy with the staffing levels and response times when people wanted to summon assistance. We received mixed feedback. People told us, "I just tell staff that I want to go out for a smoke and they come and take me." "Staff are not always available during shift change over." "It isn't easy to use the call bell." "My relative wouldn't know how to use the call bell." "There is enough staff, they are very prompt and attentive." "Staffing levels are normally good apart from it is quieter at weekends." And "Staffing depends on breaks, if they say they need changing, they may have to wait for someone to come back onto the floor first."

We observed people be responded to in a timely manner and nurse call bells were available for people able to use them. Across the two days of inspection we did not observe anyone have to wait when they requested support and the service appeared to be suitably staffed.

Staff told us, "People get the care they need." And "We all work together as a team. I have no concerns. People are well looked after."

The registered manager explained that staffing levels were based on the outcome from individual's dependency assessment scores, however we found that the dependency scoring system was flawed for some people who lived at the service due to inaccurate recording.

We recommend that dependency assessments are recalculated following reassessment of people's needs and that staffing levels are subsequently checked.

We arrived at the service at 7.30am on the first day of the inspection and undertook a tour of the building. We found four bedrooms on the dementia care unit were particularly cool and the heating system was not turned on. Some people who lived on the dementia care unit appeared cold and had not been provided with duvets, we found them in bed with a thin sheet or thin fleece blanket. At 8.00am we informed the deputy manager who took immediate action to provide all people with suitable bedding. Maintenance checks were undertaken during the first day of the inspection to turn on radiators. We found that this issue was isolated to the dementia care unit.

Emergency plans were in place at the service and systems including equipment had been serviced and

checked in accordance with the manufactures recommendations. Personal Emergency Evacuation Plans [PEEPs] had been developed for each person who lived at the service and these were accessible in the case of emergency. We checked the providers fire policy and risk assessment and found that action planning was undertaken and complete. Fire drills had been undertaken as planned.

During the first day of inspection we showed the registered manager, head of compliance and procurement/compliance manager areas of the environment we were concerned about. These included; a shower room and a bathroom on the dementia care unit without hand washing facilities, a toilet and hand basin in a locked room that stored activity equipment with no sign of use and was a risk for stagnant water collection, several fire doors that did not fully close, holes in two bedroom walls, radiators with missing thermostats and wide opening windows on the ground floor that posed as a security risk. Immediate action was taken and on the second day of inspection the registered manager provided us with reassurances that work was complete, scheduled or under review. We found that the provider was responsive to the concerns we raised.

We raised concern about a lack of good hygiene and cleaning throughout the environment on the dementia care unit, this included stained walls, unclean bathrooms and malodour in the quiet room and foyer area. The registered manager told us about refurbishment plans and showed us work already undertaken since the take over from the new financial company now responsible for the service. We were reassured that work was planned to improve the standard of environment on the dementia care unit in line with improvements made throughout the ground floor unit and understood how this needed to be phased due to potential disruption for the people that resided at Banksfield Nursing Home.

We observed staff fail to remove protective clothing when they exited the clinical setting [bathrooms/bedrooms] where they had been providing personal care, this meant that people were at risk of cross contamination should someone have an infectious disease. We checked staff training compliance around prevention of infectious disease and found that 70% of staff had completed the mandatory training. We made a referral to the public health infection prevention team and we were informed that the service would be audited on 16 October 2018.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived at the service and or their representative if they were supported by skilled and experienced staff. People who lived at the service told us, "There is one staff member who is my favourite, the rest have left now." "Yes, the staff seem to know what I like." People's representatives told us, "Some of the staff seem to know what they are doing, it is the new starters that don't." "Yes, there are sufficient trained staff, they look after relative's needs." "The staff seem to know and understand relative's condition." And "The staff are very nice, they are lovely to me and I am reassured because I am not getting phone calls in the night time anymore."

We asked the registered manager to send information after the inspection in relation to staff training. We analysed training statistics for the service and found gaps in compliance for training courses the provider stipulated should be mandatory. For example, only two employed nurses [one being the registered manager] had undertaken first aid training in the previous 12 months and no other staff members had undertaken first aid training. This meant that staff had not received adequate training to ensure that people were provided safe and correct care in the event of an accident/injury. Another example of low compliance with mandatory training we found was that only 47% of the staff team had undertaken food hygiene training. This meant that staff had not received training to ensure that people who lived at the service were protected against the risk of food related illness or injury.

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

During our inspection we looked at the personnel records for three members of staff. We found that staff were safely recruited and checks were undertaken before they started to work at the service. Staff were inducted in line with the providers induction policy and records were completed to show when this was achieved. We looked at the supervision matrix and this showed that staff received regular supervision. Staff told us, "I have regular supervisions, although I cannot remember how often they are." And "I am responsible for doing some supervisions for the carers. I have my own list of staff and we do supervisions regularly and appraisals each year."

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At this inspection we found staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not sufficient and this had led to inappropriate restrictive practices. For example, we found that one person used restrictive seating (a bean bag) and this had not been considered in line with the MCA, the same person was given covert medicines and again the service had failed to assess the person to ensure that their rights were not infringed upon. We observed another person be physically restrained by staff who did not have the skills or training to ensure that this was lawful. The provider had not ensured that people were assessed in line with the MCA prior to using bedrails, relatives had been asked to consent to the use of bedrails, however care records did not evidence if the person had been individually assessed in relation to making their own decision and providing consent.

We looked at people's care records and found the service had implemented consent and agreement documents for various decisions in relation to care and treatment and these had been signed by people's representatives before a decision specific mental capacity assessment had been undertaken to check if the person was able to independently consent. Care files did not provide detail of people's legal representation for example if they had an appointed Lasting Power of Attorney.

We discussed our findings with the registered manager who had not already identified these shortfalls. We looked at staff training in relation to the MCA and DoLS and found overall compliance to be 42% for DoLS and 35% for MCA training. The registered manager and deputy manager had both undertaken local authority training in 2018.

We looked at DoLS applications which were held centrally in the registered managers office. We found eight standard applications that had been applied for in 2014 and had not been approved. We looked in people's care records and found that information about the restrictions was not clearly risk assessed or care planned and a copy of the DoLS application was not available for care staff to easily access. This meant that it was unclear when service users were potentially being deprived of their liberty within the service and if it was lawful.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw Do Not Attempt Cardio-pulmonary Resuscitation [DNACPR] forms in some of the care files we looked at A DNACPR form in itself is not legally binding. The form should be regarded as an advanced clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. However, the process for completion must be correct otherwise the form can be deemed to be invalid. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at the time. The DNACPR forms we looked at had been fully completed, involving people who used the service and their relatives, where appropriate, and signed by their GP.

We asked people who lived at the service if they were satisfied with the standard of food provided. People told us, "I always enjoy my food." "Yes, I am given plenty of choice." And "I prefer my meal late afternoon and this is provided."

People that resided on the dementia care unit were not always able to provide us with reliable feedback so we undertook a Short Observation Framework for Inspection (SOFI) during lunch time meal service on the dementia care unit, this allowed us to observe the care provided and to help us understand the experience of people who used the service who could not talk with us. We found that people were not always assisted in a person-centred way and this meant that they did not always receive a nutritious meal because of the lack

of assistance. We saw staff take people's meals away without offering them assistance to eat or an alternative. People were given hot desserts before they had finished their main meal and they were left to stand and go cold. Staff did not always respond to people in a timely manner, we observed one person be left with their lunch time meal for over one hour and they had not touched it, the staff member did not engage with the person or attempt to assist them and took the meal away without acknowledging that the person may have been hungry or thirsty. We communicated our concerns immediately to the registered manager who agreed to take action.

We also observed lunch being served on the general nursing unit. People on the general nursing unit received a positive meal time experience and told us that they had enjoyed their meal, however we did notice that extra portions were not always offered when people had eaten all their meal.

People were assessed on an individual basis against the risk of malnutrition and nutrition care planning was undertaken. However, we found significant shortfalls in the accuracy of nutrition planning. For example, one persons' care plan stated that they were type 1 diabetic and the care plan detailed insulin administration doses and times, the care plan had been added to at a later date to state that the person was a type 2 diabetic and diet controlled. This meant the care plan was misleading and ineffectual, staff confirmed that the person was no longer prescribed insulin and was a tablet and diet controlled diabetic. Another person had lost a significant amount of weight and had been scored at very high risk on their nutritional risk assessment, however the service had failed to formulate a plan of care for this person in relation to weight loss management and supplementary diet intake records were not clear to enable dietetic screening.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access external health care professionals. We found evidence within care records that showed people had been reviewed by multi-agency health care professionals including dentist, optician, mental health teams and podiatry. Staff told us that they understood referral pathways for external health agencies such as tissue viability and dietetic.

We discussed with the provider their objectives in relation to improving the environment on the dementia care unit. We found that recent changes had been made to create a 'dementia friendly' space for people who lived at the service, however this was being undertaken in a phased approach to ensure that maintenance work did not unsettle people who lived at the service. The registered manager was aware of scheduled refurbishment plans and told us that she was confident that this would be inline with national guidance. We asked to see the providers dementia strategy on two occasions and this was not provided.

We recommend that the provider considers effective ways to adapt the environment on the dementia care unit and that this is in line with their dementia strategy.

Requires Improvement

Is the service caring?

Our findings

We received positive feedback about the care provided from people who lived at the service, their representatives and visitors. People told us, "Staff treat me fine." "I like it here, I do." "Yes, the staff genuinely care about me." "The staff give me cuddles and cups of coffee." People's representatives told us, "Staff have passion for the job they do." "When I am here the staff seem very caring." And "The staff chat to me, I know about their families and I always feel welcomed when I visit."

We asked people who lived at the service if they were encouraged to be involved in the writing of their care plans and everyone we spoke with could not recall seeing their care plans, although people's representatives told us, "I get to see the care plan when we visit and they give me a copy of all of my relative's medicines." "We went through the care plan and staff asked me to inform them of my relatives likes and dislikes." And "I was involved in a care plan review the other week with my relative's keyworker and I can ask to see the care records anytime."

We witnessed people experience variable standards of care and attention throughout the inspection. We found that people who resided on the general nursing unit were provided kind and compassionate care with the exception of one incident when a person knocked over their table and staff did not respond which then lead to a visitor helping the person as the table was wedged under their legs.

We observed mixed staff approaches towards people on the dementia care unit, some interactions were kind and compassionate including dancing and holding people's hand to provide comport and reassurance, however this was not consistent and we found that there was a significant lack of staff engagement with people who could not request support. We found that people were disengaged and staff focused mainly on routine tasks such as personal care interventions. We have already commented in the 'effective' domain of this report around our concerns on people's meal time experience. We found that people's dignity was not always maintained at meal times, for example we observed a health care assistant wipe a person's mouth during meal time and then go on to wipe another person's nose and mouth with the same tissue. We looked at staff training compliance for dementia awareness and found that only 58% of staff had completed the training.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

We observed staff throughout the service to respect people's privacy and knock on doors before entering. People were encouraged to maintain their dignity and we saw staff provide dignity blankets for residents in communal areas.

People's confidential health records were stored in a locked office and this meant that their personal data was protected.

If people could not express their views we saw examples where the service involved relatives, although this

was not always consistent for people who did not have a relative and lacked mental capacity. For example, one person who lived on the dementia care unit did not have relatives that could act on their behalf and the provider had not made a referral to an Independent Mental Capacity Advocate (IMCA). We asked the registered manager if this had been considered and she informed us that it hadn't but agreed to look into it.

We looked at minutes for 'resident and relative' meetings and found that the registered manager held meetings on a regular basis, however due to poor attendance the manager had intended to reduce to frequency and continued to operate an open-door policy. The provider met with people who lived at the service and their representatives in 2017 and 2018.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the service and their representatives if they received personalised care that was responsive to their needs. People told us, "Yes the staff know my preferences." "The staff allow me to make choices." And "My relative isn't able to make choices, but the staff know their needs and this is the main thing."

We pathway tracked the care of five people who lived at the service. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We found a significant difference in the standard of care plan writing and risk management when we compared records from the general nursing unit and dementia care unit. Across the two care files we looked at on the general nursing unit we found a good standard of person centred care planning, with the exception of nutritional assessment. People's needs and preferences had been assessed thoroughly prior to admission and detailed admission assessments had been undertaken when the person arrived at the service. We also found that people's life stories, hobbies and interests had been recorded and staff understood the holistic needs of the people we pathway tracked from the general nursing unit.

When we looked at care records on the dementia care unit and found a significant difference in the quality of care planning and saw that care plans were not always reflective of the person's current needs. For example, one person had been admitted 13 days prior to the first day of inspection and they had not been fully risk assessed in relation to their current needs including falls, unexplained bruising and behaviours that challenge. This meant that the provider could not evidence how they would ensure that the person received safe and person-centred care. The person had displayed distressed reactions before and during our inspection which posed a risk to themselves and others, however this had not been acted upon. Another person's care records did not reflect the actual care we observed staff to be providing, for example seating in a bean bag, moving and handling from a bean bag, falls management, covert medicine administration, pressure area care and weight loss.

We looked at supplementary recording across the service for areas such as pressure area care and nutrition. We found that records were not always completed and the detail was not sufficient to enable effective monitoring of a persons' health and wellbeing.

We observed people on the general nursing unit to be dressed in clean and personalised clothing. People appeared to have been supported to maintain good personal hygiene. We found that this standard of personalised care was not always provided for people that lived on the dementia care unit, across both days of the inspection we observed people to have stained clothing, men appeared unshaven and their hair unkempt and we noticed after meal times people were not supported to maintain a good standard of personal hygiene including hand washing and face cleaning. We saw that people on the dementia care unit had unclean and long finger nails, we looked in people's care plans and they did not identify their needs and or preferences in relation to personal grooming.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received feedback from people who lived at the service and their representatives about recreational activities, "We used to do a fair amount of activities." "They used to do a lot of activities from painting, pottery and cooking but that has been the case recently." "Carers used to get involved but they don't seem to now." "I think they need their minds stimulating more." And "There isn't a lot of activities, we used to play bowls, bingo and dominos."

The registered manager told us that the activity worker had not been working for the previous month but was expected to resume back to work soon.

Across both days of the inspection we observed short spells of activity engagement on the dementia care unit, these included music and dancing and a game of hoop throwing. The service did not have any stimulating accessible items on either unit for people who may have wanted to create their own entertainment such as books, magazines, newspapers or sensory items for people living with dementia.

We found that the service was not providing a consistent approach to providing stimulating activities, however the registered manager was aware of this and had started to request feedback from people who lived at the service to improve ways in which they provide activities.

We looked at complaints management and found that the manager dealt with complaints in a timely manner and maintained records. We noted that the service had received some compliments via an online service and people had commented, "Only there for five short weeks but was cared for by lovely staff and treated as though I was a member of family." "A very welcoming care home which made my great aunts last month very comfortable. All of the staff were very welcoming and had a high priority for patient dignity." And "Can't thank the management enough for the care and compassion shown to my aunt during her stay. All of her needs were met, her religion was important to her and she saw a priest within 30 minutes of arriving."

We looked at how the provider collated feedback from people who lived at the service, visitors and relatives. Survey results were available and showed how they had been adapted by the use of picture format to aid completion from people who live with cognitive and or sensory impairment. A summary of people's comments was displayed on a notice board in the reception area and showed what action had been taken for each comment. Throughout the care records we looked at we found information about support people needed to communicate, this included if people had a visual and or hearing impairment. We saw that people were reviewed by opticians and referred to audiology if needed.

We saw that people had televisions in their bedrooms and bedrooms had been personalised.

We looked at peoples' care records and found limited information about their end of life care needs and preferences. The provider had an end of life care policy and related care documents to support people in making decisions however these were not always considered for use before a person's health had deteriorated. We looked at training records and found that 51% of staff had received training in end of life care. At the time of our inspection Banksfield Nursing Home was not providing end of life care for anyone that resided at the service.

Requires Improvement

Is the service well-led?

Our findings

People and their representatives spoke positively about the registered provider and registered manager. People told us, "There has been a lot of improvements in the environment recently." "Yes, I can approach the manager." And "If I had a concern I would speak with the manager."

There was a registered manager employed at Banksfield Nursing Home. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were told that the service had been financially taken over by new share holders in August 2017, this did not affect the provider's registration. The registered manager told us that she felt supported by the new management team and was confident to embed new systems such as care plan documentation that was being slowly introduced. People who lived at the service, their representatives and staff were provided with opportunity to meet with the new senior managers.

At this inspection we found that there was a lack of consistent quality auditing and governance processes. Whilst the provider had multiple auditing systems including audits of; infection control, care planning, environment, dining experience, accidents and incidents and medicines management the systems had not picked up on the failings found at this inspection.

We spoke with the head of compliance and two compliance officers who were responsible for quality monitoring at the service and we looked at the audits undertaken by them. Again, we found that the areas of concern highlighted throughout the inspection had not been found for example in relation to the MCA, DoLS, medicines management, environment, infection control and nutrition. The registered manager and the supporting quality team were receptive to our feedback and reassured us that they would take immediate action for areas we told them placed people at substantial risk; choking, restrictive practices and maintenance of the environment. However, on the second day of the inspection following assurances that risk mitigation had been fully considered we found more examples were people had been given foods that placed them at risk of choking. We asked the registered manager to make a safeguarding referral in relation to this.

Supplementary care records (records for recording daily food intake, bedrail checks, safety and positioning) were not being consistently completed and therefore a full picture of people's care and support was not evident. This showed a failing in quality assurance as checks had not been done to ensure that important monitoring records were completed and worthwhile.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection planning we looked at routine notifications that the provider had submitted to the

Commission. We found one notification had been submitted in the last 12 months in relation to serious injury. We discussed this with the registered manager and provided further information about their legal obligation to inform the Commission without delay of incidents that are reportable under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We looked at incident and accident records and found three injuries that the registered manager had not notified us of during August 2018, two in relation to a skin tears and another in relation to a toe injury with an unknown cause.

This was a breach of the Care Quality Commission (Registration) Regulations 2009.

We looked at minutes from staff meetings and found that the registered manager organised meetings on a regular basis. Meeting minutes showed how staff were involved in development of the service and an action plan was created and reviewed after the meeting. We looked at the results from staff questionnaires completed in 2018; these showed that the registered manager encouraged staff to be involved. Staff told us, "I feel very well supported by the manager." "The managers at the home are great. Any queries I go to the manager or the deputy." And "Morale is good."

We observed positive morale throughout the staff team and staff told us that they enjoyed working at the service. We noticed that the service did not have a high turnover of staff.

We saw that the manager had informed people who lived at the service and their representatives that she operated an open door policy and encouraged people to make suggestions and be involved with the development of the service. We did not see evidence that the service involved the public, however two people who lived at the service told us they could access the community including the church and local amenities.

We received positive feedback from external professionals in relation to partnership working with the service.

We found that the registered manager did have auditing processes in place to identify lessons to be learnt, however these were not always effective. We asked the registered manager to take immediate action during our inspection for areas such as safeguarding, risk of injury and environmental hazards. We were initially concerned about the registered manager's lack of oversight at the service, however on the final day of the inspection we were reassured that the registered manager understood what areas of identified risk required immediate attention.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to continuously notify the Commission when a person had sustained a serious injury.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure peoples' needs were met in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to effectively assess peoples' needs and provide care in line with the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people had been effectively assessed in line with Deprivation of Liberty Safeguards and safeguarding systems were not robust to ensure that people were protected against abuse and improper treatment

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure peoples' nutritional needs had been accurately assessed and people did not always receive a nutritious diet.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to embed effective quality assurance systems this meant that failures found at our inspection had not been identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure the staff team were skilled, knowledgeable and sufficiently trained to support those in their care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure systems were in place to mitigate the risks to peoples health and safety and therefore people were not adequately protected from receiving inappropriate or unsafe care and support.

The enforcement action we took:

Warning notice issued.