RochCare (UK) Ltd

Bank Hall Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection of Bank Hall Care Centre 14, 15 and 28 March 2018.

Bank Hall Care Centre is a care home which is registered to provide care and accommodation for up to 56 older adults and older adults living with a dementia. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The accommodation is provided in two interlinked premises Bank Hall and Scarlett House. Bank Hall - is a single storey former hospital, which has been adapted to provide residential accommodation. It is registered to accommodate up to 36 older people. All the bedrooms offer single occupancy and 11 have en-suite facilities. There are three lounges two having conservatory areas. There is a separate dining room and a hairdressing 'salon'. Additional seating is provided in the entrance hallway. Scarlett House - is a two storey purpose built extension linked to the Bank Hall building, but with its own entrance. It is registered to accommodate up 20 older people with a dementia. All the bedrooms are single with en-suite facilities. There is a lounge with a joining dining area and a separate conservatory. A passenger lift provides access to the first floor accommodation. At the time of the inspection there were 27 people accommodated in Bank Hall and 11 in Scarlet House.

At the time of the inspection there was no registered manager at the service. However the manager, who had worked at the service for over 10 years had applied for registration. 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. Following the inspection we were informed the manager had achieved registration with the Commission.

At our last inspection on the 25 and 26 January 2017 the overall rating of the service was 'Requires Improvement'. We found progress was needed with medicines management, checking systems and provider oversight of the service. We therefore made recommendations on these matters.

During this inspection we found there were no breaches of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. Sufficient improvements had been made. However, although we found medicine management processes to be safe, we again found some shortfalls which were in need of attention. We have therefore made a further recommendation on this matter.

During the inspection we were provided with information which gave us some cause for some concern about people's well-being and safety. These matters were proactively and appropriately responded to by managers; however on writing this report the concerns were still under investigation. We have asked the provider to inform the Commission of the outcome of the investigations.

People told us they felt safe at the service. Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns. Training had been provided on safeguarding and protection matters.

Arrangements were in place to ensure staff were checked before working at the service. We found some checks had not been properly completed. But the area manager took swift action to make improvements.

There were enough staff available to provide care and support for people. Staffing levels were kept under review and changes made to ensure they were sufficient.

Systems were in place to ensure staff received ongoing training and development; action had been taken to monitor and achieve completion of the required training and development.

Arrangements were in place to promote the safety of the premises, this included servicing and checking systems. We found the service to be clean in the areas we looked at.

People were happy with the accommodation. There were adaptations and equipment to assist people with mobility and orientation. We found there was a good standard of décor and furnishings to provide for people's comfort and wellbeing. People had personalised their rooms and had been asked for their choice of colour schemes and furnishings in communal rooms.

People's needs were being assessed and planned for before they moved into the service. People were supported with their healthcare needs and received appropriate medical attention. Changes in people's health and well-being were monitored and responded to.

Each person had a care plan, describing their individual needs, preferences and routines. This provided guidance for staff on how to provide support. People's needs and choices were kept under review.

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

People made positive comments about the caring attitude of staff. They said their privacy and dignity was respected. Throughout the inspection we observed staff interacting with people in a kind, pleasant and friendly manner. They were respectful of people's choices and opinions.

There were opportunities for people to engage in a range of group and individual activities. People were keeping in contact with families and friends. We found visiting arrangements were flexible.

People said they were satisfied with the variety and quality of the meals provided. We found various choices were available. Support was provided with specific diets. Drinks were readily accessible and regularly offered. We found some aspects of meals provision would benefit from review and these matters were positively responded to during the inspection.

People spoken with had an awareness of the service's complaints procedure and processes. They indicated they would be confident in raising concerns.

We found there were management and leadership arrangements in place to support the effective day to day running of the service. The manager had made a number of improvements and the area manager was providing ongoing support.

A variety of audits on quality and safety were completed regularly. Arrangements were in place to encourage people to express their views and be consulted about Bank Hall Care Centre, they had opportunities to give feedback on their experience of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were some concerns about people's well-being and safety which were under investigation.

There were some shortfalls with staff recruitment checks, however appropriate improvements were made during the inspection. There were enough staff available to provide people with safe care and support.

We found some medicine management processes needed improvement to promote best practice.

Processes were in place to maintain a safe and clean environment for people who used the service.

Is the service effective?

Good

The service was effective

People were satisfied with the quality and variety of meals provided. We found some catering arrangements needed to be reviewed. During our visit action was taken to make improvements with the involvement of people who used the service.

Processes were in place to find out about people's individual needs, abilities and preferences. People's health and wellbeing was monitored and they had access healthcare services.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

Satisfactory arrangements were in place to develop and supervise staff in carrying out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

People made some positive comments about the supportive and caring attitude of staff. We observed positive and respectful interactions between people using the service and staff.

Staff were aware of people's individual needs, backgrounds and personalities, which helped them provide personalised support.

People were cared for in a way which aimed to promote their dignity, privacy and independence. Residents meetings were held to involve people in making group choices and decisions.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Processes were in place to monitor, review and respond to people's changing needs and preferences.

People were offered a range of individual and group activities. They were able to engage in varied activities at the service and in local community.

There were processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service.

Is the service well-led?

Good

The service was well-led.

There was a management team providing effective leadership and direction. The manager, supported by the area manager had introduced various improvements. There were clear action plans in place to monitor progress and achieve improvements.

Staff were knowledgeable and positive about their work. They indicated the service had improved and the manager was supportive and approachable.

There were processes in place to monitor and check the quality of people's experience of the service.

Bank Hall Care Centre

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.

We visited Bank Hall Care Centre on 14, 15 and 27 March 2018 to carry out an unannounced comprehensive inspection. The inspection team consisted of one adult social care inspector and a hospitals directorate inspector who attended on the first day.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team, the local authority safeguarding team, commissioners of care, a pharmacist and visiting health care professionals. The provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit, we spent some time with people, observing the care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who might not find it easy to talk with us. We talked with six people who used the service about their experiences of their care and four visiting relatives. We talked with a training provider/assessor, five carers, three senior carers, a cook, an activity coordinator, a housekeeper, the deputy manager, the manager, the area manager and a director of the service.

We looked at a sample of records, including four care plans and other related care documentation, three staff recruitment records, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Requires Improvement

Is the service safe?

Our findings

We reviewed how the service protected people from abuse, neglect and discrimination. People spoken with made the following comments, "Yes I feel safe here there are plenty of people around" "Oh yes I feel safe here which is good," "I have not seen anything untoward. No-one has been harmed, they won't have that here" and "I do feel safe here." Relatives said, "I visit at different times. I have never seen anything untoward. I trust the staff. I have no concerns" and "I am here often. I have never seen anything of concern. I think [my relative] is safe here I am very happy with the staff." The service's electronic care planning system included a safeguarding assessment, which highlighted people's vulnerability and potential risks around abuse and neglect.

During the inspection we received some comments of concern which required further investigation and action. We discussed these matters fully with the manager and area manager. We noted some of the concerns had already been pursued and proactive action had been taken to make appropriate improvements. But some of the allegations shared with us were unknown to the managers and therefore warranted further action. The manager and area manager demonstrated an appropriate response to the allegations and concerns raised. They followed the safeguarding and protection procedures and raised safeguarding alerts with the local authority. During the course of the inspection we were also made aware of a specific incident, which the manager had appropriately reported to the police and local authority. At the time of writing this report these matters remained under investigation.

Prior to the inspection we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We discussed and reviewed some of the concerns with the manager. We found action had been taken to liaise with local authority and other agencies in relation to the allegations and incidents. The manager indicated the service was working in accordance with the local authority's revised safeguarding protocols. It was apparent the service had taken seriously their responsibilities to monitor any safeguarding incidents and accidents and to ensure there was a proactive 'lessons learned' approach. Systems were in place to record and manage safeguarding matters, including the actions taken to reduce the risks of re-occurrence.

Staff spoken with expressed an understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse, including physical abuse, psychological harm and potential discrimination. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. There was a whistle blowing (reporting poor practice) policy which staff were aware of.

We looked at the way people were supported with the proper and safe use of medicines. Comments from people spoken with included, "I get my medicines on time" and "They bring my tablets at the right time." We noted everyone had been asked if they wanted to know more about their prescribed medicines and this had been responded to accordingly. One person explained, "I am aware of them all and what they are for."

At our last inspection we found there were some shortfalls with medicines management processes which were rectified during our visit. We recommended the medicine management auditing systems be developed. At this inspection we found more comprehensive medicines audit and checking systems had been introduced to identify shortfalls and make improvements. However although there were some safe medicine management processes in place, we found some improvements were needed.

We looked at the arrangements for the safe storage of medicines. There was a monitored dosage system for medicines. This is a storage device provided and packed by the pharmacy, which places tablets in separate compartments according to the time of day. We found medicines were being stored safely and securely. Room and fridge temperatures were monitored in order to maintain the appropriate storage conditions. Arrangements were in place for the safe management and storage of controlled drugs; these are medicines which may be at risk of misuse. We checked one person's controlled drugs and found they corresponded accurately with the register. However, we noted for one entry, the correct columns in the record had not been appropriately completed.

Processes included staff having sight of repeat prescriptions prior to them being sent to the pharmacists. We found there were protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols are important to ensure staff were aware of the individual circumstances this type of medicine needed to be administered or offered.

The medicines administration records (MARs) we reviewed were mostly appropriately kept, complete and accurate. However, we noted there were consecutive gaps on the MARs which did not provide confirmation of the medicines administration process, for example that the person had taken their medicine. Effective processes were not in place to demonstrate the application of people's external medicines, such as transdermal patches. Although there were 'body map' diagrams to provide directions to staff on where to apply the patches and topical creams, these records were not always appropriately completed. This meant the MARs were lacking in clarity to confirm they had been appropriately and safely applied. There was no evidence these shortfalls had a resulted in a negative impact upon people who used the service, however more detailed instructions were needed to provide clear directions.

There was a stock of 'homely remedies.' The visiting nurse practitioner had formally approved the use of the items. This meant people would benefit from access to 'over the counter medicines' in a timely way. Staff responsible for administering medicines had received medicines management training and processes to assess their competencies in undertaking this task were ongoing. Staff had access to a range of medicines management policies, procedures and nationally recognised guidance which were available for reference.

There were daily and weekly checks on aspects of medicine management practices and monthly 'peer' audits were completed by senior staff. Action plans were devised to address any identified discrepancies.

We recommend medicine management processes be further developed in accordance with current recognised guidance.

We checked if the staff recruitment procedures protected people who used the service. The recruitment process included candidates completing a written application form and attending a face to face interview. Character checks including, identification, obtaining written references and evidence of any qualifications had been carried out. An appropriate DBS (Disclosure and Barring Service) check had been completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We found the reasons for leaving previous employment had not always been properly checked. We also noted there was a lack of satisfactory

information about any physical or mental health conditions for one person. However during the inspection the area manager proactively took action to rectify these matters and prevent any recurrence. Arrangements were in place for new employees to undergo a probationary period to monitor their conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct. There was evidence to demonstrate these procedures were appropriately followed.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. People spoken with did not express any concerns about the availability of staff at the service. They told us, "I think there are enough staff. When they are busy we might have to wait a bit longer, but it's not a problem," "If I press the buzzer they come to help me," "I only have to press the buzzer and they come," "Sometimes they seem short of staff, but I have no complaints, they have time to spend with me" and "If I want anything there is somebody here to help." Relatives spoken with also considered the staffing arrangements were satisfactory, one commented, "There are usually enough staff around."

At our last inspection we made a recommendation on keeping staffing levels under review and with the involvement of people who used the service and staff. The manager indicated staffing reviews were ongoing. There was a staffing tool completed monthly, to monitor and review staff arrangements in response to the numbers, needs and abilities of people using the service. People using the service and/or their relatives had also been consulted by survey on staffing levels. The outcome of this had resulted in an increase in the numbers of care staff on duty. During the inspection we found there were sufficient staff on duty to meet people's needs. We observed support being provided in a timely and consistent way. Staff spoken with considered there were mostly enough staff on duty at the service. We were made aware of some shortfalls in staffing levels in Scarlet House; however the acting manager proactively investigated and took action to rectify this matter during our inspection. We will continue to monitor staffing levels the staff deployment at our next inspection.

We looked at how risks to people's individual safety and well-being were assessed and managed. The electronic care planning system routinely generated a risk screening rating on all assessed care needs. There were more specific risk assessments which included, use of equipment, skin integrity, nutrition, behaviours, mobility, falls and moving and handling. The process resulted in actions for staff to follow on minimising the risks to the individual. We found risk assessments provided person centred details for staff on providing people with safe support. They were reviewed monthly or earlier if there was a change in the level of risk. The system signalled when a risk assessment was due for review or had been updated. Each person had a personal emergency evacuation plan in the event of emergency situations. Staff spoken with were aware of people's individual risk assessments. They knew people well and were able to describe how they managed risks. There were also specific risks carried out whenever people accessed activities and events in the community.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. There were contingency procedures to be followed in the event of emergencies and failures of utility services and equipment. There were various health and safety checks carried out on the premises. There were accident and fire safety procedures available. Records and service agreements showed processes were in place to check, maintain and service fittings and equipment, including fire extinguishers, hoists and the passenger lift. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out. We found the services electrical installations safety certificate was due for renewal in January 2018, however we saw evidence to confirm this matter was in hand. Arrangements were in place for the safe storage of records to promote confidently of information data protection.

We reviewed how people were protected by the prevention and control of infection. People spoken with did not express any concerns about the cleanliness of the service. One person said, "Oh yes it is clean here," "There is always somebody polishing something" and "My bedroom gets cleaned every day." The areas of the service we looked at were kept clean. Suitable cleaning equipment and laundry facilities were provided. There were housekeepers with designated responsibilities for cleaning and defined cleaning schedules were available. Protective personal equipment, including gloves, aprons and anti-bacterial hand wash was available. Guidance on effective hand hygiene was appropriately displayed. Records and discussion indicated staff had recently completed training on infection control and there were associated policies and procedures, to provide direction and guidance for staff. There were processes to audit, monitor and respond to infection prevention and control measures at the service. This meant arrangements were in place to check, maintain and promote good hygiene standards.

Good

Is the service effective?

Our findings

We looked at the way people's needs were assessed and planned for, prior to them using the service. We asked some people how they were involved with this process they said, "I came to look around. I thought it was very good" and "When I first came, I didn't want to stay, but the manager supported me. Physically and emotionally." One relative said, "[The area manager] came do an assessment. We went through everything."

The manager described the process of initially assessing people's needs and abilities before they used the service. This involved meeting with the person and completing a needs assessment, by gathering information from them and any relevant health and social care professionals. We looked at recent records which showed a wide-ranging needs and preferences assessment had been carried out, including the person's capacity to make their own decisions. It was apparent the person had been involved with the process and had signed in agreement with the outcomes of the assessment. People were encouraged to visit the service, for meals activities and short stays. This was to actively support the ongoing assessment process and provide people with the opportunity to experience the service before moving in. The service had policies and procedures to support the principles of equality and human rights. This meant consideration was given to protected characteristics including: race, sexual orientation and religion or belief.

We looked at how consent to care and treatment was sought in line with legislation and guidance. During the inspection, we observed examples where staff consulted with people on their individual needs and preferences and involved them in routine decisions. One person explained, "They ask me what I want, for example, they go in my wardrobe and show me clothes. They ask me to pick out what I want what I want to wear," another person said, "I can have a bath or shower; they always involve me with this decision." Staff spoken described how they involved people in making decisions and choices and asked for their consent before providing personal care. The care records we reviewed included agreements on consent to care. People spoken with also indicated they were involved with their care plans some had signed a form in agreement with them.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions or authorisations to deprive a person of their liberty were being met. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Processes were in place to assess and monitor people's capacity to make specific decisions about their care, treatment and lifestyle choices. The area manager explained that the care planning processes was being

further developed, to encompass people's decision making all aspects of their care and support. We saw examples of this approach being progressed.
There was information to demonstrate appropriate action had been taken to apply for DoLS authorisations in accordance with the MCA code of practice. Records had been kept to monitor and review the progress of pending applications. Policies and procedures had been devised and introduced to provide guidance and direction on meeting the requirements of the MCA. Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and provide care and support in the least restrictive way possible. People spoken with indicated there were no unnecessary restrictions on their liberty. Their comments included, "To an extent, I can do whatever I want," "Oh yes I can do what I want. I don't feel like I have been taken over" and "There are no restrictions here."

We looked at how people were supported to live healthier lives. People were offered the opportunity for physical exercise, including local walks, dancing and seated exercises. The people we spoke with indicated they had access to health care professionals when needed. This included GP's, district nurses, mental health professionals and chiropodists. They told us, "Oh yes they will get the GP if needed and the district nurse visits regularly," "I see the specialist nurse practitioner whenever I want, we have eye tests here, the chiropodist visits and the came to check our teeth" and "I haven't seen the GP but I know could if I needed to." One representative from a health care service told us, "We have worked with Bank Hall for many years and find the staff very approachable. All the residents seem happy and content."

People's medical histories and conditions were included in the care planning process. Their healthcare needs were monitored and considered as part of ongoing reviews. Records were kept of healthcare visits and appointments. The service was signed up to a system whereby they could access remote clinical consultations; this meant staff could access prompt professional healthcare advice at any time.

People's medical histories and healthcare needs were included in the care planning process. Their wellbeing was monitored daily and considered as part of ongoing reviews. This meant staff could identify any areas of concern and respond accordingly. Records were kept of healthcare checks, visits from healthcare professionals and appointments in the community. This included consultations with GPs, speech and language therapists, opticians and chiropodists. A nurse practitioner from a local GP surgery attended the service three times each week. The service was also signed up to a system whereby they could access remote clinical consultations; this meant staff could access prompt professional healthcare advice at any time.

We checked how people were supported to eat and drink enough to maintain a balanced diet. People spoken with made some positive comments about the quality and variety of food provided. Their comments included, "We can have whatever we want for breakfast. It doesn't matter how many eggs you want ," "The food is alright. We can choose what we have. They ask us the day before. If I don't like it they find something else," "We have two choices at lunch and tea and if I don't like it I can have a sandwich or whatever," "They come round with drinks all the time," "If you don't' like it, they go to all lengths to get you something else" and "We definitely can choose what we have; they have just asked me what I would like for dinner and tea."

At our last inspection we made a recommendation about effectively supporting people living with a dementia with their nutritional needs and meal choices. At this inspection we found improvements had been made. A 'dining experience' audit process had been introduced. This involved an observational evaluation of people's experience at mealtimes; we noted any actions for improvements had been identified and implemented.

We observed the mealtime service in Scarlett House. The day's menu was displayed and the tables were set

with tablecloths, flowers and napkins. Adapted cutlery was available as appropriate, to help promote independence. We noted people enjoying the mealtime experience as a social occasion, in an unhurried way. We observed examples of people being sensitively supported and encouraged by staff with their meals. Meals were prepared and cooked in the main building and transported by heated trolley. We found some meals were not always fully prepared before leaving the kitchen; this meant care staff having to spend time blending some foods prior to serving. We discussed the suitability of this approach with the manager and during the inspection action was taken to make improvements.

Mealtimes were flexible and people could eat in their rooms if they preferred. People said, "Breakfast is anytime from 7:30 onwards" and "My family came so we had a meal together in my bedroom." We discussed the arrangements in place for effectively supporting people who had a late breakfast and who may not ready for a main meal at lunch time. We were told people's individual needs and preferences were catered for. However during the course of the inspection, the manager and area manager proactively reviewed the mealtime service. A 'nutrition champions board' was introduced, this was made up of people who used the service, relatives, cooks and carers. We noted an outcome of the first meeting was to trial the main meal to being served in the evening. A 'nutrition resource pack' had also been introduced to provide guidance and information on good nutrition and healthy eating.

We spoke with the cook who told us of the progress being made with meal choices and nutrition. There was a three-week rotating menu system. The menus we looked at showed a variety of meals were offered and a 'light bite menu' had been introduced. Information was recorded about people's individual dietary requirements, the support they needed and any risks associated with their nutritional needs. This information was shared with kitchen staff who were aware of people's dietary needs, likes and dislikes. Processes were in place to check people's weight at regular intervals. This was to help monitor risks of malnutrition and support people with their diet and food intake. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary.

We looked at how the provider made sure that staff had the skills, knowledge and experience to deliver effective care and support. Processes were in place to support an initial induction training programme which included the completion of the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. A training provider/assessor told us, "Bank Hall is very receptive to training. I can confirm there is ongoing training for staff." Staff spoken with described the training they had received and said that learning and development was ongoing at the service. However, the manager and area manager, had identified progress was needed to ensure staff completed the provider's mandatory refresher training programme. We noted clear time measured action plans were in place to monitor and ensure progression. There was evidence to indicate staff had been given clear directives on the providers' expectations that they update their learning.

Staff were enabled to attain recognised qualifications in health and social care. They had either attained a Level 2 or 3 NVQ (National Vocational Qualification) in care or equivalent, or were working towards a level 2 or 3 QCF (Quality and Credit Framework) diploma in health and social care. The acting manager explained that due to changes management at the service, the programme of staff supervision and appraisal was behind schedule. However staff spoken with confirmed supervision meetings had been reintroduced. The meetings had provided the opportunity for two-way discussions on the staff's role, responsibilities and any concerns. We saw records of the meetings which had taken place and those planned for the future.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises. Comments from people spoken with included, "I think the facilities here are okay. I have been to all the other lounges" and "We have a lovely dining room." We looked around the premises and noted furnishings,

carpets and decoration were of a good standard. We found people had been encouraged and supported to personalise their rooms with their own belongings. One person explained, "I like my bedroom; I have all my own things. I even brought my own bed with me." People had also been actively enabled to choose colour schemes and make shared decisions on furnishings for communal areas. This had helped to create a sense of 'home' and ownership. In Scarlett House consideration had been given to providing a suitable living environment for people living with a dementia, including signs, facilities and colour schemes to help with orientation and recognition. There was access to the enclosed garden areas with garden furniture and a 'poly tunnel' for gardening activities.

We reviewed how the provider used technology and equipment to enhance the delivery of effective care and support. The service had internet access to enhance communication and provide access to relevant information. This included: sending and receiving e-mails and downloading health and social care practice guides and updates. There was a computer based care planning system and a video games console to promote interaction and exercise.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion and were given emotional support when needed. People spoken with made positive comments about the staff team and the care and support they received. They said: "The staff do have time to talk with us," "They are alright we have loads of good staff," "The staff are definitely patient here," "Staff are okay they are fine," "The staff are great, really great" and "I think this little care home is the best around here for caring for people." One relative said, "I know the staff here very well. They are extremely helpful and go the extra mile," another commented," It's a nice, caring homely place." We observed meaningful and positive interactions between people using the service and staff.

Staff spoken with were aware of equality and diversity, training had been provided on this topic. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences. One member of staff commented, "Everyone is different, but they are all to be treated with the same respect and dignity." The training provider/assessor told us, "The staff here are good. They are respectful to the residents."

The care assessment process took into consideration people's rights, personal history, cultural needs, relationships, religion, hobbies and interests, likes and dislikes and lifestyle preferences. This information was used to develop their individual care plans, highlight their needs and expectations and how they wished to be supported. We reviewed how the service supported people to express their views and be involved in making decisions about their care and support. Our discussions and observations indicated people's care needs and preferences had been discussed with them. People spoken with expressed an awareness of their care records. One person said, "I have a care plan. "They review things with me. I had a chat with the manager it's all on the computer." Relatives spoken with indicated they had been involved as appropriate, with the care planning process.

People indicated they were happy with the approach and attitude of staff at the service. All those spoken with felt that staff treated them respectfully. They said, "People here are treated with dignity," "The staff treat me fine," "They treat me alright" and "They are very respectful." A relative said "All the staff are good they are respectful." We observed examples where staff were respectful and kind when supporting and encouraging people with their daily living activities and individual lifestyles. Staff indicated they had time to provide care and support, also to listen to people and involve them with decisions. The service had a 'keyworker system.' This linked people using the service to a named staff member who they worked more closely with.

People had free movement within the service and could choose where to spend their time. We asked people about privacy they said, "They knock on the door they have to, its good manners" and "I like to spend time in my room it's alright they leave me alone." Bedrooms were fitted with suitable locks to effectively promote privacy. One person told us, "I have a key for my room. I keep it locked." We saw staff respecting people's private space by knocking on doors and waiting for a reply before entering. Staff described how they upheld

people's privacy within their work, by supporting people sensitively with their personal care needs and maintaining confidentiality of information.

We asked people if the support they received promoted their independence. They described how they had been enabled to develop independence skills, by doing things for themselves. One person said, "I can do things for myself and they encourage me." During the inspection, we observed people doing things independently and making their own decisions, some with staff support. Promoting choices and encouraging people to be independence was reflected in the care plan process. Staff described how they encouraged independence, in response to people's individual abilities, needs and choices. One staff member said, "We support people in a way which is appropriate for them. For example, we encourage independence by enabling people to brush their own hair and do whatever they can."

Regular residents meetings had been held. This had provided people with the opportunity to make suggestions, be consulted and make shared decisions. We noted from the records of meetings that various matters had been raised, discussed and followed up, including menus, activities and changes to the accommodation. One person explained, "We have residents meetings. They listen to us; we talk about all kinds of things."

There were notice boards which provided details of proposed activities and events, also complaints and fire safety procedures. There were information leaflets from various health and social care agencies, including details of local of local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. We noted the service's CQC rating and the previous inspection report was also on display, this was to inform people of the outcome of the last inspection.

Good

Is the service responsive?

Our findings

People indicated they received care that was responsive to their needs and personalised to their wishes and preferences. People spoken with said, "Nothing could be better – if I want something they sort it for me," "They do as much as they can to help me," "It's okay, they try to make us as comfortable as they can," "I have every comfort. Night and day." One relative said, "It's good and consistent, because they know who [my relative] is and what she needs. There isn't a big turnover of staff. The seniors are the same mornings and afternoons."

People had individual care plans, which had been developed in response to their needs and preferences. Records and discussion showed people and/ or their relatives were involved with care planning process. One person told us, "Yes, I think I have a care plan," others said, "Oh yes they talk with me about my care needs" and "Oh yes, they make sure I have the things I need and want." There was a computerised care planning system in place. Staff had their own personal login details to access the information. The system included people's identified needs and preferences. There were 'pages' for areas of identified need, including: personal care, mobility, nutrition, night care, religion and language, recreational activities and environmental control. There were action plans providing details of people's routines, likes and dislikes and how best to provide their support. The system generated reminder's for reviews and indicated when care plans had been updated in responses to changes in people's needs and choices. Staff spoken with indicated the care plans were informative, they said they had access to them during the course of their work. We were made aware of the progress people had made, resulting from the service being responsive and developing ways of working with them.

Records were kept of people's daily living circumstances, their general well-being, involvement with social activities and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours, accidents and incidents. There were 'hand over' and 'huddle' discussion meetings between staff to communicate and share relevant information. These processes enabled staff to monitor and respond to any changes in a person's needs and well-being. There was evidence that the care plans were reviewed and updated regularly with the involvement of people who used the service.

People spoken with indicated they were satisfied with the range of activities provided at Bank Hall Care Centre. They explained, "There's often something going on. They say we are having such a thing if you want to come and join in," "They take us for a walk round the park," "We had a brilliant party last night, we had fancy hats and an entertainer" and "We can play games and do crafts."

There were two activity organisers responsible for planning and coordinating activities in response to people's individual and group needs. A 'trolley shop' had recently been introduced and person who used the service was actively involved with managing this. There was a monthly programme of planned activities on display in both areas of the service. This information was also publicised in the service's monthly newsletter. We observed organised group activities taking place during our visit. There were 'rummage bags' containing various tactile items for people to engage in and 'music therapy' sessions, for relaxation and reminiscence.

One relative commented, "[My relative] is not neglected in anyway with activities." There were photographs available showing people experiencing previous events and activities. Records were kept of people's participation and engagement in activities and discussions.

We found positive and meaningful relationships were encouraged. People were actively supported as appropriate, to have contact their family and friends. One relative commented, "They are always friendly and welcoming. I feel at home when I visit." There were no visiting restrictions at the service; we saw several family members and friends during the inspection. The service also had a 'keyworker system.' This linked people using the service to a named staff member who they worked more closely with. The main aim of the 'keyworker system' was to develop more trusting and beneficial relationships.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The care planning process reflected people's communication needs, to highlight appropriate methods of engagement and interaction. We reviewed the guide to Bank Hall Care Centre; this included much relevant information about the service. Although some photographs were included, it was produced in a conventional style. We therefore discussed with the manager ways of producing the service's written material, including the guide, important policies and the complaints procedure in a 'user friendly' format, which would help with meeting the expectations of the Accessible Information Standard. The manager agreed to give this matter their attention.

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. People we talked with had awareness of the complaints processes and expressed confidence in sharing their concerns. They said, "If I had a compliant I would tell [acting manager] about it to see if she could make it right, I think she would" and "I have no concerns. But, I would go to [acting manager] if I had. She would sort things out." People were also given opportunity to express dissatisfaction or concerns in the residents meetings and in surveys. Relatives spoken with expressed confidence in the complaints procedures.

The complaints procedure was assessable to people who used the service. The information provided guidance on making a complaint. Included were the contact details of people who complaints could be raised with, such as the person in charge, manager and provider. The procedure also included information on other agencies that may provide support with complaints, including the local social care government ombudsman.

There were processes in place to record, investigate and respond to complaints and concerns. There was information to demonstrate that action had been taken to investigate and resolve people's dissatisfaction and make improvements. This showed that the matters raised had been taken seriously and acted upon. The manager described the systems in place to monitor complaints, to identify and proactively respond to any patterns and trends. The service had policies and procedures for dealing with any complaints or concerns. Staff spoken with expressed an understanding of their role in responding to concerns and complaints.

We evaluated how people were supported at the end of their life to have a comfortable, dignified and pain-free death. Some staff had received training in end of life care to help ensure they were able to provide the best care possible at this important time. The service worked with other agencies as appropriate, when responding to people's specific needs. The care planning process included a scope for records to be kept on the agreed care and support people wished to receive at the end of their life. The area manager explained

that a concise person centred care plan would be drawn up and families would be involved as appropriate. We noted there were letters and cards of appreciation from families expressing their appreciation for the care and attention their relatives received during this sensitive time.

Good

Is the service well-led?

Our findings

People spoken with expressed an appreciation of how the service was run. They told us, "It's the best move I have made," "I'm satisfied here. This is my home," "I would recommend this place to anyone" and "They have been real good to me here." They had an awareness of the overall management arrangements at the service and they knew who the acting manager was. They said, "I know the manager I see her regularly," "I know the manager, she asks how I am, "The manager comes around every so often. I can talk with her I like a chat," and "If I wanted to see the manager they would come and see me. It would be a private conversation." A relative said, "The managers are always approachable and are good at dealing with things."

Since our last inspection there had been some changes in the management team. The previous registered manager had left the service and had de-registered with the commission. The area manager explained some of the circumstances around the changes and the action taken to sustain the day to day running of the service. Following the inspection we received information which further demonstrated provider involvement in monitoring and effectively managing the service.

The management team in place included the manager, deputy manager and senior carers, supported by the area manager and provider. The staff rota had been arranged to ensure there was always a manger/senior on duty to provide leadership and direction. There was an administrator providing additional management support. We found the managers had an 'open door' policy that supported ongoing communication, discussion and openness. A training provider/assessor told us, "The managers are very approachable and always responsive."

The manager had attained recognised qualifications in health and social care and was completing diploma in management and leadership. They had updated their skills and knowledge by completing training and through attending relevant seminars. Throughout the inspection, the manager expressed commitment to the ongoing developments at the service and demonstrated a proactive response to the inspection processes. We noted the manager had devised clear, time focused action plans to steer and monitor ongoing improvements. Staff spoken with said, "The manager is fine, approachable and supportive" and "Things here are much better."

The service's philosophy of care, vision and values was reflected within the written material including, the guide to the service, staff induction and policies and procedures. There were displays at the service which promoted dignity and dementia awareness. Some staff had been given 'lead roles' on specific work themes, such as 'dignity champion,' 'nutrition and hydration champions' and a 'dementia friend.' There was a welcoming and friendly atmosphere at the service. We observed numerous positive interactions between people who used the service, staff and managers. Staff spoken with expressed an understanding of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions and a code of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates. Various staff meetings were held on a regular basis. We looked at the records of the most recent staff meetings and noted various work practice topics had been raised and discussed. Staff spoken with told they

were encouraged to make suggestions and voice their opinions during meetings.

We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. Arrangements were in place for ongoing audits and checks on processes and systems including: 'dementia friendly' audits, finances, medicines management, accidents, activities, housekeeping, health and safety, falls, infection prevention and control and care plans. We noted examples where shortfalls had been identified and addressed. The manager had introduced evening and weekend 'spot checks' to ensure people were receiving safe and effective care. The area manager carried out compliance visits on behalf of the provider; this involved ensuring the audits were completed and actioned. The provider also made regular visits to the service. We discussed with the provider and area manager, ways of introducing a more structured approach to demonstrating the provider had oversight of the service.

We looked at how are people who used the service, staff and others were consulted on their experiences and shaping future developments. The service encouraged regular feedback from people informally and through regular meetings. People who used the service and their relatives had been given the opportunity to complete a satisfaction survey in January 2018. This was an in-depth survey focussing on staff availability, staff conduct, consultation and respect. The responses had been collated and analysed. We found following the survey action had been taken to make improvements, for example staffing levels had been increased. The outcomes of the surveys were due to publicised at the service. A further survey on privacy and dignity had recently been distributed. One person who used the service told us, "They come round with surveys and ask us what we think. I feel involved with things." There had been a staff consultation survey the previous year; however the area manager explained this was under review to improve the process.

We reviewed how the service continuously learned, improved and developed. There were several detailed action plans which clearly identified matters for future improvement. Information in the PIR also showed us the provider had identified some matters for ongoing development over the next 12 months. We evaluated how the service worked in partnership with other agencies. We found arrangements were in place to liaise with others including: social services, healthcare professionals, churches, pharmacists and training providers. There were established links with local forums, groups and incentives, for example the service was part of the 'Red Bag Scheme.' This was an information sharing initiative, to improve the transition process when people accessed other services such as hospitals. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding team and public health. Our records showed that the management team had appropriately submitted notifications to CQC.