Mrs Safia Bano Hussain

Bankfield Manor Care Home

Inspection report

Boothtown Road
Halifax
West Yorkshire
HX3 6HG

Tel: 01422352398

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 15 December 2016.

The last inspection took place on 11 April 2016 when we rated the service as 'requires improvement' and found the service was in breach of one regulation relating to staff recruitment.

Although the service is registered to provide care and support for up to 25 people the maximum capacity of the home is 21. All of the bedrooms are single and nine have en-suite toilet facilities. There are two lounges and a dining room on the ground floor and an enclosed garden area at the front of the building. Accommodation is arranged over two floors, which can be accessed using a passenger lift in the main building, or a stair lift in the extension. On the day of the inspection there were thirteen people living at the home and one person was in hospital.

There was a registered manager in post. 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.

We found, staff were being recruited safely and staffing levels were appropriate to the needs of the people living at the home. Staff were supported to make sure they received the training they needed to be effective in their role.

Systems were in place to make sure people were safe and staff understood how to identify and act on any allegations of abuse. Overall systems for managing medicines were safe.

Environmental safety checks were completed appropriately and adaptations had been made to meet the the needs of people living with dementia.

People who used the service told us they liked the staff and found them kind and caring. We saw staff were kind and patient with people.

We found better systems were needed to make sure the service was working in line with the legal requirements relating to Deprivation of Liberty Safeguards (DoLS) and staff needed more training to better their understanding of this.

People told us they liked the meals and work had been done to make sure the diet was suitable to the nutritional needs of the people living at the home.

People's healthcare needs were being met and systems were in place to make sure people received their medicines safely and appropriately.

People engaged in activities on a daily basis with dementia friendly materials available to people although no structured programme was in place.

Complaints were investigated and responded to although improvements were needed to make sure investigations were thorough and objective.

A range of checks and audits were in place with analysis and actions taken. However audits had not always picked up issues where actions were needed.

Regular staff meetings were held and people's opinions of the service were sought through annual surveys.

We found one breach of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were being administered and managed safely.

People told us and we observed there were enough staff on duty to provide care and support.

Staff understood the safeguarding process and how to report concerns.

Risk assessments were in place to mitigate personal risks to people and environmental risks.

Regular checks were taken to make sure the environment was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not fully understand the Mental Capacity Act and Deprivation of Liberty Safeguards.

Records showed people had access to healthcare professionals, such as GPs, opticians, district nurses and chiropodists.

Most people told us they liked the meals; however, we saw people had to wait for long periods for a drink when they got up in the morning.

Adaptations were in place to support people living with dementia.

Is the service caring?

Good

The service was caring.

People were treated with respect and consideration was given to promoting people's dignity.

Staff knew people well including likes, dislikes and care needs.

Staff communicated well with people using a variety of communication techniques.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all care plans had been updated to reflect the current needs of the person.

Complaints were responded to but investigation of complaints was not always appropriate.

There were some activities on offer to keep people occupied.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance audits were in place and actions taken as a result. However, audits had failed to identify some areas requiring action.

People were asked for their views of the service.

Regular staff meetings were held.

Bankfield Manor Care Home

Detailed findings

Background to this inspection

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

The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We had asked the provider to complete a Provider Information Return (PIR) prior to the inspection in April 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document had been completed and returned to us prior to the April 2016 inspection and therefore we did not ask for another to be completed for this inspection.

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

We spoke with five people who lived at Bankfield Manor, three care workers, the senior care worker in charge, a visiting district nurse, the registered manager and registered provider. There were no people visiting on the day of our inspection.

Good

Is the service safe?

Our findings

Staff we spoke with were aware of how to identify and act on any allegations of abuse. They told us they thought people were safe living in the home and raised no concerns with us. People told us they felt safe in the company of staff. One person told us how they always felt safe and secure whilst being transferred by hoist.

People did not raise any concerns over staffing levels. One person said, "Mostly enough staff but sometimes a bit busy in the mornings." Staff we spoke with told us the planned staffing levels were appropriate. We observed care and support and saw staff were visible in communal areas and able to offer assistance promptly when required. Staff had time to engage in activities and social interaction with people as well as care based tasks.

The registered provider told us the staffing levels for the service at the current occupancy and dependency levels of the people living there were three care staff including a senior staff member between 8am and 8pm, and two care staff (including a senior staff member) during the night. They told us a dependency tool was used to calculate staffing levels. The manager worked approximately 8am until 3pm Monday to Friday. Care staff were supported by a domestic working four hours each morning and a cook working between 8am and 1.30pm each day. At the time of our inspection the service was in the process of recruiting a cook. Care staff were covering this vacancy until the new cook started work.

We looked at two staff recruitment files and saw safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people. Documentation showed the required checks were undertaken before staff started work. References were requested and checks performed with the Disclosure and Barring Service (DBS) to establish whether potential applicants had any criminal convictions before they were offered a position. A new staff member we spoke with confirmed that they had been recruited safely with the appropriate checks taken and attendance at an interview.

In addition to staff working in the home on a permanent basis, we saw checks had been completed for the visiting chiropodist and hairdresser.

Risks to people's health and safety were assessed and risk assessment documentation put in place. This included risks associated with skin, moving and handling, nutrition and falls. These were subject to regular review, although we found a couple of assessments had not been reviewed following changes in people's needs.

Personal Evacuation plans were in place which described how to evacuate people safely in the event of an emergency.

We saw a number of environmental risk assessments and saw regular audits were taken to make sure the building was safe. This included checks on gas and electrical safety, checks of water storage and temperatures and checks of the passenger lift and lifting equipment including slings. Records showed staff

undertook regular fire training. COSHH (Control of Substances Hazardous to Health) assessments were in place for all cleaning products used in the home and we saw this had recently been audited.

We found the home to be clean and tidy although there was a malodour in one of the upstairs corridors. The provider told us they were aware of this and had had the carpet cleaned a few days before our inspection. They accepted the cleaning had not been effective and assured us they would attend to the problem.

The home had achieved a five star rating from the Food Standards Agency. This is the highest rating that can be achieved. Anti-microbial door handles were in place to reduce the likelihood of cross-infection between different areas of the home and hand washing and sanitizing equipment was available in all areas.

We reviewed accidents and incidents and saw these had been reported appropriately and analysed monthly for any themes and trends such as particular times of day and which people were involved in the incident. A further six monthly review of accidents was conducted to give a broader picture of themes and trends. Any actions taken to mitigate the risks to people were recorded within the action plan.

We found medicines were managed in a safe way. Medicines were administered by senior care staff. We observed the administration of the morning medicines and saw staff did this with care and patience, asking people what drink they preferred to take their medicines with.

We looked at a sample of medication administration records (MARs) and found they were appropriately completed with the correct recording codes indicating people had received their medicines as prescribed. We checked four medicines supplied in boxes and found the balance available was consistent with the amounts recorded as received and administered.

Some people were prescribed topical creams but we did not see any related body maps to show where the cream should be applied.

We saw the majority of medicines supplied to the home in tablet form were supplied in dosette boxes with all the tablets for each administration time in a single sealed pod. Staff told us they carefully checked each tablet within the pod against the description supplied to make sure the pods contain the correct tablets.

Some people were prescribed 'as required' or PRN medicines, for example to control pain or distressed behaviour. We saw clear protocols were in place for staff to follow to ensure these were offered in a consistent manner. We also saw that where a PRN medicine to control distressed behaviour had been given regularly, staff had recorded the reasons why the medicine had been given and had discussed this with the appropriate health care professional.

We saw one person's medicine instructions said they could have their tablet crushed and mixed with food or juice. The senior care assistant told us they had a letter from the GP with these instructions. However we saw the letter asked staff to crush regular medicines but did not mention putting it in food. We were concerned that putting the crushed tablet in food could mean the medicine was given covertly. The senior care assistant told us the medicine was never put in food but to make sure this did not happen the provider asked for the instructions to be changed immediately.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs. Whilst there were no controlled drugs on the premises at the time of the inspection we saw appropriate arrangements were in place to ensure their safe storage and use.

Storage of medicines was safe and daily checks taken on the storage temperatures.

Requires Improvement

Is the service effective?

Our findings

The provider told us that new staff without previous care experience completed the Care Certificate. The Care Certificate is a nationally recognised study plan for people new to care to ensure they receive a broad range of training and support. Staff with previous experience in care undertook a self assessment from the Care Certificate to establish their current skill level and any initial training needs.

Staff received regular training updates in subjects such as safeguarding, manual handling, mental capacity and infection control. We spoke with a new member of staff who told us the induction process had been very thorough and they had been taught in depth about the needs of the people living in the home.

We saw each member of staff had an individual training monitoring form and a personal development plan. The training monitoring forms showed when training was due to be updated with some training updates planned on a three yearly basis and others in areas such as moving and handling and fire safety on an annual basis.

The provider told us training was delivered in a variety of ways including in-house training by the provider, on-line training and external providers. The provider told us about some training they had booked to particularly help staff support people receiving respite care so they could focus on improving their skills in readiness for returning home.

Staff received regular supervision during which any training they had undertaken was revisited to make sure they had understood the training and were applying it effectively to their work.

Staff were supported to stay healthy with arrangements in place for them to access free hepatitis and flu vaccinations.

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. In the case of a residential home a Deprivation of Liberty Safeguards (DoLS) must be in place. The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control.

DoLS applications had been made although we had some concerns about the blanket approach adopted by the provider. Applications had been made for all people living in the home rather than careful consideration of whether people had the capacity to consent to their care and treatment and whether any restrictions placed on them accumulated to deprive the person of their liberty.
We also found one person's DoLS Authorisation had expired in November 2016 without the manager being

aware. This meant that the service was potentially depriving the person of their liberty without the necessary authorisation.

The service had not reviewed the conditions placed on DoLS authorisations in order to plan and deliver appropriate care. For example one person had a condition stating that best interest decisions within their care plan needed to be more specific but this had not been done. Another person's DoLS conditions stated the home must ensure a structured activity plan was in place and a risk assessment for community access but these had not been actioned by the registered manager.

We reviewed best interest decisions in place within people's care files. The outcome of these was not always clear. For example, one person was known to refuse personal care and support. Although the best interest decision established they did not have capacity to consent to personal care, it not did specify what the plan of care going forward was and how to manage their refusals. The document also made reference to their relative having Lasting Power of Attorney when this was not the case.

We also found staff and management were not clear about who had a Lasting Power of Attorney or DoLS in place.

The provider was aware they needed to have a better oversight of DoLS authorisations and had a planned audit of DoLS to take place within December 2016 to ensure a clear matrix was in place of when DoLS expired and that the conditions attached were included in care plans and met.

However the lack of compliance with conditions attached to DoLS authorisations and the lack of staff understanding about which people had DoLS in place demonstrated a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people said they enjoyed the food in the home. One person told us, "Food is alright, nothing wrong with it," and another person said, "Food is ok." A third person said, "Lots of things I can't eat, they are very good and always make me something different that agrees with me." However a fourth person told us, "Food was rubbish."

We saw there was sufficient choice of food available to people. People had the choice of a cooked breakfast, cereals and toast at breakfast time. A structured lunchtime and teatime menu was in place which rotated over three weeks. People had the choice of two hot options at lunchtime and a hot and cold option in the evening. Where people did not like the options available an alternative was made, for example we saw one person was not keen on their lunchtime meal so was provided with sandwiches.

The provider told us they had consulted people living at the home and their families when formulating the menu. They said they had also gathered information relating to nutrition for the elderly from the British dietetic association.

We observed the lunchtime meal and found overall it was a pleasant experience. Tables were set and people had access to condiments. We saw crockery and cutlery had been purchased to support people living with dementia in their independence and dignity. People who required assistance were supported patiently and kindly by staff. However we identified one person's mealtime experience could have been improved. The person was taken into the dining room at lunchtime; however as another person objected to them sitting at their table, they were removed from the room and had to sit on a table by themselves in the sub-dining room which was covered in folders and paperwork. When we spoke with the person they said they would have preferred to eat in the main dining room with other people. We concluded the dining arrangements

could have been better arranged to ensure this person was included.

People's weights were monitored and where weight loss identified referral onto the QUEST (community nursing service) matron was undertaken. Where people were at identified as being at risk, control measures such as food supplements, fortified food and recording of food and fluid intake was undertaken.
Staff we spoke with were clear on who required adapted diets, for example pureed food. They were clear on who required thickeners and exactly how much needed adding to drinks. This gave us assurance that people were receiving the required support in line with their plans of care.

Snacks were provided throughout the day which included biscuits, cakes, fruit and milky drinks. However when we arrived at the home at 8am we saw a large number of people were already up and had not received a drink. People were left without a drink until they were called into breakfast at 9am, despite the mealtime planner stating that people should receive a drink when they got up. We saw staff meeting minutes which showed staff had been reminded of the importance of providing people with drinks when they got up in the morning. The provider told us they were disappointed to hear our observations and said they would speak again with staff.

People's healthcare needs were assessed and plans of care put in place. We saw evidence staff had referred people to external health professionals such as district nurses, QUEST matrons, doctors and the mental health service. The advice and outcome of these visits was recorded to assist staff in providing appropriate care.

We spoke with a visiting district nurse who told us they were happy with the way staff at the home worked with them. They said staff requested their involvement appropriately and followed any advice they were given.

The home had been adapted to make it suitable for people living with dementia. Clear signage was in place, for example on bedroom doors there were large pictures of the person on their door to aid in its identification. Doors were painted a distinct colour to aid people navigating throughout the home. Appropriate dementia friendly signage was present throughout the home. A varied and stimulating environment had been created throughout the home including various sensory areas to provide a sensory journey for people to enjoy.

Good

Is the service caring?

Our findings

People told us staff were kind and compassionate and treated them with dignity and respect. One person said "staff very helpful" and another person told us " I like living here"

We saw a compliments form which said, "(Name) is treated with utter respect and decency/dignity, the home is nicely decorated taking into account sensory needs… we are very satisfied with (Name's) care and welfare."

As a number of people were unable to communicate verbally with us we observed care and support for an extended period in the communal areas. We saw staff treated people well and interacted positively with them. As well as undertaking task based interactions, staff had the time to sit with people and provide companionship, social interaction and sensory activities for people. Staff used a mixture of verbal and non-verbal techniques to communicate effectively with people. When people became anxious or distressed, staff recognised this and provided appropriate comfort for people.

People's privacy and dignity was respected. For example, staff knocked on doors before entering and during moving and handling tasks we saw care was taken to adjust people's clothing and ensure their privacy and dignity was maintained. People were offered clothing protectors at mealtimes and adapted plates were provided to reduce the risk of spilling food and helping people to maintain their independence. We also saw Ottoman style boxes had been provided in bedrooms. The provider referred to these as 'dignity boxes' as this was where personal items such as incontinence aids were stored without being seen by people visiting the bedroom.

People looked clean, tidy and well-dressed indicating their person care needs were being met by the service.

People were offered choices, listened to and their views acted on. Most people living in the service were living with dementia. Communication was supported through the use of pictorial cards to promote understanding. These included cards containing daily living choices and activities. At lunchtime the cook used pictures of the food on offer to obtain people's views and choices; this was then supported by show plates when the meal arrived which were a visual prompt of what food was being served.

Information on people's likes dislikes and preferences had been sought including life history. This helped staff to understand people's experiences and helped provide personalised care.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race.

We saw an example of how the service took account of people's protected characteristics in the care assessment and planning where consideration was given to potential sexual needs of people and how their

privacy could be maintained. The provider also told us about how they had recently supported a service user on respite care who had particular needs in relation to their race and religion.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said they were satisfied with the care and support provided by the service.

People's care needs were assessed and plans of care put in place. These covered areas such as mobility, falls and continence. We saw consideration had been given to how physical and psychological factors may have affected people's well-being. For example, we saw a falls prevention plan included questions about the persons mood, whether they might be suffering from an infection or whether conditions such as constipation might be having an adverse effect on the person.

The care plans provided a good level of personalised information including people's preferences , likes and dislikes and privacy and dignity needs with regards to their care and support.

Care plans were regularly updated with any changes written in the evaluation section of the plan. Although this provided clear evidence that people's needs were regularly re-assessed, in some cases care plans would benefit to be rewritten following substantial changes evidenced in the evaluation sections.

We found some omissions in care plans. For example one person did not have a social/emotional care plan in place which is important for people living with dementia. Another person's skin integrity risk assessment had not been updated following deterioration in their condition and the fact that they were bedbound. Their skin care plan also stated they were fully mobile despite this no longer being the case. The person had also had a catheter in situ until recently but there had been no accompanying care plan or mention of this fact within the continence care plan. Although we were assured they had the required equipment and provision of care, heavily supported by external health professionals this was not reflected in the records.

Staff we spoke with had a good understanding of the care and support people required. We saw evidence care plans were followed. For example, where a person required regular pressure relief records confirmed this had taken place and staff were clear about the plan of care. Where people required pressure relieving cushions and nutritional thickeners we saw these were provided in line with the plan of care.

Prior to our inspection we had received concerns from a visiting professional, which had been shared with the service, relating to a person living at the home who was unsafe using the stairs but attempted to do this independently. The registered manager told us they had spoken with this person and offered them a room on the ground floor. The person had agreed and the move had taken place. The meant the service had responded to feedback and taken action to mitigate the risks to the person concerned.

Although there was no activities co-ordinator employed or structured activity plan, people were provided with activities on an ad-hoc basis by care staff. We saw staff engaged people in a range of activities tailored to the needs of people living with dementia. Reminiscence and photo books, textured materials and sensory lights were made use of. We saw a lifelike baby doll was brought to the home for people to interact with if they wished. Staff were careful to ask people if they would like to look at it and understood that some people would not want to engage with it. Staff had time to interact with people in between care and support

tasks and this created an atmosphere where everyone received some one to one attention.

We saw plans were in place for a Christmas party where people who lived at the home would go to another of the provider's services to enjoy a very festive occasion including a sleigh and reindeer and a buffet meal.

We looked at how complaints to the service were managed. Whilst complaints were recorded along with the outcome, we found the investigations into the concerns were poor and appeared to lack appropriate responses rather than staff accepting responsibility for the situation and making appropriate apology.

We also saw records of compliments to the home. For example one person wrote to compliment the service on the new astro-turfed outside seating area.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had recently returned to work from a period of sick leave. They had been supported by the provider in a phased return and at the time of the inspection was back to full time hours. Staff working at the home told us, "Manager is nice, supportive; told me everything I need to know." Another member of staff when asked how they felt about working at the home said, "Fantastic, very happy here."

A senior care worker undertaking management training to support the manager had also needed to take a period of leave but had returned at the time of the inspection.
The provider told us they had provided extra input to the service during this time.

We saw a range of systems were in place to audit the quality and safety of the service provided. Monthly audits took place with particular attention given to to an identified area each month for example weight monitoring and nutrition. Monthly audits covered areas such as health and safety, infection control, care plans, accidents and incidents and medicines. We saw evidence that action plans were produced following these audits and action taken in relation to any issues. However, we noted the issue we identified with regard to possible covert administration of medicine had not been picked up on the previous medication audit and lack of updating of some care plans had not been identified. We also noted that although the provider had planned an audit relating to DoLS, issues relating to management of DoLS applications had not been picked up through care plan audits.

We saw evidence the provider undertook monthly quality audits of the service which included checking the quality of the audits completed by staff at the home.

In addition to audits we saw a number of safe systems of work had been produced covering areas such as working in the laundry and bed making.

We saw staff meetings were held on a regular basis which were organised to include night staff. These provided staff with an opportunity to discuss any issues and any recent training was discussed to make sure it had met staff needs. We saw issues around supporting people with their dignity needs were discussed at the meetings.

The provider told us they did not hold meetings for people who lived at the home and their relatives but did seek their views through annual satisfaction surveys. Surveys had just been sent out at the time of our inspection and we saw the one returned indicated high levels of satisfaction with the service.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had not complied with conditions attached to DoLS authorisations. Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.