Tamaris Healthcare (England) Limited

Bannatyne Lodge Care Home

Inspection Report

Manor Way
Peterlee
County Durham
SR8 5SB
Tel: 0191 586 9511
Website: www.fshc.co.uk

Date of inspection visit: 23/04/2014
Date of publication: 13/08/2014

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask about services and what we found 3

What people who use the service and those that matter to them say 7

Detailed findings from this inspection

Background to this inspection 8

Findings by main service 9

Action we have told the provider to take 18

Summary of findings

Overall summary

Bannatyne Lodge is a purpose built care home in the town of Peterlee, County Durham. It provides general nursing, residential, respite and palliative care for older people over two floors for up to 50 people. The home is close to shops and local amenities. On the day of our inspection 34 people were living at Bannatyne Lodge.

Since our previous inspection in January 2014 the service had made significant changes to the management of the home and had improved the quality of staff training to ensure staff were able to meet the needs of people who used the service, keep them safe and minimise the risks of abuse. However, the home did not have a permanent registered manager. At the time of the inspection the manager had submitted an application to register with the Care Quality Commission.

People who used the service and people and their family and friends, had been encouraged to make their views known about their care. People's care plans had information about how each person should be supported. However, the care plans we looked showed the provider had not always assessed people in relation to their mental capacity and considered whether the services needed to make notifications to other authorities for anyone who may be deprived of their liberty under the deprivation of liberty safeguards. We also noted that some risk assessments were not included in people's care plans and some care plans were not detailed. This meant people were at risk of not having their fully needs met.

Everyone looked relaxed and comfortable at Bannatyne Lodge. People told us they were happy living in the home and they felt safe. People described the staff as kind and caring. We observed staff supporting people with respect, being polite and courteous. This was an improvement following our previous inspection in January 2014, where people expressed they were unhappy and care staff did not respond to their needs in a caring manner.

We found people were cared for, or supported by sufficient numbers of suitably qualified, skilled and experienced staff. We saw people were offered a range of activities both as part of a group and individually.

The home was clean and hygienic. This again was an improvement as the service had previously failed to provide an environment which was clean and hygienic.

The problems we found breached Regulation 9 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report. People's safety and care was put at risk because care plans were not sufficiently detailed or up to date to guide staff and did not accurately reflect people's mental capacity as assessments had not been completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People's safety was put at risk because care plans were not sufficiently detailed or up to date to guide staff and did not accurately reflect people's mental capacity as assessments had not been completed.

The care plans we looked at showed the provider had not always assessed people in relation to their mental capacity, whether people were able to make their own choices and decisions about their care and that deprivation of liberty safeguards had not been taken account of where appropriate for every person who used the service. We noted in some people's care plans consent had been obtained but in other people's care plans there was no evidence of consent being obtained. This meant there had been a breach of the relevant legal regulation (Regulation 18) and the action we have asked the provider to take can be found at the back of this report.

People we spoke with told us they felt safe. However, two members of staff were not able to explain the service's safeguarding procedures which could put people who used the service at risk of unsafe care and support. We noted safeguarding training had been changed and was now more effective.

Risk assessments were included in people's care plans; however, in some instances these had not been completed. For example, one person did not have a risk assessment for their hygiene needs.

The service had an effective system to manage accidents and incidents and to learn from them, so they were less likely to happen again. This helped the service to improve and develop, and reduced any risks to people.

The home was clean and hygienic and the people we spoke with told us they had no concerns with the cleanliness of the home.

Are services effective?

We saw people's care plans were not detailed and clear enough to ensure people's needs were being met appropriately; therefore people could be at risk of not receiving the care and support required. This meant there had been a breach of the relevant legal regulation (Regulation 9(1)(a)(b)(i)(ii)) and the action we have asked the provider to take can be found at the back of this report.

People's health, care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative or advocate prior to them living at

Summary of findings

the home. We saw people's care plans reflected individual current needs. However, some care plans did not always describe people's physical and mental health conditions. This meant people were at risk of not having their needs met.

People could make decisions about their care and those decisions were respected. People told us they were happy with the care and support they received and their needs had been met. It was clear from our observations and from speaking with staff they had a good understanding of people's care and support needs.

People told us if they felt unwell they had access to a range of health care services and this was reflected in people's care plans.

People were supported by staff who were trained to deliver care safely, and to an appropriate standard. Staff had a programme of training, supervision and appraisal. Staff had received training in the core subjects needed to provide care to people. The service also had an induction programme for new people coming to work in the service.

Are services caring?

When speaking with staff it was clear they cared for the people they supported and they understood people's care needs. We saw staff were patient and kind with people who used the service. We saw staff sat chatting with people in the lounge areas and people were encouraged to share their views with members of staff and the management team.

Making sure people's privacy was protected was part of people's care plans. People's preferences, interests, aspirations and diverse needs had been recorded and care and support was provided in accordance with people's wishes. We saw staff maintained people's privacy and dignity while providing care and support.

People we spoke with said they were happy with the care provided and could make decisions about their own care and how they were looked after. People told us staff were kind and caring and said they were not rushed into doing things. We saw staff were attentive to people. Staff and people who used the service related to each other with warmth.

Are services responsive to people's needs?

We saw people's needs had been assessed before they moved into the service which included recording in their care plan their preferences, interests, likes and dislikes. They also contained information of how each person should be supported and cared for.

Summary of findings

We saw people were offered a range of activities both as part of a group and individually. An activity co-ordinator was available daily. The list of daily and monthly activities were available in people's bedrooms and in the entrance to the home. We saw people were encouraged to maintain relationships with friends and family.

People knew how to make a complaint if they were unhappy. We saw how to complain information was displayed in the entrance to the home and was provided in people bedrooms. We spoke with the manager regarding how they monitored complaints. They explained the complaints procedures. They said complaints were fully investigated and resolved where possible to the person's satisfaction. The provider took account of complaints and comments to improve the service and we saw evidence of this on the day. People could therefore be assured complaints were investigated and action taken as necessary.

Staff asked for people's views, encouraged them to make decisions and listened to them. However, this was not always reflected in people's care plans.

Are services well-led?

At the time of the inspection the manager had submitted an application to register with the Care Quality Commission.

The provider had systems in place to assess and monitor the quality of the service at Bannatyne Lodge. Monthly quality visit reports were completed by the area manager. We saw records which showed identified problems and opportunities to change things for the better were addressed promptly. As a result the quality of the service was continuously improving and action plans were in place to address failings identified at the last inspection. We also saw reports regarding the running of the service that were sent to the senior management team. However, We saw people's care plans were not detailed and clear enough to ensure people's needs were being met appropriately; therefore people could be at risk of not receiving the care and support required.

We saw people were asked for their views and had a chance to say what they thought about the service and what was important to them. People were asked to fill in questionnaires about the quality of the service and were able to attend resident and relatives meetings if they wished.

We saw records to show staff attended meetings and discussions included the values of the service which were based around the ethos of the home. We also saw policies and procedures around the values which were part of the staff induction programme.

Summary of findings

The service had systems in place to make sure managers and staff learnt from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This helped to reduce the risks to people who used the service and helped the service to continually improve and adapt.

The area manager told us they took people's care and support needs into account when making decisions about the numbers, qualifications, skills and experience of staff required. We saw staffing levels were regularly reviewed and a system was in place to monitor if there were sufficient numbers.

Staff told us they were clear about their roles and responsibilities. They said the service had improved and the new manager was professional and supportive. However, four staff we spoke with said they were not aware of the organisations ethos and objectives. This may mean people could be at risk of receiving care in an environment which was not well lead.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 16 people who used the service and five relatives.

People we spoke with said they were happy with the care provided and could make decisions about their own care and how they were looked after. Everyone we spoke with told us their privacy and independence was preserved. They said staff encouraged them to be as independent as possible. People told us they were able to join in with the planned daily activities if they wanted to. We saw people had access to advocacy service if required. Advocacy information was display on the notice board in the entrance to the home.

People shared their experience of receiving personal care with us and told us how staff maintained their dignity during intimate care moments. People said, "I get help with showering. Staff keep as much of me covered that they can", "I no longer feel embarrassed, after a while you get used to someone washing you but they keep my independence and privacy as much as they can" and "Well it is something you get to accept. They do whatever I ask, I have a bath about three times a week, they always keep me well covered over and private."

Staff supported people without rushing, giving them time to do things at their own pace. People we spoke with told us they were happy living in the home. They said, "She, (pointing to a care worker) is wonderful, nothing is too much of a problem for her", "Staff are pleasant and more helpful, they are getting there." The relatives we spoke with said, "We are much happier with the care mam is getting. It is good that they have a meeting where residents and families get together and can have their say."

The relatives we spoke with told us they were happy with the care and support their family member received at the home. They told us the staff understood the care and support needs of their family member. They also told us they were contacted by the home straight away if their family member required any treatment.

Bannatyne Lodge 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 was meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We visited the home on 23 April 2014. We spent some time observing care in the lounge and dining room areas to help us understand the experience of people who used the service. We looked at all areas of the home including people's bedrooms, the kitchen, laundry, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care and the management of the home.

The inspection team consisted of a lead inspector, two Care Quality Commission inspectors, an inspection manager and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience gathered information from people who used the service by speaking with them in detail.

Before our inspection, we reviewed the information we held about the service. We contacted the local authority who told us they did not have any current concerns and Healthwatch also stated they had no comments or concerns regarding Bannatyne Lodge.

On the day of our inspection 34 people were living at Bannatyne Lodge. We spoke with 16 people who used the service, five relatives and seven members of staff. Staff we spoke with included the area manager and the director of operations. We also looked at seven care plans.

We visited the service in October 2013 and January 2014 to follow up on concerns identified at our visit in July 2013. In January 2014 we found ongoing breaches of Regulation 17, 9 and 12 relating to respecting and involving people who use the service, care and welfare and cleanliness and infection control. We also found a breach of Regulation 11 in relation to safeguarding people. The provider sent us an action plan every week to tell us how they were making improvements. During this inspection on 23 April 2014 we looked at whether the required improvements had been made.

Are services safe?

Our findings

Care plans did not accurately reflect people's mental capacity as assessments had not been completed. The service were not following the Code of Practice to the Mental Capacity Act 2005 when assessing whether people have the mental capacity to take particular decisions, or when taking decisions on their behalf. This meant there had been a breach of the relevant legal regulation (Regulation 18) and the action we have asked the provider to take can be found at the back of this report.

We looked at seven care plans and information showed the provider had not always assessed people in relation to their mental capacity to make their own choices and decisions about care. For example one person's care records stated they had fluctuating capacity to make decisions about their care but there was no record of the person's capacity being formally assessed. We noted in some people's care plans consent had been obtained, including a record of verbal consent. However, in other people's care plans there was no evidence of consent being considered.

We saw that deprivation of liberty safeguards had not been taken into account where appropriate for people that used the service. For example we noted this had not been considered for one person who had the use of bedrails.

In one person's care plan we saw a tool to assess the levels of depression in people with dementia had been used in which a score of eighteen had been recorded. The guidance for this tool stated 'depressive symptoms are suggested by a total score of 8 or more'. However, no action had been taken and no associated care plan or risk assessment had been completed.

People who used the service informed a member of the inspection team they felt safe living at the home and knew how to report abuse. We spoke with one member of staff who told us they had attended safeguarding training which covered the categories of abuse and how to identify and report abuse. The member of staff was able to tell us how to report abuse to their managers and external authorities such as the local authority, police and the Care Quality Commission. The training records we saw confirmed safeguarding training had taken place. However, two staff members we spoke with were not able to describe categories of abuse or inform us of external authorities they could contact should they suspect abuse.

When staff received training in moving and handling they were assessed afterwards to make sure they put into practice what they had learnt. For example the area manager was able to show us regular supervisions where the nurse in charge and the manager would work alongside staff to ensure safety during moving and handling situations. Where practices fell short of expectations these were managed with additional training and supervision.

We saw people being hoisted for example from a sitting position in an armchair. We saw this was done safely and it was clear from their reactions they felt safe. We noted staff spoke reassuringly to people, supported people in their movement and encouraged them to do as much as possible for themselves during this process. Staff used correct techniques and carried out the moves safely. One person told us, "Yes, I feel quite safe when I am in the hoist. There are always two staff and they ask if I am OK."

The care plans we looked at had an assessment of care needs and a plan of care, which included some risk assessments. The risk assessment we saw included choking, self-neglect, going out with family members and heat waves. We saw staff were present in dining area at all times. This meant people at risk of choking were kept safe and were supervised. However, in one person's care plan for infection control if stated they required help with 'hygiene needs.' There was no risk assessment for hygiene needs which meant they may not have received the care they needed.

We noted the home was clean and tidy throughout and there were no unpleasant smells. Staff confirmed they were supplied with the correct personal protective equipment when carrying out infection control procedures. We saw there were appropriate foot operated yellow bins in the bathrooms and toilet areas for clinical waste. We looked in the laundry and saw there was a system in place to make sure dirty and clean laundry were kept separate. There were effective systems and numbers of staff in place to reduce the risk and spread of infection.

We saw a number of the people's bedrooms had been or were in the process of being redecorated. We noted bedrooms and bedding were clean, new carpets had been

Are services safe?

laid and several new wardrobes and dressing tables arrived whilst we were inspecting the home. We were told by two people who used the service that they were expecting new armchairs to be delivered to them in the near future. We saw daily, weekly and monthly infection control tasks were carried out in the home and these included bedrooms, lounge and dining areas. We saw one member of staff was deep cleaning people's bedroom carpets on the day of our inspection. One member of staff told us the manager checked the standards of cleaning on a daily basis.

Staff demonstrated good knowledge and awareness of their responsibilities for infection prevention and control and there was evidence staff had received relevant training. Members of staff we spoke with said they had completed infection control training and the training records we looked at confirmed this. There were up to date infection control policies and procedures in place.

Are services effective?

(for example, treatment is effective)

Our findings

Three people we spoke with who used the service said they had not seen their care plan and did not know what it entailed. They said, "I don't know about care plans, I know nothing about them" and "I have not heard of any plans, what are they."

We looked at care plans for seven people and found people's health and care needs were assessed with the involvement of the person or their families. However, care plans were not detailed and did not always contain relevant details about people's physical and mental health conditions. For example, one person had osteoporosis but this was not included in their moving and handling documentation. Another person's NHS discharge notification dated 3 January 2013 included their medical history. There was no reference in their care plans to a condition they had which could cause cognitive problems.

We spoke with staff about what information they had prior to people coming to live at the home. Staff told us the nurse in charge or the manager would meet with the staff to ensure they had up to date knowledge of the person's personal preferences such as preferring male/female care worker and the person's care needs.

We spoke with three staff members about people's care plans and asked if they had been given opportunities to read them and understand people's care needs. Staff told us they had not read people's plans in any detail.

We saw in one person's care plan that between 3 February 2014 and 4 April 2014 they had lost 13.1kg but it had taken two months for staff to refer the person to the dietician and speech and language team regarding this severe weight loss. This meant there was a delay in the person receiving appropriate advice and treatment.

People could make decisions about their care and those decisions were respected. For example, one person refused to stop drinking alcohol and displayed behaviour which was a challenge for staff. Staff respected the person's choice whilst trying to promote the safety of all involved. People were able to say how they wanted to spend their day and what care and support they needed. We saw the layout of one person's room and the building allowed them freedom to move around and do things for themselves. However, we saw one person's end of life care plan was not detailed. It outlined their choice of undertaker and whether burial or cremation but there was no evidence they had been involved or they had been consulted about their wishes for their last days.

We saw people's care plans were not detailed to ensure people's needs were being met appropriately. This meant there had been a breach of the relevant legal regulation (Regulation 9(1)(a)(b)(i)(ii)) and the action we have asked the provider to take can be found at the back of this report.

People who used the service told us if they felt unwell or if the manager felt they needed to see their GP then the GP was called to see them within the home. On the day of our inspection we saw one person was visited by a GP. People told us they were quite happy with the care they received when they felt unwell. People said, "If I don't feel too good and want to see the doctor, then the doctor comes to see me. I have been with the same doctor for years", "I suffer from low blood pressure, I was not feeling so well. My GP came to see me today. I was given medication to remedy my problem"; "The nurse is coming today to give me an injection. I get the injection every month and she writes it down on my chart. She is a really nice person."

We looked at staff training records and found staff received training in key areas such as moving and handling, medication administration and recording keeping, privacy and dignity, safeguarding people from abuse, infection control, person centred care, reflective practice and managing complex conditions such as dementia. The quality manager told us future training would include the resident experience, the Mental Capacity Act 2005 and deprivation of liberty safeguards. We saw a staff knowledge and skills audit had been completed. This identified individual training requirements.

We found when staff had received training it was assessed to ensure it was effective, for example the area manager was able to show us regular staff observational supervisions took place where the nurse in charge and the manager would work alongside staff to ensure they were ensuring people's safety during moving and handling situations and where practices fell short of expectations these were managed with additional training and supervision.

We spoke with one member of staff who was new to the service and asked about information relating to their induction. The staff member showed us a booklet they had

Are services effective?

(for example, treatment is effective)

been given to work through which covered areas such as delivering personal care, keeping people safe and information regarding the organisations policies. The staff member told us their induction initially consisted of shadowing another member of staff appointed to them for a period of two weeks to learn what to do.

We saw from the records we looked at that staff received supervision on a monthly basis. We noted also that staff observational supervisions were conducted monthly. We spoke with staff as they worked and saw they had the necessary skills needed to carry out certain tasks such as moving and handling. People's care needs were met by suitably qualified staff.

Are services caring?

Our findings

During our inspection we observed positive interaction between the staff and people who used the service. Staff and people who used the service were sat in the lounge chatting. Staff had a good rapport with people and were pleasant and friendly. It was clear from the way staff spoke with people that they cared about them.

Staff supported people without rushing, giving them time to do things at their own pace. People we spoke with told us they were happy living in the home. They said, "He is good to have around, we have a bit of a banter and joke together, he is great", "It is a lot better in here now than it used to be."

We saw staff were kind and compassionate to people in the dining room at lunch time. We observed the staff supporting people to eat at the pace the person could manage. People were not hurried in any way. People were given a choice of pudding and they decided when they had had enough to eat. A member of staff was very kind to one person and they did their utmost to try to support the person have some lunch. The person did have a small sandwich and a bowl of ice cream.

During observation in one of the dining areas at lunch time we noted it was noisy initially as the TV in the adjoining lounge was left on loudly. However, one member of staff came and turned the TV off and put classical music to play softly in the background. Staff chatted with people asking what they would like to eat. The staff asked people if they wanted help and assisted when needed with cutting up meat at the table. We observed one staff member trying to encourage someone to eat who had stayed in the lounge area. They sat with them and they were kind and encouraging. When they refused vehemently the staff member didn't make a fuss they just left quietly. A few minutes later a different member of staff came with fresh food and sat with the person who then started to eat their food.

We saw people being offered choice with regard to where and how they wanted to spend their time. For example, some people wanted to watch television, some people were reading and others were listening to music. We observed staff helped people into wheelchairs or walking when needed and staff related well with people and smiled and had fun with them. People we spoke with told us staff listened. They said, "Yes, I believe I do matter to them", "If you ask for a shower they will let you have one but sometimes you have to wait a while, but they do what you ask. Yes I think I do matter to them", "They listen to you. When I lost a cardigan I told them and they found it for me" and "They are always so busy I don't like to bother them too much, but yes they do listen and are helpful."

People we spoke with said they were happy with the care provided and could make decisions about their own care and how they were looked after. Everyone we spoke with told us their privacy and dignity was preserved. They said staff encouraged them to be as independent as possible. People told us they were able to choose what they wanted to do each day and decide if they wanted to join in with the activities. People told us, "When you get to my age you have to have help. I am a private person and I appreciate I need help with bathing but I like to do as much as I can for myself. The girls accept this and I dry myself mostly, then they finish off. They do whatever I ask, I have a bath about three times a week, they always keep me well covered over and private."

We saw in the entrance to the home a 'Dignity in Care' display which included information about privacy, practical assistance, social inclusion and pain management. The home also had a member of staff who was a dignity champion. This included attending training and providing advice and support to other members of staff.

We observed staff attending to people's needs in a discreet way which maintained their dignity. During our visit we spoke with members of staff who were able to explain and give examples of how they would maintain people's dignity, privacy and independence. We saw staff kneeling down on the floor to be at the same level as the people who used the service when they were talking. However, we noted in one person's care plan language was used such as "wandering" "demanding" and "argumentative" which was not respectful or appropriate.

We observed staff gave people time and engaged with people in a respectful, encouraging and patient way. Staff knocked on people's bedroom doors before entering. However, one person we spoke with also told us their name on their bedroom door was not the name they liked to be called. Staff had not paid attention to their preferences.

During our inspection the staff we spoke with demonstrated a good knowledge of people's care, support

Are services caring?

needs and routines and could describe care needs provided for each person. For example, a member of staff told us they were aware of how one person would react in certain circumstances. This corresponded with what was written in their care plan.

People we spoke with told us staff welcomed their relatives and friends into the home. They said, “Oh, yes staff are always very pleasant to my daughter when she comes. She is always offered a cup of tea and can stay as long as she wants”, “Staff are very welcoming to my son and his wife, they chat together, always very nice to them”, “They keep my family informed. I was poorly and they rang my daughter to tell them I wasn’t well. I am pleased they do that” and “Now there are better relationships with the staff my wife comes with me to see my mum.”

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The area manager told us an activity co-ordinator worked at the home each day. We saw a list of activities for the month were displayed in the entrance to the home and also in people's bedrooms. These included an Easter egg raffle, games, exercise, cake decorating, arts and pet therapy. We spoke with the activity co-ordinator who told us they spoke with people on a six monthly basis to obtain their views about what activities they wanted. They also said they spoke with people when they were new to the home.

We looked at people's care plans which included people's likes, dislikes and what activities they enjoyed. People told us, "The activities girl is lovely. We made Easter bonnets and decorated them, we also painted boiled eggs, it was good fun" and "We have plenty of activities, I have always liked arts and crafts.

People said their day to day choices were respected such as when they got up and what time they went to bed; when they wished to bath or shower and where they wanted eat their meals and one person explained, "You can choose what you want to do, if you want to have a walk to the shop then you can but you have to tell them you are going."

People were made aware of the complaints system. People were given support by the manager and staff to make a comment or complaint where they needed assistance. The area manager told us people's complaints were fully investigated and resolved where possible to their satisfaction.

The home regularly audited the views of people who used the service and ensured that individuals were aware of who to make a complaint to and what the procedure was. The managers of the home told us they were always available to speak with people and listen to their concerns. They said this helped them to resolve any minor issues before they became complaints and people had their comments and complaints listened to and acted on.

People we spoke with told us they felt confident enough to express their concerns and make a complaint. They said, "I would not hesitate now to make a complaint if any staff member did not treat me properly", "I would not put up with it if anyone was rude and unkind to me, or if I saw anyone else being mistreated, I would speak up", "This is my home, I should not be made to feel unhappy living here, it is not acceptable. I would make a complaint to the manager" and "If I had any concerns about anything then I would tell my son – he would certainly put an end to any problems."

Are services well-led?

Our findings

We spoke with the managers about the long term leadership of Bannatyne Lodge and expressed our concerns over the fact the home did not have a permanent registered manager. At the time of the inspection the manager had submitted an application to register with the Care Quality Commission.

Although action plans were in place to address failings identified at previous inspections these had not led to the necessary improvements in all areas. We saw people's care plans were not detailed enough to ensure people's needs were met appropriately; Improvements had been made to the cleanliness of the home and to infection control.

People we spoke with told us they had been asked their views on the care they were receiving. We saw the results of the February 2014 questionnaire displayed in the entrance to the home. The results showed positive outcomes and people were happy with the service. One comment said, 'People cannot always access buzzers.' The response from the provider stated they had ordered clips for the buzzers making it easier for people to access them.

We saw the provider consulted with people living at the home and those that were important to them. Resident and relatives meetings had been held and actions had been identified from these. People and their relatives had a chance to say what they thought about of the service at the meetings. We saw the feedback from the March 2014 meeting displayed in the entrance to the home. We saw one comment said, 'People want to be more involved in the formulation and evaluation of their care plan.' The response from the provider was also displayed which said, 'All staff involved in writing your care plan will have training around care plan documentation including person centred care.' People were also able to provide confidential feedback about the quality of the service to the provider. This showed the management team asked people to give feedback about their care and support to identify any improvements they needed to make at Bannatyne Lodge.

We saw from the records we looked at staff meeting were held on a monthly basis. We saw meeting minutes for March and April 2014 which included discussion topics such as activities, the treatment room, team work, care documentation and supervision. We also saw staff had discussed the values of the service that were based around the ethos of 'Residents first and foremost.' This was understood by staff because these values were in the policies and procedures and were part of staff induction and on-going training. When there were any actions that needed to be taken because of what staff or people said in the meetings or in surveys, there were action plans in place that showed what people said was taken seriously and acted upon. This contributed to making sure people had a good quality service.

The area manager said they produced a monthly quality visit report which included medication, care documentation and the environment. If issues were identified an action plan would be produced and actions were monitored monthly. We saw audits were carried out on a monthly basis which included medication, kitchen, dining experience, infection control and the environment. Where action plans were in place to make improvements, these were monitored to make sure they were delivered. There was a cycle of learning lessons to ensure that any themes and trends were identified and acted upon to improve the service. This meant that the management and staff learned from incidents and took action to improve services following these.

The senior management team from the organisation were informed through regular reports about the running of the service, including information about accidents and incidents.

We saw a policy about whistle blowing and the area manager told us staff were supported to question practice and whistle-blowers were protected. Staff we spoke to told us they felt confident enough to do this and said they felt the management team were willing to listen. They said they now felt that they worked in a good, open and inclusive team and that they felt able to challenge and speak out if needed. However, two staff we spoke with were not aware of how to report incidents in line with the whistleblowing policy.

The area manager told us they regularly reviewed the staffing at the home. We saw that there were systems in place to monitor that there are sufficient numbers of staff available to meet people's needs. We saw that staffing levels were assessed depending on people's need and occupancy of the home; staffing levels were adjusted when

Are services well-led?

needed. There were sufficient staff in the lounge and dining room areas that we saw. There was a team leader and towards the end of the shift they met with the team to feedback any relevant information.

We saw there were emergency plans in place to help staff deal with any emergencies. There was a management on call system in case staff needed management support outside of office hours. Staff we spoke with confirmed this.

Observations of interactions between the area manager and staff showed they were inclusive. Staff told us things had really improved and they did not want to go back to the previous culture. They thought the new manager was professional and they hoped any new management would be the same. They said since the home had a new manager they felt much better supported and training and development was seen as important. A member of staff we spoke with told us, “It’s a much nicer calmer place.” Other members of staff told us, “It feels like staff are more involved with residents”, “The manager is more accessible and approachable”, “Culture is changing on all fronts”, “I feel valued and I have been involved in the changes and have been given more responsibility”, “Changes are for the better” and “Staff morale has gone through the roof, we are chuffed to bits.” However, four members of staff told us they were unaware of the organisations ethos and objectives. Failure to ensure staff are aware of the organisations objectives could mean people may be at risk of receiving care in an environment which was not well lead.

We saw a copy of the complaint procedure displayed in the entrance to the home and a copy was in people’s bedrooms. The provider took account of complaints and comments to improve the service.

We saw evidence in people’s care records that risk assessments and care plans had been updated in response to any incidents which had involved people who used the service. People we spoke with told us if they had any concerns they would talk to a member of staff or the manager and they said they felt their concern would be acted on.

We saw up to date policies and procedure were in place. These included complaints, selection and recruitment, whistleblowing, dementia and nutrition.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations** **2010**. The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. The provider had not always assessed people in relation to their mental capacity to make their own choices and decisions about care.

Regulated activity	Regulation
	Regulation 9 HSCA 2008 (Regulated Activities) Regulations **2010**. People did not experience care, treatment and support that met their needs and protected their rights. Care plans were not detailed and involved tick boxes. Care plans were not always clear about the physical and mental health conditions of people which could lead to people not receiving the appropriate care.