Bannow Retirement Home Limited

Bannow Retirement Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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

Bannow provides care and support for up to 26 older people most of who are living with dementia. The care needs of people varied, some people had complex dementia care needs that included behaviours that challenged. Other people's needs were less complex and required care and support associated with old age, mild dementia and memory loss. Most people were fully mobile and able to walk around the home unaided. At the time of this inspection there were 23 people living at the home.

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.'

This comprehensive unannounced inspection took place on 7 and 10 November 2017. Bannow was last inspected in October 2016 and was rated Good. We brought this inspection forward to follow up on concerns raised by whistle-blowers and because there had been a high number of safeguarding referrals. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called, 'making a disclosure in the public interest.' We originally planned to carry out a focussed inspection but during our inspection we changed from a focused to a comprehensive inspection.

In recent months we received concerns from two whistle blowers (WB). During our inspection we received concerns from a third WB and following our inspection we received further concerns from another WB. Concerns included a lack of cleanliness, poor moving and handling and poor care. We looked at some of the concerns raised and asked the provider to carry out an investigation of the remaining concerns. We found some of the concerns were substantiated and some the provider had already addressed.

We found there was a lack of consistent and strong leadership or provider oversight. We identified areas of record keeping that needed to improve to document more clearly the running of the home. For example, in relation to incident records. Improvements were needed in relation to auditing as a number of areas we identified had not been picked up as part of regular monitoring. This included auditing in relation to care planning and cleanliness. Staff morale was low, staff did not receive regular supervision and did not feel supported. There were also some shortfalls in the management of medicines prescribed on an 'as required' basis, in relation to monitoring of catheter care, and in consideration of risks when caring for people whose behaviour can challenge. We saw some practices did not demonstrate a caring approach was always used.' We made a recommendation to expand the dementia friendly activities available.

Information regarding Deprivation of Liberty Safeguard (DoLS) and mental capacity were not detailed in

care plans. (A DoLS is used when it is assessed as necessary to deprive a person of their liberty in their best interests and the methods used should be as least restrictive as possible).

Staff did not have all the information they needed to understand why some people had restrictions in place and this left the potential for some people to have been unnecessarily restricted.

Whilst on the first day of inspection the environment was not clean, staff morale was low and there was a tense atmosphere. There was a marked difference on our second day. The environment was clean, staff were positive and there was a calm and pleasant atmosphere. Staff spoke about it having been a difficult year but were keen and eager for change and were positive about changes that had already been planned. Management had recognised that changes were needed and a senior's meeting had been planned with the area manager to assess how improvements could be made.

There were on-going improvements to the environment; painting in the lobby and stairways was underway. Equipment checks were consistently carried out and fire safety checks were up to date.

Appropriate checks had taken place before staff were employed to ensure they were able to work safely with people at the home.

People had enough to eat and drink and the menus were varied and well balanced. Appropriate referrals were made to health care professionals when needed and people were supported to attend health appointments.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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?

Requires Improvement

The service was not safe.

The management of medicines prescribed on an as required basis were not always safe.

Risk assessment documentation in relation to the management of behaviours that challenged was not always clear.

There were no proper systems to ensure there were enough staff to meet people's needs safely.

Staff understood the procedures to safeguard people from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Information regarding Deprivation of Liberty Safeguard (DoLS) and people's capacity assessments were not decision specific.

The provider had not ensured staff were appropriately supervised at regular intervals.

People were offered a choice of meals, snacks and drinks throughout the day.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with respect and dignity

Staff knew people well and treated them with kindness and warmth.

Staff adapted their approach to meet people's individual needs and to ensure care was provided in a way that met their

particular needs and wishes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a lack of 'dementia friendly' activities for example, rummage boxes for people.

There was information in care plans about people's lives before coming to live at Bannow and about how they wished to receive support.

There was a detailed complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of strong leadership or provider oversight.

Quality assurance systems had not identified issues found during the inspection. Systems used were not robust and record keeping did not always clearly demonstrate the running of the service.

Management and staff recognised that change needed to occur and were keen for this to happen.

Bannow Retirement Home

Detailed findings

Background to this inspection

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

We visited the home on the 7 and 10 November 2017. This was an unannounced inspection. The inspection team consisted of two inspectors. We originally planned to carry out a focussed inspection to follow up on concerns raised by whistle-blowers and because there had been a high number of safeguarding referrals. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called, 'making a disclosure in the public interest.' Due to the number of concerns identified during this inspection we changed from a focussed to a comprehensive inspection.

Due to technical problems, the provider was not able to complete a Provider Information Return. 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 took this into account when we inspected the service and made the judgements in this report."

During the inspection, we spoke with a visitor to the home, the area manager, deputy manager and four care staff. Most people were unable to tell us of their experience of living at Bannow. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) in the lounge area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we reviewed the records of the home. These included staff training records and

procedures, audits, three staff files along with information in regards to the upkeep of the premises. We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at Bannow. This is when we looked at their care documentation in depth and obtained their views on how they found living at Bannow. It is an important part of our inspection, as it allowed us to capture information about a selected group of people living there.

Requires Improvement

Is the service safe?

Our findings

A visitor to the home told us they thought their relative was safe at Bannow and said staff would contact them if there were concerns. We observed people were supported to move about the home safely. Despite these positive comments and observations we found practices that were not always safe.

The management of medicines prescribed 'as required' (PRN) was not always safe. One person was prescribed medicine for agitation. The guidance stated this could be given if the person was unsettled and more mobile and if they started to confront others. There was no advice about what action staff should take to reduce the agitation before giving the medicine so this left it open to interpretation. This medicine had been given recently and the record showed, 'getting agitated.' There was also no system for monitoring the effectiveness of this medicine. One person's medicine PRN pain killer had been discontinued. The deputy manager told us this had been done as the GP had assessed the person as 'end of life' but the person was not in their final days. They confirmed they would speak with the GP again to clarify this. One person had refused to take medicines for their diabetes for seven consecutive mornings. There was no risk assessment regarding this and the GP had not been informed. A lack of medicine for diabetes could lead to unstable blood sugars and significant health problems.

On the first day of inspection the morning medicine round was completed at approximately 10.30am. On the second day it was 10.10am. The lunchtime medicines were then started at 1pm. Staff could not be assured that medicines prescribed to be given four hourly apart had this gap. This is not in line with the National Institute for Health and Care Excellence (NICE) good practice guidelines and does not ensure that people received their medicine on time or safely.

A number of people were prescribed creams. The staff member doing the medicine rounds signed that the creams had been applied. However, they were often not the person applying the cream and did not see the creams applied. There were no body maps to ensure staff knew where to apply the creams. Staff and records could not demonstrate the creams had been applied, in the correct place.

People's care plans contained risk assessments for a range of daily living needs such as falls, nutrition, skin pressure areas. Risk assessment documentation in relation to the management of behaviours that challenged were not detailed to ensure staff knew how to support people. Staff told us one person did not like receiving personal care in the mornings. They became agitated and records showed regular incidents where staff had been assaulted. Records stated the person had been aggressive and listed the injuries staff had sustained. There was no advice about how the person should be supported to minimise the distress for them and how to reduce the risk of injuries to staff. For another person, the daily records stated, 'became very aggressive and violent towards us.' However, this had not been expanded upon to describe what had happened before, during and after the incident. The risk assessment referred to verbal aggression but not to physical aggression. Advice to staff was to 'explain what they were doing, walk away, if the person becomes verbally aggressive, to monitor from a distance.' There was no reference to using distraction techniques or advice about what worked well to assist the person to calm. There were no incident reports or analysis of these incidents and this left people at staff at risk of harm. We asked staff if incident reports were always

written. They said they were not. One staff member told us, "Nothing is done about it so there's no point. We just get on with it." There was no system to ensure that when people displayed behaviours that challenged, incident reports were written, incidents investigated and risk assessments updated as a result. Whilst minutes of staff meetings showed staff had been advised of the importance of completing incident reports, it was evident this had not been done. As they were not always reported, management did not have an understanding of the number of incidents, how serious they were, how they had been managed and how people or staff were after the incidents. There was no learning from these incidents and this left the potential for people and staff to be at risk of serious harm.

On arrival, we spent time in the lounge. One person requested tea and toast and they repeated this request continually along with a number of expletives. The person's tone went from a singing happy tone to a very agitated high pitched tone. When a staff member gave them a cup of tea the requests stopped but as soon as the tea was finished the cup was flung across the room and the requests began again. Whilst the cup was plastic it could have caused injury to others sitting in the area. This person also turned over a table in this area. There was a volatile atmosphere. Whilst most people in the room ignored this, some people became agitated and used expletives to encourage the person to be quiet. We were told this was a known behaviour in the mornings. Whilst staff popped in and out to try to settle people during this period there was no consistent staff presence and this left people at risk of harm from injury. On the second day of inspection we were told a request had been made to have this person's placement reviewed.

Some risk assessments did not include sufficient guidance for care staff to provide safe care. For example, one person needed support with moving and handling. The care plan and risk assessments stated the person used a stand aid. However, through discussions with staff it was evident that this was not a suitable method of supporting this person. An instruction had been written in the house diary on 5 November 2017 that a hoist should now be used. The care plan had not been updated and there was no specific advice about how this should be done or about what type sling to use. One staff member told us they needed clearer advice on how to move this person and another staff member said they needed further training. No advice had been sought from a suitably qualified professional to determine the safest method for supporting the person to transfer. On the second day of inspection we were told a request had been made to have this person's needs and equipment reviewed by a suitably qualified person.

Five people needed support with catheter care. One person's guidelines stated staff should monitor there was sufficient output but staff did not know what sufficient output should be for the person. Whilst staff recorded they had emptied the catheter there was no fluid input or output chart. Records also showed staff should ensure the leg strap was alternated weekly to minimise and identify any soreness caused by the strap. This was not recorded. In recent weeks two people had removed catheters and emergency attention had to be sought. Incident reports had not been completed. We were told senior staff had received training in catheter care a couple of years ago but this type of care had not generally been provided then and staff had gone from caring for one person with a catheter to five people in a matter of weeks.

On the first day of inspection flooring in the lounge areas were dirty with food debris. There were no records for the weekend cleaning and the records for the day before our inspection did not show these areas had been hoovered. We observed one person throwing biscuits and another person picking them up. We could not be assured that other food debris had not been eaten and that there was a risk of infection control. Staff told us there had been a problem with cleanliness. One staff member said, "Standards have slipped." Another said, "I would up the cleaning." We discussed the cleanliness of the flooring with the deputy manager and the floors were hoovered after lunch. On the second day of inspection the home was clean and tidy.

The above issues meant that the provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not adequately deployed at key times of the day. At the time of inspection there were vacancies for a care staff member on the twilight shift (7-10pm) and for the activity coordinator. Rotas showed a high number of staff sick leave. Core staff either covered these shifts or agency staff were used. The rotas showed that medicines would be done between 7-8am and the senior staff would then work a care shift. However, on both days of inspection it was after 10am before medicines had been completed so the senior was not available on the floor during this time. There was no system for assessing suitable staff levels to meet people's needs. Some people required two staff to support them during personal care and this meant ensuring adequate staffing in communal areas was at times difficult to manage. Some people had behaviours that may challenge and needed a high level of support. The home had an increased number of people that needed to be supported and monitored in relation to catheter care and the impact of this had not been assessed.

There were not enough staff deployed to meet people's needs and this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of the management of 'as required medicines' and the signing of topical creams, procedures for the management of medicines were safe. There was information in each person's care plan about how they liked to take their medicines. Medicines administration records (MAR) showed people received their medicines as prescribed.

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults.

Staff had an understanding of different types of abuse and told us what actions they would take if they believed people were at risk. All staff had received training in safeguarding. They told us if an incident occurred they reported it to the management team who were responsible for referring the matter to the local safeguarding authority. One staff member said. "I wouldn't hesitate." Where appropriate, matters had been reported to the Local Authority for further advice and support. Minutes of a staff meeting showed the meeting had been called as a result of a safeguarding. Records showed this included a discussion about the incident and lessons learned from the incident.

During the inspection one person alleged another person had, 'poked them in the eyes.' We asked if this matter had been reported to the safeguarding team. However, when the deputy manager spoke with staff who had witnessed the incident they said there had been no physical contact and there was no sign of any injuries to either person. The deputy manager recorded this as a near miss incident.

Possible risks to people's safety from the environment and equipment were well managed and staff carried out regular health and safety checks. This included regular servicing for gas and electrical safety. There were procedures to make sure regular and ongoing safety maintenance was completed. A fire risk assessment had been done and identified works had been completed. Personal emergency evacuation plans (PEEPs) ensured staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation.

Requires Improvement

Is the service effective?

Our findings

People told us the food was good. A visitor to the home told us the meals always looked good and were presented well. Despite positive comments in these areas we found shortfalls in how staff were supported and in the service complied with legal requirements in respect of caring for people who lacked capacity to make decisions.

Support systems for staff were not effective. Records for two staff showed they had not attended a supervision meeting throughout 2017 but one had received an appraisal of performance in September 2017. Records for two other staff showed they had attended a supervision meeting in April 2017 but not in July 2017 as planned. Both had received an annual staff appraisal in September 2017. One staff member told us they felt supported. They said, "I've been helped loads." However, all other staff said that support over the past year had diminished. One staff member said, "There is no point talking. I come in and do my work and go home. The way we are spoken to is appalling," Another said, morale is not great, we are tired." A fourth staff member said "Management are stressed and everyone is feeling it." One of these staff said, "Staff meetings are all about what the manager wants." Staff had not recorded incidents of behaviours that challenged. Whilst we were told an agenda was posted in advance of staff meetings giving staff the opportunity to think about and raise any concerns they might have, staff rarely took the opportunity to do so. They had not looked for support because they felt this was not being provided. Low staff morale had therefore an impact on staff, and as a result, on people.

The above is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were consent to care and treatment forms within care plans for each person that stated the person could consent to some or all of the areas listed. These areas included information about the person's physical health and cognitive ability, spiritual and sexual needs and sensory needs. However, the information provided was general and not related to each person's individual capacity to give consent to specific aspects of their care.

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 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We were told a number of applications to restrict people's freedom had been submitted to the DoLS office as per legal requirements. Records showed eight people had a DoLS. Records did not show how many other applications had been made and it did not say in care plans what the applications had been for. One person's care plan stated that there was a DoLS in place. Whilst this had been requested it had yet to be processed. The deputy manager told us the DoLS were in relation to the locking of the front door but staff were not clear what, if any, other restrictions were in place on an individual basis. This was because there was no formal assessment within individual care plans to assess each person to determine if there were other ways in which their individual liberties were restricted. There were keypad locks at the entrance to the home. There were stair gates fitted at the tops of the stairs on each floor and there was a sensor fitted at the bottom of the stairs so that staff could monitor who was using the stairs at any time and provide support if needed. Other restrictions included the use of recliner chairs for a couple of people, lap belts on wheelchairs and sensor mats. Staff did not have all the information they needed to understand why some people had restrictions in place and this left the potential for some people to have been unnecessarily restricted.

The above areas are a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One of the exceptions to this was in relation to medicines. Some people regularly refused medicines. Discussion had been held with their families and their GPs to check if the medicines could be given covertly and where this had been agreed, this was clearly documented.

The registered manager was committed to ensuring staff had the skills to carry out their roles effectively. However, in some areas there was a lack of monitoring to ensure that training received was always effective. Staff told us they received training which included safeguarding, mental capacity and DoLS, infection control and food hygiene. We asked if staff had received any specific training to meet the needs of people living at Bannow. Staff had received training on dealing with behaviours that challenged in May 2017. Whilst staff said they had the training there was a lack of guidance on how to support particular individuals with behaviours that challenged. Most of the staff had received training on dementia. One staff member told us they had not received any training on dementia. However, the registered manager told us all the newer staff had received information about dementia as part of their induction training. Most of the staff had received training on end of life care in 2016. Staff told us they had received training on equality and diversity, dignity and empowerment. Only senior staff had received training in catheter care. A staff member told us a more senior staff member had shown them how to change and empty a catheter but no further training had been provided. As part of the commitment to ongoing training, thirteen staff had completed a health related qualification at level two or above and a further three staff were about to start a course. We observed staff supporting people appropriately with their moving and handling needs throughout the inspection. However, there was a lack of guidance on how to support one person with moving and handling and staff stated they needed clearer guidance. One person needed the hoist to transfer to another chair. Staff explained the procedure, supported the person and reassured them throughout. There were no systems to routinely check that all training provided was effective, and this is an area that requires improvement.

There was a structured induction programme for new staff to make sure they knew what was expected of them in their role. This included time to get to know people, to read their support plans and to shadow other staff. An in-house induction checklist was completed to ensure that staff knew the home's procedures. On completion, staff who had not previously worked in care went on to complete the Care Certificate. The Care Certificate is a set of 15 standards that health and social care workers follow. The Care Certificate ensures staff that are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. A staff member told us that they found shadowing a more experienced staff member had been invaluable. They said they still worked in pairs to

meet the needs of some people who had complex needs, for example when a hoist was needed or to support people whose behaviours were challenging.

People were supported to maintain good health and received on-going healthcare support. Records confirmed staff liaised with a wide variety of health care professionals. This included regular contact with the community nurse, continence service, GP and chiropodist. We were told that if people had difficulties swallowing a referral would be sent to GP for specialist advice from the speech and language therapist team. When staff raised concerns about their ability to meet one person's needs, advice had been sought from the local mental health team.

People had enough to eat and drink. There was a four week rolling menu that was varied, nutritious and well balanced. People had a choice of meal at each mealtime. The meals were presented well and smelled appetising. People could choose where to have their meals. Some people chose to eat either in the lounge or their bedrooms, but most people ate in the dining room. People were asked where they wanted to sit. They were offered a choice of drink with their meal. The mealtime was not rushed. Staff offered to cut food up and assisted people with their meals, if appropriate. Staff told us they could cater for specialist/cultural diets. Where appropriate, and assessed as needed, a soft or pureed diet was served. A vegetarian choice was always available.

At the last inspection the registered manager ensured there was signage on doors to assist people in finding their way around the home. For example, in addition to room numbers on bedroom doors, each person's name was on the door and there was a picture of a bed. The registered manager had told us they would also be adding a picture of each person on the door. However, we were told at this inspection that people had removed the signs. This had been raised in a recent meeting and the maintenance man had been tasked with creating dementia friendly signs that could be secured to doors and would assist people to move about the home more easily. This had yet to be done as there was a programme of painting underway.

There were two large lounge areas and a separate library. We were told the library was often used for people to entertain their guests and visiting professionals also used this area to consult with people in private. The dining room could also be used to entertain guests. An area was also set aside as a hair salon. There was a secure garden area to the back of Bannow that was used mainly during summer months. A sensor beam was used at the foot of the stairs to alert staff that someone wanted to use the stairs and staff could then offer support as needed. There were murals on the walls in the dining room and centre pieces on the table which gave a homely feel to the environment.

Requires Improvement

Is the service caring?

Our findings

A visiting professional told us, "I have always found the members of staff I come in contact with to be very caring and aware of the residents comfort and safety." Despite these positive comments we found examples of where support provided was not always caring.

One person was wearing clothing that was torn around the collar. Later we noted the person had been out with a visitor for a meal. We discussed this with the deputy manager who had changed the top on their return to the home. This had not been identified by staff when they supported the person to get dressed or before they went out and this showed a lack of dignity and respect for the person. This is an area that requires improvement.

On both days of inspection staff stood over one person to assist them with their meal. There was good interaction between staff and the person throughout the meal. However, consideration had not been given to finding seating for the staff member that could have enabled appropriate eye contact and made the experience more sociable for both. Following our inspection we received confirmation in writing that suitable stools had been bought to enable staff to move about the dining room and offer support as needed appropriately.

Despite these negative observations we also saw examples of staff showing kindness and a caring attitude to people. For example, staff noted when the sun was disturbing one person and made sure that a curtain was used to block this. Staff continued to provide discrete assistance when needed. They supported people who used zimmer frames when they walked to the dining room. However, if people could do this independently they stood back and walked alongside them and enabled them to retain their independence.

One person chose to have their meal in the lounge but when other people left to go to the dining room they needed regular reassurance that the, "Others will be coming back." A staff member was in the vicinity to provide this reassurance and although they checked again if the person wanted to join those in the dining room, they respected the person's decision.

A number of the staff team had worked in the home a long time. They knew people well and had a good understanding of them as individuals. Within care plans each person had a biography that gave details of their life and what had been important to them before they were diagnosed with dementia. Some were detailed and gave a very clear picture of people's personality, likes and dislikes. We observed staff supporting people. Staff spoke to people in a calm and caring manner and provided regular reassurance when people showed confusion about what was happening. This showed they understood the approach needed when caring for people living with dementia. For example, when one person was upset because they didn't know what they should be doing a staff member asked them what they wanted to do. The person said they liked singing and the staff member encouraged them to sing a song and took them to the lounge area where they were more settled.

A number of people had been affected by recent GP practice closures. People and/or their representatives had been informed of their new GP arrangements and where representatives lived at a distance the home supported people with all the paperwork linked to the move. We saw one person refused to sign a document that they could not read and the relative agreed to retype the letter in larger print to assist the person to understand what they were signing.

Records were stored in the office and only made available to those with a right to see them. Staff told us they had regular opportunities to read through care plans to make sure they were kept up to date with people's needs.

Requires Improvement

Is the service responsive?

Our findings

A visiting professional told us, "I am always made to feel welcome and if I ask for help with any of the residents, one of the staff will always make themselves available." A visitor to Bannow told us staff contacted them if they had any concerns about their relative or if there were any changes in their health. They also told us they were invited to reviews and this was confirmed in the annual relatives' survey. Despite these positive comments we found examples of where support provided was not always responsive.

There was information to guide staff about how people communicated in each care plan. A staff member told us, "Everyone is different and has different needs. We try to respect their differences and treat each person as an individual." From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff had not received any guidance or training in relation to AIS and people's care plans did not contain an assessment to see if they had particular needs in line with AIS that should be met. This is an area for improvement.

Although there were activities taking place and a number of the staff had received training on activities there was limited emphasis on activities for people with dementia. For example, there were no memory triggers such as rummage boxes. Rummage boxes contain objects that can help people with dementia to trigger memories and enhance past skills, hobbies or occupations.

We recommend the provider explores NICE guidelines in relation to expanding the activities available to meet people's individual social needs related to living with dementia.

The weekly activity programme was displayed by the library. The home was in the process of trying to recruit for an activity coordinator and in the interim staff were organising and running activities on a daily basis. During the inspection a senior carer read the newspaper to a large group of people. Before doing this, care had been given to repositioning chairs in a circle to ensure maximum involvement of the group.

We were told external musical entertainment was provided regularly. There was a separate library that was stocked with many books, puzzles and games. We were told some people liked doing exercises, bingo and quizzes. Others liked hand pampering and having nails painted. The home had their own hair salon and a hairdresser visited regularly to provide a service for people. There was a well maintained garden with a good lawn area with plentiful seating. This was secure with ramps in several places to ensure everyone could make use of this space. Staff told us people used this area regularly throughout the summer months and if someone wanted to spend time in the garden they would be supported to do so.

Care plans contained information about people's needs in relation to personal care, mobility, skin integrity, nutrition, health and personal preferences. Any shortfalls found in relation to care plans have been referred to either within the well led sections of this report. There was guidance for staff about how to support people to move about the home, this included the use of mobility aids or the support of staff. There was

information within care plans that was personal and specific to each individual. For example, in one person's care plan it was stated the person chose not to have a male carer. There was a personal history page for each person that described the person's life before coming to Bannow.

There was a complaint's policy which was displayed so visitors were clear about how they could raise concerns should they wish to. Only one complaint had been recorded and this had been raised by the home on behalf of a person. We were told that if a staff member had raised a complaint or concern this would be stored within their staff file. Staff knew that whilst people could not always follow the complaint procedure they could voice concerns in a variety of ways. For example crying, showing distress or anger or being more withdrawn. Staff told us they tried to find out what was upsetting a person and tried to give reassurance. We saw examples of this during our inspection when staff reassured people who were confused and needed support.

As part of the relative's annual survey, one person's relative had commented that 'a loud speak phone would be beneficial.' The home had responded that the phone did have this capability and that the mobile phones could also be switched to loud speaker. The results of the survey were sent to all relatives so that everyone would have been advised of this facility if they wished to try it to aid communication. One person had their own mobile phone and staff supported the person to keep this fully charged. We saw that when a relative of another person rang the home the house mobile was taken to the person so they could have a chat in private.

There was no one in receipt of end of life care. However, apart from the newer staff, all staff had received training on this subject. A staff member who had been on duty when there was an unexpected incident that was particularly traumatic said they had been supported by the registered manager throughout the incident and subsequent investigation. Where possible, people, and their representatives, were asked their views about end of life wishes and these were recorded within people's care plans.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post but they were on leave at the time of inspection. The deputy manager facilitated the inspection and the area manager supported them on the first day of inspection.

Since the last inspection the registered manager had appropriately raised a number of referrals to the local safeguarding team. In the two months before this inspection we received concerns from two whistle-blowers (WB), a further WB contacted CQC the day before our inspection and another a few says after our inspection. Each contained similar information. Some of these concerns were addressed during the inspection and we asked the provider to investigate further. The deputy manager confirmed the events in the last year had an impact on staff, had led to some staff leaving their post and to disciplinary actions being taken. This had led to low staff morale. Staff told us they did not feel supported and were 'tired.' One staff member said, "It would be nice to be appreciated for the work we do." Another staff member said, "The manager has been through a difficult year but they forget we have too."

Leadership and direction had been affected by events in the past year and this had an impact on the running of the home and the support provided to staff. Two staff meetings had been held in the last year. There was no reference in either set of minutes to staff morale. One staff member told us, "Staff meetings are all about what the manager wants, morale is terrible and there has been no team building." Another staff member said, "Sometimes I feel supported and other times not. We are told to call out of hours if we need help but sometimes when we do there is a frosty reception." Another said, "We are trying to pull together as a team. There is a good core staff team. When we are happy the residents are happy." A staff member told us the registered manager and area manager had been very supportive when they had attended a coroner's inquest. Following the inspection the registered manager told us, on call staff had spent many hours supporting staff at night and weekends. Staff had been asked to make sure that any staff called in the middle of the night were given time to wake up and adjust before they could respond to the situation.

The provider's systems to monitor the management and quality of the home were not effective as they had not identified a number of areas that did not meet regulatory requirements. External management carried out a periodic quality assessment of the home and this had been done three times in the last year. Records showed that during visits they spoke with people, the registered manager, examined a range of documentation such as complaints, audits and care plans and looked at the environment. There was reference to the names of staff on duty and that no concerns were raised by the staff. However, staff told us they did not have an opportunity to speak with senior management during these visits. Following the inspection the registered manager confirmed staff had regular opportunities to speak with the area manager on their twice monthly visits but they did not take these up. The area manager was also the point of contact when the manager was on leave.

There were systems for auditing care plans that ensured they were all audited at least once every three months. Where shortfalls were found, actions had been taken to address them. However, the auditing was more about checking that required items were present rather than an analysis of the quality of the documents. For example, it did not focus on whether a particular care plan was effective in meeting the

needs of a person whose behaviours challenged. Current auditing systems had not identified issues in relation to incident reporting, the extent of staff morale, lack of appropriate risk assessments in relation to behaviours that challenged, lack of records related to cleanliness at weekends and lack of detail regarding MCA and DoLS. The provider representative checked that audits were done but there was no analysis of their findings in the provider reports. There was no dependency tool used to determine if there were enough staff to meet people's needs and to ensure this was kept under review as people's needs changed.

Systems for ensuring the cleanliness of the home were not effective. Two members of cleaning staff were employed to carry out cleaning duties four days a week. An additional cleaner worked flexible hours at weekends, sometimes one day and sometimes two days. The rotas regularly showed days at weekends when there was no cover and there were no records of cleaning tasks completed at weekends. Although there was reference to bedrooms being cleaned there was no schedule of tasks that needed to be completed when a room was cleaned. Records related to COSHH had not been reviewed. Communal areas were not clean on the first day of inspection, cleanliness had been highlighted in the complaints made by WBs and staff on shift at the time of inspection confirmed standards had slipped in this area.

The personal care audits provided limited information. For example, it stated one person preferred showers but they had only one shower in the previous month. There was no monitoring that people's individual needs and preferences in relation to baths/showers and oral hygiene were met and that people had enough toiletries to meet their needs. One person, due to their individual needs required specific support with dressing. Staff told us they found it difficult to provide this support. There was no guidance or risk assessment in the care plan related to this. This person's BMI had not been completed since May 2017 but it was evident the person was losing weight. We were told no action had been taken as their weight was still what was considered within normal range but without an accurate BMI it was not possible to say what was an appropriate range. The deputy manager confirmed this would be addressed.

Daily records were kept detailing how people had been, what they had done and any support they had received. One person's care plans started with a statement about things they liked. The first statement was, 'I like to moan.' A statement in the person's daily records included the person had been, 'His usual grumpy self. He has upset staff and residents.' We discussed this with the deputy manager who agreed that these types of statements were not appropriate.

A pressure relieving mattress was used for one person who had been assessed at risk of pressure damage. These need to be set in line with people's individual weights and according to the manufacturer's instructions. Records were kept in the office that staff checked the setting was in line with the person's needs. However, there were a number of gaps in the records related to this.

As part of the recruitment process, potential staff completed health questionnaires. Two staff had highlighted they had particular health issues that could have affected their ability to work with people who had behaviours that challenged. No risk assessments had been carried out to determine what support they needed in relation to their health.

Five people were in receipt of support with catheter care. One record was used to record the five catheters had been emptied but there was no individual record of each person's output. This was not a person centred approach and would not have assisted a health professional to monitor if the person was going into retention or needed medical support.

The above areas are a breach of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured good governance had been maintained.

Although we had received a number of negative comments and identified a number of shortfalls, we found on the second day of inspection the atmosphere in the home had changed. The deputy manager told us they had spoken with staff individually and there was a general consensus that staff wanted to see improvements made. They had time to take stock and felt they had been ignoring the problem by not talking about it. Staff were clear they wanted to get back to where they had been a year ago when they and people had been happy and they had enjoyed coming to work. The lounges and dining rooms were clean and a seniors meeting had been organised. Incident reports had been written.

Satisfaction surveys were carried out annually and the last surveys were carried out in May 2017. The results of the relative's survey and staff survey were sent to us after the inspection. There were a number of closed questions that would not encourage staff or relatives to comment. However, where issues were highlighted the actions taken had been documented. Records showed that the home had listened to what staff and relatives had said. For example, one relative had asked for more scented plants in the garden and the response was that this would be discussed with the gardener to ensure this action was taken.

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 Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of people by assessing the risks to their health and safety during care or treatment and doing all that is reasonably practicable to mitigate any such risks. 12(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance had been maintained. Appropriate systems and processes were not in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1)(2)(a)(b)(c)(f)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured staff were given appropriate support and supervision to enable them to carry out their duties.

The provider had not ensured sufficient numbers of suitably qualified and competent staff were deployed at all times.

18(1)(2)(a)