Freshfield Care Limited

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Inspection report

Bankfield House Care Home
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12 May 2016

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out over three days on the 10, 11 and 12 May 2016. Our visit on 10 May 2016 was unannounced.

We last inspected Bankfield House Care Home on 24 September 2014. At that follow up inspection we found that the service was meeting the regulations we assessed.

Bankfield House Care Home is a privately owned care home located in the Woodley area of Stockport. It is a large detached two-storey building. Accommodation is arranged over two floors accessed via stairs or a lift. The communal areas include the Jasmin lounge leading through to a conservatory, the Bluebell lounge which are both at the front of the property, and the Snowdrop lounge which is quieter lounge and dining area at the rear of the property and a dining room.

There is safe, well maintained, enclosed garden to the rear of the property and car parking facilities are available. There are twenty seven single bedrooms and three double bedrooms, although at the time of this inspection only was being used as a double room. Fifteen bedrooms have en-suite facilities.

Bankfield House Care Home is registered to provide care and accommodation for up to thirty older people some of whom may also have a diagnosis of dementia. At the time of our inspection there were twenty eight people living in the home.

The service did not have a registered manager in place. The home had been without a registered manager since August 2015. 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.

During this inspection we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Some medicines were not managed safely. We found there were gaps in the recording of prescribed creams which meant there was a risk that creams had not been applied when required, which could have resulted in unnecessary discomfort to the person.

We had concerns in relation to staff supervision because staff were not receiving supervision on a regular basis, which meant that staff were not being appropriately guided and supported to fulfil their job role effectively.

Recruitment processes required improvements to ensure only suitable staff were employed.

We saw there was a risk of cross infection because hoists and hoist slings were not clean and there was inappropriate storage of the hoist slings.

Some of the routine safety checks had not been undertaken for example checks of the means of escape, window retractors and nurse call bells. In addition there was no evidence that fire evacuation drills had been undertaken. This meant the provider could not be sure the service was safe.

People's care records contained conflicting information and although they had been reviewed some plans of care had not been rewritten in over two years. This meant there was risk that people could receive inappropriate care.

Staff spoken with understood the need to obtain consent from people using the service before a task or care was undertaken. However there were gaps in the recording of consent and consent for some people had not been appropriately obtained.

Some systems were in place to monitor the quality of service people received however they we not robust and due to the shortfalls we found during our inspection they require improvements.

Just prior to this inspection it came to the attention of CQC that an allegation of abuse had been made which had not been referred to the local authority safeguarding team as set out in Multi Agency Policy for Safeguarding Adults at Risk but had been investigated internally and CQC had not been notified of this allegation. During this inspection it was identified that the provider had not complied with their duty to notify us of a further two allegations of abuse, one death, one serious injury and one deprivation of liberty safeguards authorisation. This is a failure to notify the Commission of required events.

We recommended that the provider implements the use of a staffing tool to determine the number of staff and range of skills required in order to meets the needs of people using the service and keep them safe at all times.

Although we saw some written signage around the home we recommend that the service considers current best practice in relation to the specialist needs of people living with dementia in respect to the signage to help orientate people to their surroundings and support them to remain as independent as possible whilst using the service.

We recommend that the service considers current best practice in relation to implementing and reviewing the plans of care that are designed to meet the individual needs and personal preferences needs of people who use the service.

People told us they enjoyed the food and there was plenty of it. However we saw that there was a choice of food at breakfast and the evening meal but choices were not encouraged at the lunchtime meal.

We saw evidence that staff had completed the homes own induction training. However from April 2015 new health and social care workers should be inducted according to the Care Certificate framework. This replaces the Common Induction Standards and National Minimum Training standards.

From looking at the training record and speaking with staff we found that staff had received appropriate training.

People living at Bankfield House Care Home and the visitors we spoke with told us it was a caring place to live and they felt well looked after.

Relatives spoken with told us they thought any issues raised would be dealt with to their satisfaction.

We saw the food looked and smelt appetising and was attractively presented with good size portions. However we recommend that choice is actively promoted at the lunch time meal.

We saw that meaningful activities were provided by an activity co coordinator based on people's personal preferences.

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.

Prior to this inspection it came to the attention of CQC that suitable arrangements had not been put into place as set out in the Multi Agency Policy for Safeguarding Adults at Risk.

We found that the provider had not done all reasonably practicable safety checks to mitigate risk to people.

Shortfalls were found in the medication administration processes for prescribed cream.

There was a risk of cross infection due to hoists being dirty and the hoist slings not being appropriately stored.

Is the service effective?

Requires Improvement

The service was not always effective

Not all staff had received ongoing and regular supervision.

Consent to care and treatment was not always sought in line with legislation.

Food was plentiful and people appeared to enjoy their meals although choices were not encouraged at the lunchtime meal.

Is the service caring?

Good

The service was caring

People living at Bankfield House Care Home and relatives told us they thought staff were kind and caring.

The atmosphere in the home was calm and relaxed and we observed positive interaction between staff and people who used the service and their visitors.

Care staff on duty demonstrated that they knew and understood the needs of the people they were supporting and caring for.

Is the service responsive?

Requires Improvement

The service was not responsive

Care records were inconsistent with the recording of people's personal preferences.

A system was in place for receiving, handling and responding to concerns and complaints.

Meaningful activities were provided by the activity coordinator and we saw people enjoying activities during our inspection.

Is the service well-led?

Inadequate

The service was not well led

At the time of this inspection the manager was not registered with the Care Quality Commission.

The registered provider has a duty to notify us of certain incidents and this had not been done.

The quality assurances systems in place were not sufficiently robust to identify the issues and concerns we found during our inspection.

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Detailed findings

Background to this inspection

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

This inspection was carried out over three days on the 10, 11 and 12 May 2016. Our visit on 10 May 2016 was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the previous Care Quality Commission (CQC) inspection reports about the service and notifications that we had received from the service. We also contacted the local authority commissioners to seek their views about the home and Stockport Health Protection and control of Infection Unit.

Part of our information gathering included a request to the provider to complete and return to us a Provider Information Return (PIR). This is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

During our visit we spoke with the acting manager, two directors, the administrator, a house keeper, two senior carers, five care workers, a cook, a kitchen assistant, two visiting relatives and four people living at Bankfield House Care Home.

We looked around the building and looked in a sample of bedrooms on each floor, all communal areas, toilets and bathrooms,

We examined four people's care records, medicine administration records, the recruitment, supervision and training records for four staff and records relating to the management of the home such as auditing records.

Requires Improvement

Is the service safe?

Our findings

We looked at what systems were in place for the management of medicines.

We saw that accurate records were not being maintained of prescribed creams being administered to people on the Medication Administration Record (MAR) or on the 'cream charts.' There were no clear written directions for their use to enable staff to apply the creams as prescribed by their GP. We saw one person was receiving two creams but there were no care plans in relation to the use of these creams. We saw another person was having cream applied that had not been prescribed by the GP and there was no plan of care for its use. This meant there was a risk that people may not have received prescribed creams as intended by their GP, which could result in unnecessary discomfort for the person.

We saw that one person was prescribed medication to help control seizures. The MAR stated a specific time for this medication to be administered to the person which was outside the normal administration times. The senior care staff told us it was given at the stated time and the person had not suffered any seizures but there was no recorded evidence of the exact time of administration.

We found stock balance checks of boxed medication but no other areas of medication administration was being audited. For example there were no checks that there were no gaps in the recordings, that the appropriate code had been used when medication had not been administered, that there were clear instructions for 'apply as directed' instructions or that medication had been administered at the prescribed times. This meant were was no system to clearly identify shortfalls and the specific action taken in response to the shortfall so there was a risk that people may not receive their medication as intended by the prescribing GP.

We saw that there was a medication administration policy available for staff to access. However the policy required reviewing and updating as it referenced the now obsolete essential standards of quality and safety and Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The above examples demonstrate a continued breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the systems for the receipt, storage, administration and disposal of medicines in the home. There was a dedicated treatment room on the ground floor that was used to store and lock away medicines, including controlled drugs. Medication was stored in a locked medication trolley, in a locked treatment room to ensure only authorised people could access them.

We were told that care staff were not allowed to administer medication until they had received training and had undertaken a competency assessment. From staff spoken with and from viewing the training records we saw evidence of this which is considered good practice.

There was a list of staff signatures available to show those staff with the responsibility for administering

medication. Such a list enabled the acting manager to identify staff who had administered medicines or made an error.

The home operated a Monitored Dosage System (MDS). This is a system where the dispensing pharmacist places medicines into a cassette containing separate compartments according to the time of day the medication is prescribed. A visual check of the cassettes demonstrated that medication had been given to people as prescribed by their doctor.

We saw that the medication administration record (MAR) had a running stock balance of all boxed medication not included in the MDS system. A tablet count on three boxed medication were found to be correct.

We found no excessive stocks of medication being stored.

We found that appropriate arrangements were in place for the storage of controlled drugs which included the use of a controlled drugs register.

We asked how the home stored and recorded medication that was to be disposed of. We saw that there was a record kept of medication that was waiting to be disposed of. We saw that medication was stored in a plastic bag in a locked cupboard in the treatment room while awaiting pick up from the dispensing pharmacy. In line with the National Institute for Health and Care Excellence (NICE) guidance medicines for disposal should be stored in a tamper-proof container until they are collected or taken to the pharmacy to ensure they are not tampered with.

We looked at the care records of four people who used the service. We saw that one person had admission details dated 25 March 2016 and a needs assessment but did not have any plans of care. For example we saw from the need assessment that this person was epileptic and had seizures but there were no plans of care to direct care staff how to manage this particular care need. The needs assessment identified that the person had vascular Dementia, confusion and disorientation but there was no plans of care for these identified needs.

We saw in the four care files looked at that it had been documented that regular reviews had been undertaken. However we saw in two care files the plans of care were dated 2014 and in another care file the care plans were dated 2013. We saw one care file contained conflicting information. A manual handling risk assessment which had been reviewed on a regular basis stated 'requires the use of the stand aid hoist.' A further manual handling assessment stated 'requires the use of full hoist and medium sling' to transfer. The washing and dressing plan of care stated that the person required the use of the full hoist. This conflicting and confusing information puts the person at risk of receiving unsafe care.

We saw an entry on a washing and dressing care plan that was incomplete and started with 'now requires assistance with keep'. We asked the director of the service if they knew what the entry was referring to but they did not. This could indicate a risk that a care need was not being met.

We found some parts of the plans of care to be vague and lacked information to direct care staff to deliver safe, effective care whilst promoting independence. For example in one care file we saw a plan of care titled 'skin condition'. The plan of care stated 'help [the person] by creaming the areas she cannot reach.' There were no details of what the skin condition was, what creams were to be applied, how often they were to be applied or to which areas of the body they should be applied to. We saw a plan of care titled 'washing and dressing' which stated '[the person] to do all the tasks as much as possible. Assist with areas that [the

person] is unable to do'. There were on details of what the person was able to do or exactly want assistance was needed. This meant that people were at risk of not receiving safe care and treatment that had been planned to meet all of their individual needs

There was no regular, formal audit process of the care files and care plans. This meant were was no system to clearly identify any shortfall and the specific action taken in response to the shortfall. .

We saw that not all appropriate safety checks had been carried out to ensure people were cared for in a safe environment. We saw documentation which indicated they had a clinical waste contract, the lift had been regular serviced, portable appliance testing (PAT) had been undertaken and emergency lighting was checked on a monthly basis as was the fire extinguishers and fire alarm. However following a fire risk assessment undertaken by Tameside Fire Protection in January 2016 some of the recommendations had not been met. For example there was no evidence that any fire evacuation drills had been undertaken, means of escape were not being checked and although there were fire risk assessments in place there was not a review process for them. There was no evidence that window restrictors were checked or checks of the nurse call bells, and we were told that bath temperatures were not taken prior to a person being assisted into the bath. This meant people were at risk of being bathed in water that was above recommended maximum temperatures.

The acting manager said following the fire risk assessment in January 2016 they were in the process of implementing a personal evacuation plan (PEEP) for each person. This meant that until these plans were in place for every person staff were not provided with the information or directions to follow in order to keep each person as safe as possible should an emergency evacuation of the home be required.

There was no formal audit process in place to ensure safety checks were being undertaken. This meant that there was a risk people were not being cred for in a safe environment.

The above examples demonstrate a continued breach of Regulation 12 (1) and (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We reviewed four staff personnel files for staff who had been recruited between February 2014 and February 2016. We saw photocopied documents of proof of identity and proof of address in the files we looked at. It was discussed with the acting manager that these photocopied documents should be signed and dated by the person taking the photocopy as proof of authenticity.

We saw in one file there were gaps in the person's employment history from 2004 to 2010 which had not been explored. The acting manager said they thought it had been discussed with the person but had not been documented. There were no interview notes. In another file we saw that only one reference had been obtained for person. This meant that appropriate checks were not undertaken to ensure suitable staff were employed.

In all four staff files we saw evidence that a Disclosure and Barring Service (DBS) first check had been received but there was no evidence that the staff had worked under supervision until a clear DBS had been received. Staff should work under supervision until a clear DBS has been received. There was no evidence that a clear DBS had been received although we were shown a clear DBS certificate for one of the staff members on day three of the inspection. The acting manager told us that the other three members of staff had received a clear DBS but they had not brought them in for the information to be recorded on their file. The DBS is a national agency that holds information about criminal records. DBS checks aim to help employers make safer recruitment decisions and minimise the risk of unsuitable people being employed to

work with vulnerable groups of people.

The acting manager told us there was no audit process in place for staff files. The Health and Social Care Act (2008) Regulated Activities Regulations (2014) Schedule 3 sets out the information required when employing people. As there was no audit process in place for staff files the provider could not be sure that the information had been received for each member of staff.

The above examples demonstrate a continued breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked around the home, we looked at all the communal areas, toilets, bathrooms and some bedrooms.

We saw that two hoists while being charged were stored on the upstairs corridor and wheelchairs were stored in the downstairs shower room and staff confirmed that was normal practice. These items posed a trip or obstacle hazard to people.

We saw the cleaning schedule completed by care staff in relation to the hoists, mattresses, wheelchairs and the commode cleaning were vague and did not evidence exactly what had been cleaned.

We were told that the service did not undertake any internal infection control audits to ensure a high standard of cleanliness.

We saw that hoists were dirty even though there was a written record stating that the hoists had been regularly cleaned by the care staff. We saw that the hoist slings were stained and were inappropriately stored on top of each other which posed a risk of cross infection. There was no formal audit process in relation to infection control or checking the cleanliness of the home which meant the service could not demonstrate good infection control and cleaning systems were in place to ensure people received safe and effective care.

The service did not have a copy of the Department of Health code of practice on the prevention and control of infections and related guidance. All services should have a copy of this code of practice.
We saw that the home had infection control policies and procedures although they needed to be reviewed and updated as they made reference to the previous registered manager who deregistered in August 2015.

The above examples demonstrate breaches of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safe care and treatment

There was evidence of refurbishment at Bankfield House Care Home since the last inspection. For example the dining room, the main corridor, the corridor to the snowdrop lounge and the snowdrop lounge and dining area and two toilets had been repainted.

During our inspection we saw personal protective equipment (PPE) such as disposable aprons and gloves were available throughout the home as was hand sanitiser which would help reduce the risk of cross infection.

During our tour of the building there were no unpleasant odours detected and the bedrooms and communal areas we viewed were found to be clean. However we did see in one bedroom on the first floor that the service was inappropriately storing rolls of paper towels. We asked that these be removed.

All bathrooms and toilet areas were clean and contained wall mounted liquid soap and paper towel dispensers.

We saw the use of colour coded mops for cleaning and we saw good stocks of cleaning products which helped staff to maintain good standards of hygiene and cleanliness throughout the home. All cleaning products were in a locked cupboard to ensure people's safety. During the course of our inspection we saw that Substances Hazardous to Health (COSHH) Regulations were obtained from the suppliers of the cleaning materials used in the home. COSHH is the law that requires employers to control substances that are hazardous to health.

We saw the house keeping staff had cleaning schedules in place in relation to the communal areas, bathrooms, toiles and peoples bedrooms. The schedules did not clearly evidence exactly what cleaning had taken place but these were updated during the course of the inspection visit by the housekeeper.

We saw that the kitchen areas were clear with no spillages or greasy build-ups and the equipment such as the cookers, microwaves and fridges were kept clean. Fridge and freezer temperatures were appropriately monitored and recorded on a daily basis and stored food in the fridge was labelled, covered and dated.

Care staffing levels in the home consisted of four care staff and one supervisor during the day and two care staff and one supervisor for night duty to care for up to thirty people. The acting manager worked on a supernumerary basis.

We looked at the staffing rotas for a four week period which confirmed that levels of staffing were consistent on a day to day basis. However feedback from staff was sometimes the staffing levels dropped to three care staff and one supervisor in the morning which meant there were not enough staff to safely deliver care and supervise people. This was discussed with two of the directors who said the staffing numbers were only decreased if they had vacancies in the home.

We recommended that the provider implements the use of a staffing tool to determine the number of staff and range of skills required in order to meets the needs of people using the service and keep them safe at all times. Staffing levels and skill mix must be continuously adapted to respond to the changing needs and circumstances of the people using the service.

Although thirty staff had undertaken first aid training we saw that there was not an identified first aider for each shift. It was discussed with the acting manager that to help reduce the risk to people there should be an identified first aider for each shift in case of an emergency. The acting manager assured us that they would update the staff rota to identify this.

People we spoke with told us they were happy living at Bankfield House Care Home and the staff were nice, kind and gentle. One person said "The staff are really very good and very kind."

All of the visiting relatives spoken with told us they felt confident that their relative was safe and well cared for. One person said, "I don't worry one bit about their [relatives] safety." Another person said "they [the staff] are all lovely and kind."

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. We saw twenty nine staff out the 33 staff employed, which included domestic and catering staff, had undertaken safeguarding adults training. Staff had access to a safeguarding policy, including local authority's multi-agency safeguarding adult's policy which included details of how to make a

safeguarding referral and a Whistle Blowing policy. The Whistle Blowing policy is a policy to protect an employee who wants to report unsafe or poor practice.

Prior to this inspection we received some information that an allegation of abuse regarding a member of staff had been made to the acting manager during 2015. The allegation of abuse had not been reported to the local authority safeguarding team as set out in Multi Agency Policy for Safeguarding Adults at Risk but had been investigated internally and an action plan put into place to support safeguard people living at Bankfield house and support the member of staff. The safeguarding team and CQC had been notified retrospectively.

Requires Improvement

Is the service effective?

Our findings

We asked to looked at the records to demonstrate how often staff received supervision and appraisals. We were told that thirty three members of staff were employed in total. The records we were given related to twenty seven staff members. We saw that twenty one staff had received an annual appraisal, four staff had received one supervision session and nothing was recorded for two members of staff. The acting manager was unaware of the need for staff to have ongoing, regular supervision as well as an annual appraisal. This meant that staff were not receiving appropriate support and guidance to enable them to fulfil their job role effectively.

The above examples demonstrate a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 there best interests and as least restrictive as possible.

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

On the staff files we looked at we saw evidence and the staff we spoke with all confirmed they had undertaken MCA and DoLS training. Staff spoke with demonstrated an understanding of them both and understood the need to obtain consent prior to care being delivered or a task undertaken. We did observe staff obtaining verbal constant from people during our inspection.

We saw evidence that one person living at Bankfield House Care Home had an authorised DoLS in place. Providers must notify CQC about applications to deprive a person of their liberty when the outcome is known about any applications they make under the Mental Capacity Act 2005 (both by use of the DoLS process and by applying directly to the Court of Protection) and about the outcome of those applications. CQC had been notified that the application had been submitted but not the outcome that the application had been authorised.

We saw an urgent DoLS application had been sent on 29 December 2015. An urgent authorisation can never be given without a request for a standard authorisation being made simultaneously. There was no evidence to demonstrate that a standard application had been applied for, that the application had been authorised, that an extension had been applied for after the seven day "Urgent" period or that the local authority had been contacted regarding the application. This meant that the care given may have been unlawful.

We saw that the service did not have copies of the Mental Capacity Act 2005 code of practice or the Deprivation of Liberty Safeguards Code of Practice for staff to refer to.

During this inspection we looked at how decisions were made for those people who had been assessed as lacking capacity to make decisions for themselves, ensuring this was in the person's 'best interests'. In one care file we saw the person receiving a service had signed their consent agreeing to the care plan. However in another care file there was no evidence of consent and in another two care files looked at we saw consent been signed by the person's relative. We asked the acting manager if the relatives had the statutory authority to give consent on their behalf. A person can give another person authority to make a decision on their behalf if a power of attorney (POA) for health and welfare has been granted. This is a legal document that allows the nominated person to do so. The acting manager told us one relative was in the process of applying for POA and the other relative had been given verbal consent by the person receiving a service to sign on their behalf. There was no evidence to support this.

We noted, on the care files we looked at, that generic capacity assessments had been carried in 2014. This is not in line with the Mental Capacity Act 2005 Code of Practice.

The above examples demonstrate a breach of regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Bankfield House Care Home who we spoke with told us the food was very good. One person said "The food is all homemade and very nice." Another person said "The chef is very good and will do you something else if you want."

We spoke to the cook and a kitchen assistant who had a good understanding of people's personal preferences, including their likes, dislikes and any special dietary requirements such a pureed or diabetic diets. They explained what alternatives were available for people.

We saw that a daily menu was on display outside the main dining room. As part of our inspection, we carried out an observation over the lunch time period. Lunch looked appetising and was well presented, with good portions. We saw that lunch was plated by the chef and serviced by the care staff. This meant that people were not given a choice with regard to the meal. For example the meal of chicken and mushroom casserole with green beans and mash potato was served without asking people if they wanted all parts of the meal or even if they wanted the meal. Staff told us the people were given a choice at breakfast and teatime but choices were not actively encouraged at lunchtime. They said if somebody was given the meal and they said they didn't want it or if the chef knew they didn't like that particular meal than an alternative would be provided.

We saw some written signage within the home to support people to orientate themselves around their surroundings. Examples included signs to identify where the toilets and bathrooms were, numbers on bedroom doors had the name of the person on. We recommend that the service further develops the signage in line current best practice in relation to the specialist needs of people living with dementia.

We looked at how the provider supported and trained staff to carry out their job roles effectively. All staff completed the homes own induction training when they commenced working at the home which was over a twelve week period. The first two or three days, depending on prior experience, the new staff member worked supernumerary, shadowing an experienced member of care staff, becoming familiar with the policies and procedures for the service and they were given a staff handbook.

From April 2015 new health and social care workers should be inducted according to the Care Certificate framework. This replaces the Common Induction Standards and National Minimum Training standards. The acting manager told us that they were unaware of the Care Certificate but would look into accessing and implementing it.

We saw that staff training was recorded on individual files along with certificates or if on line training had been undertaken there was a computerised record. There was not an overall staff training record and there was no audit or overall system to check staff training. This meant the provider could not be confident that all staff were properly trained to meet the assessed needs of people receiving a service and minimise identified risks to their health and safety. However following the inspection we received a list of training completed by staff. We saw from looking at the staff files, the computerised records and the list of staff training that training included first aid, food hygiene, nutrition and diet, health and safety, moving and handling, safeguarding adults, infection control, COSHH, Dementia Care, Person centred care, fire training MCA and DoLS and Health and Safety. We saw that nineteen staff had achieved National Vocational Qualifications (NVQ) level two and ten staff had had achieved NVQ level three. One member of staff had achieved NCQ level four and one member of staff had achieved a Diploma at level 5. Two staff were currently undertaking NVQ level two and two staff were undertaking NVQ level three and two staff were undertaking the Diploma at level 5. All staff spoke with said that training was supported and a lot of training was provided. Regular training for all staff is important to support and further develop them to carry out their job roles safely and effectively.

Care records we looked at showed that the service involved other professionals to meet the healthcare needs of people who used the service such as, GP's, opticians, chiropodists and district nurses.

We were told by the staff spoken with that 'handover' meetings took place at the start of each change of shift. In addition to the verbal handover a written handover sheet and a communication book was available for staff to look at which they found useful.

Good

Is the service caring?

Our findings

People living at Bankfield House Care Home told us they were happy and had everything they needed. One person when asked said the staff did respect their privacy and dignity and said "I am as happy as I can be, I go downstairs for my lunch and this is what I like to do." Another person said "I have everything I need and the staff are very nice and caring."

Relatives we spoke with told us they felt confident about the care their relative received living at Bankfield House Care Home. One person said "From the moment I stepped through the front door I felt very impressed, it looked and felt homely and was fragrant." Another comment was "I couldn't ask for anything better." We were told that the staff gave relatives lots of support and reassurance and visitor were always greeted with a tray of tea. One relative said "Every single carer here is lovely."

The relatives we spoke with told us they could visit at any time and were always made to feel very welcome.

We saw that the home actively encouraged people to maintain contact with family and friends. We were told and relatives spoken with confirmed that they could book a private meal in the dining area in the Snowdrop lounge to spend quality time with their relative or for family celebrations or gatherings.

It was evident from the discussions with the staff and from the interactions we observed, they knew the people they supported very well. This was confirmed by the relatives we spoke with. One person told us they thought privacy and dignity was always respected and their relative was a very private person and that was respected by staff. They said "[their relative] is very happy and thinks the staff are wonderful and is forever thanking them."

During our inspection we heard staff speak to people in a friendly and kind manner.

We observed staff caring for people with dignity and respect. We saw that people living at Bankfield House Care Home had good relationships with the staff and felt relaxed and at ease in the company of the staff.

There was a relaxed, friendly atmosphere in the home and staff we spoke with told us they enjoyed working at Bankfield House care Home. One member of staff said "We have a good staff team here." Another member of staff said "The atmosphere is good here."

We saw that people's individual preferences and independence was promoted by the staff team and we observed and heard care staff encouraging people to make choices about their daily life style.

People were well-groomed and dressed appropriately and the hairdresser had been in the home on day one of our inspection which the ladies were seen to enjoy. Staff told us that sometimes people did not want personal care at the time it was being offered. When this happened, they would leave the person for a while then go back and ask them again and this usually worked.

We saw that information relating to advocacy services and contact details were available in the main reception area of the home. Such a service supports a person who may need help in making decisions about important aspects of their life and to support them in making sure their individual rights are upheld.

We were told that Bankfield House Care Home provided End of Life Care to people and had monthly meetings with the district nurses and the End of Life Lead Nurse from Stockport NHS Foundation Trust who supports them to deliver the care. In addition we saw they attend the End of Life Forum held by Stockport NHS Foundation Trust to ensure they are up to date with current good practice guidance.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care plans for four people who used the service. We saw that people had a 'personal history' in place which contained person centred information and a plan of care for activities that included people's hobbies, interest and preferences.

In the three of the four care files we saw plans of care were in place. These explored areas such as washing and dressing, nutrition, mobility and falls. Personal details and personal preferences were recorded inconsistently. Some parts of the plans of care contained details of people's personal preference for example what time people liked to go to bed and get up, and shaving preferences. However other parts of the plans of care were vague and did not give specific personal details of, for example people's food preferences, whether the person preferred bath or shower or detailed information of what the person was able to do for themselves to promote independence.

We recommend that the service considers current best practice in relation to implementing and reviewing care plans that are designed to meet the individual needs and personal preferences needs of people who use the service.

Relatives of people using the service told us that they felt their relative's needs were being met. One person told us, "Yes all of their care needs are met". Another relative said "They really accommodate [their relatives] person needs."

We heard staff and people living in the home communicating well with staff and each other and we saw people freely expressing their needs. We saw that staff responded appropriately in supporting people.

The acting manager told us that unless it was an emergency admission people had their needs assessed before they moved into the home. All the information gathered helped to ensure the home could meet the individual assessed needs of the person. The acting manager said if it was appropriate and the person was able they would be invited to visit the home and perhaps have lunch and meet the staff and other people living at the home before they made a decision about moving in. Relatives spoken with confirmed this. The acting manager said if it was an emergency admission they expected the Local Authority to fax them all the information relating to the person's care needs.

We saw a 'Resident information pack & Statement of Purpose' was available for people which included key names and contact numbers, the organisational structure of the home, the aims and objectives of the home, information regarding the facilities available including meals, the complaints procedure, plus other relevant information. This required updating as it contained the name of the previous registered manager and qualifications.

During our inspection we reviewed the policy in relation to complaints, which was included in the 'resident information pack.' We saw that the acting manager held a 'Weekly Wednesday surgery' where they made themselves available should anybody wish to speak with them or raise any concerns.

We saw a complaint log was kept which contained the nature of the complaint, the date and time of the complaint and who received it. We saw that appropriate investigation, actions and outcomes had been recorded for each complaint. The acting manager said it was her intention to formalise the process of sending an acknowledgment letter and an outcome of the investigation to the person making the complaint.

Although there was a record of complaints there was no formal audit or analysis of the complaints received or lessons learnt.

The relatives we spoke with told us they did not have any complaints but felt certain that any issues raised would be listened to and action would be taken.

We saw that the home employed the services of an activity coordinator. We saw that people were assisted to engage in a wide variety of meaningful activities of their choosing. Some of these activities included armchair exercises, holistic therapy, reminiscence groups, musical entertainment, canal trips, trips to the theatre, outings to the garden centre and a verity of games. People living at Bankfield House Care Home relatives and staff all spoke positively about the activities provided and the person providing them. One person living at Bankfield House said "I enjoy all the activities, I especially liked the outdoor bowling." A member of care staff said "The activity coordinator is brilliant, they [the people living at Bankfield House] have just had two trips out and have been sat in the garden enjoying the sun." We saw that a record was kept of the activities undertaken by each person.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection the service did not have registered manager in post. A registered manager had not been in post since August 2015.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was an acting manager in place who had taken up the post on 31 August 2015. Just prior to this inspection the acting manager who was also the nominated individual (NI) for the service told us they were unaware they were required to submit an application for registration as manager. They thought the certificate relating to the NI meant they were also registered as manager. During the inspection we were informed that they had now started the registration process and had submitted their application to register with CQC on 4 May 2016.

Part of a registered managers or registered providers responsibility under their registration with the Care Quality Commission is to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered managers/registered provider's responsibility to notify us of certain events or information. There had been six incidents within the home that CQC should have been notified about. There was a death, three allegations of abuse, a serious injury and a DoLS authorisation. By not notifying us of incidents such as these, we are unable to assess if the appropriate action has been taken and the relevant people alerted.

The above examples demonstrate a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw that the service had a copy of the outdated, previous regulations but did not have a copy of the current regulations.

We saw that policies and procedures were available and accessible to staff. However all the policies and procedures we looked at required reviewing and updating as they made reference to the outdated, previous standards and regulations. The acting manager acknowledged that the policies and procedures all required reviewing. This meant staff were not provided with access to up to date information that reflected current legislation and best practice guidance to support them in their roles.

We found the registered provider had failed to establish and operate effective systems to assess, monitor and improve the quality of service; had not mitigated the risks relating to the health, safety and welfare of people who used the service and did not effectively asses and monitor all aspects of the quality of the service. There was no structured and meaningful process in place for regularly auditing care plans, staff

training, staff personal flies, complaints, safeguarding, accidents and incidents, infection control and general cleanliness of the home and all aspects of the medication administration records. This had resulted in many of the shortfalls and breaches of regulations we had found during the inspection process.

The above examples demonstrate a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that feedback questionnaires were sent out to relatives twice a year, the last questionnaires were sent out in February 2016. We saw that the responses had been analysed by the service and action had been taken in response to some of the feedback. We saw that the majority of people rated the overall service as excellent. The acting manager said they were considering sending out an annual anonymous questionnaire to staff and an annual questionnaire to visiting health professionals in an attempt to obtain their view of the service.

We saw that relatives had good relationships with acting manager and were seen to be happy to approach them thought the three days of the inspection.

We looked at records relating to staff meetings and saw they were held approximately every three months. The last meeting was held on 26 March 2016 where moving and handling training and night duty shifts were discussed. The acting manager told us that all staff were given a copy of the minutes so they were kept informed of what was discussed. Staff we spoke with confirmed that staff meetings were held on a regular basis.

Staff told us that the values and principles of the home was to provide a safe, homely environment for people to live. One member of care said "We are a friendly team who provide a homely environment and we support the relatives as much as the residents."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not ensure that valid consent had been sought ensuring people's rights were protected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that the registered provider had not protected people against the risks associated with the safe administration and management of medicines. We found that the registered provider had not taken all reasonable steps to help manage and reduce the risks ensuring the health, safety and welfare of people. Some equipment was found to be dirty and inappropriately stored increasing the risk of cross infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed We found that the registered provider did not have robust recruitment process in place to ensure people using the service were kept safe.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

People were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary direction and support to carry out their role

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not read, and consider guidance in relation to the regulated activities they provide, they did not notify us of certain events or information.

The enforcement action we took:

Fixed panalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found the registered provider had failed to establish and operate effective systems to assess, monitor and improve the quality of the service

The enforcement action we took:

Warning notice