Mrs Safia Bano Hussain

Bankfield Manor Care Home

Inspection report

Boothtown Road
Halifax
West Yorkshire
HX3 6HG

Tel: 01422352398

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our inspection took place on 8 January 2018 and was unannounced. At our last inspection in December 2016 we rated the service as 'requires improvement' overall and identified a breach of the regulation relating to need for consent. At this inspection we found the provider had made improvements and were no longer in breach of regulation.

Bankfield Manor Care 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. The home is registered to accommodate 25 but, due to changing double occupancy bedrooms to single occupancy, the home now has a maximum capacity of 21 people. At the time of our inspection there were 17 people using the service including one person who was in hospital. There was a registered manager in post. They were relatively new to the position having been registered for only four months. 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.

Systems were in place to promote people's safety and to review with them if they felt safe. We found the home was well maintained although we noted more thorough cleaning was required in some areas. We saw accidents, including near misses, and incidents were managed appropriately and reviewed to see if risks could be mitigated. Staff understood how to identify and report any potential abuse.

Staff were recruited safely and told us they received regular training and effective support.

We noted particular times of day when care staff were engaged in duties other than care which impacted on their availability to people. Although we did not observe people being put at risk, the provider said they would take action to address this.

Improvements had been made relating to capacity and consent. However we noted family members were sometimes involved in decisions where it was not clear this would be the person's wish.

People were able to choose how and where they spent their time, and lifestyle choices were respected. People had access to appropriate recreational and social activities and equipment was available for people living with dementia to occupy their time.

A new research based menu was in place and people said they enjoyed the food and had choice. The cook had good knowledge of people's nutritional needs.

We saw staff and people who used the service knew each other well, and we saw examples of caring practice during our inspection. Equality and diversity principles were well embedded in the culture of the home.

Care plans were detailed, person centred and up to date. There was some evidence of people being involved in their care planning but this was not evident for everybody.

There were systems in place to ensure complaints were managed appropriately, and people told us their concerns were dealt with well.

There was a robust system in place for auditing quality and safety within the service.

Staff and people who used the service felt it was well-led, and we saw the registered manager and provider were a visible presence in the home and clearly knew people well.

Systems were in place for people to voice their opinions and we saw the provider shared results of surveys and plans for development with people involved in the home. We saw examples of actions taken to improve the service as a result of feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines management was safe and systems were in place to maintain people's safety.

Staffing levels needed to be kept under review to make sure people's needs were met in a timely manner. Staff recruitment processes were safe.

Systems were in place to promote effective infection control although more thorough cleaning was needed in some areas.

Is the service effective?

Good

The service was effective.

Staff had received the induction, training and support they required to fulfil their roles and meet people's needs

The service meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were assessed and staff supported people in accessing a range of health professionals. People received a nutritional diet which met their needs.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with kindness.

People's lifestyle choices and dignity needs were respected.

Is the service responsive?

Good

The service was responsive.

Care records reflected people's current needs and were accurate and up to date. People were well supported at the end of their lives.

People engaged in a variety of activities.

Systems were in place to record, investigate and respond to complaints.

Is the service well-led?

Good

The service was well-led.

Leadership and management of the service was consistent and staff reported improvements in this area.

Quality assurance systems were effective in assessing, monitoring and improving the quality of the service

Bankfield Manor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 8 January 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert by experience is a person with personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed all the information we held about the service including action plans, past inspection reports and notifications about incidents which the provider is required to send us. We also contacted other bodies including the local commissioning authority, safeguarding teams and Healthwatch (a consumer champion which gathers information people's experience of using health and social care services in England), to ask if they had any significant information to share about the service. We did not receive any information of concern and received positive feedback from the local commissioning authority.

We sent a provider information return (PIR), which was returned to us. A PIR is a form that asks the provider to give some key information about the service; what it does well and what improvements they plan to make.

During the inspection we spoke with the provider, the registered manager, three staff and seven people who used the service. We also spoke with two visiting friends and relatives and a visiting district nurse. We looked at documents relating to the running of the service including audits, maintenance records and the care plans of five people.

Good

Is the service safe?

Our findings

Staff we spoke with understood how to recognise signs of potential abuse and their responsibility to report any concerns. We saw the safeguarding and whistleblowing policies were displayed in the home, meaning they were accessible at any time. Accident and incident records we looked at showed the provider was recognising when these should be reported to the local authority safeguarding teams and the CQC.

We saw systems were in place to review safeguarding issues, accidents and 'near miss' incidents to identify any themes or trends for which action could be taken to minimise the risk of reoccurrence.

Care plans we looked at contained a range of assessments which evidenced the provider had a good understanding of risks associated with people's care and support needs, and how these could be minimised. The risks considered included nutrition, skin integrity, falls, mobility, and management of behaviours that challenge people and others, and social exclusion.

We saw there was an assessment of the likely impact on people were these risks not minimised, and guidance for staff which showed actions they needed to take in order to protect people. Staff we spoke with were knowledgeable about specific risks associated with people, and could tell us what they needed to do to ensure people were safe.

We saw documentation relating to a discussion between the provider and a person living at the home entitled 'How safe do I feel'. The person had been asked questions about what made them feel safe, if they had any concerns about their safety and what the home did, or could do to make them feel safe. The person's responses were very positive and demonstrated their faith in staff to understand and respond to their needs effectively in order to maintain their safety.

There was guidance and equipment in place to ensure people who did not always speak English or communicate verbally were supported to express their needs, meaning the provider was taking action to ensure people had equality of access to care and support.

Personal emergency evacuation plans (PEEPs) were in place for each person. Copies of the PEEPs were attached the people's bedroom doors, included in care files and in a folder easily accessible to staff in the case of an emergency.

The provider told us that staffing arrangements were kept under review in line with the outcome of the tool used to assess the dependency levels of people living at the home. We looked at staffing rotas which showed three care staff on duty between 8am and 8pm and two care staff during the night. The registered manager worked between 8am and 4pm on weekdays in addition to the care staff and we saw they were involved in the delivery of care. The provider told us they spent time at the home carrying out general administrative and managerial duties to support the registered manager.

Rotas showed cleaning staff worked between 8am and 1pm and a cook worked between 8am and 1.30pm.

Staff we spoke with told us they were responsible for preparing the evening meal, although the cook got components of this ready for them. This meant one member of staff was not available to assist people during this time. We observed some people waiting a long time after being supported to the dining room before the evening meal was served as the two available staff were busy attending to people's needs. When we raised this with the provider and registered manager to illustrate the need to keep staffing levels under constant review, the provider accepted our feedback and assured us they would review staffing hours to cover busy periods.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included requesting a criminal record check with the Disclosure and Barring Service (DBS), two written references and explanation of gaps in employment.

We found the environment to be generally clean and tidy but did alert the provider to some areas where more thorough cleaning was needed. This included a stained mattress and dirty chair which staff had supported a person to sit in. Whilst this was attended to immediately we pointed the issues out, we were concerned that staff had not taken more timely action. We saw weekly quality and safety checks of the environment were in place and noted where issues had been identified, appropriate action had been taken. Records of environmental safety checks including fire, gas and electrical safety, water storage and moving and handling equipment were all in place and up to date.

We saw new equipment had been purchased to support effective infection control within the home. This included antibacterial door handles in communal areas, single cartridge hand wash dispensers and covered toilet roll holders. Antibacterial hand gels and wipes were available in communal areas and bathrooms and we saw staff using personal protective equipment (PPE) as needed. We saw documentation relating to an infection control meeting involving people who lived at the home. The meeting included information about equipment such as hand sanitizers in the home to promote infection control and explanation and demonstration about how to use them.

We found medicines were managed safely within the home. Medicines were stored safely with temperatures of the storage area recorded daily. Systems were in place to make sure people were given their medicines at the right time. For example, medicines to be taken before the person received any food were administered over thirty minutes before breakfast.

Where medicines had been prescribed on an 'as required' (PRN) basis, protocols were in place detailing the circumstances in which the medicine should be given. We saw staff recorded when the PRN medicine was administered and if it had been effective.

We checked the stock levels of a sample of medicines, including controlled drugs, against the amounts recorded as received and administered and found the levels to be correct.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

At our last inspection in December 2016 we found the service was not complying with conditions attached to DoLS authorisations. The service provided us with an action plan detailing the actions they had taken to address this issue.

We checked to see if improvements had been made to make sure 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.

Care plans contained assessments of people's capacity to make a range of decisions associated with their care, including to contribute to their care planning, to consent to interventions such as bed rails, continence care, and to share information about their care with health and social care professionals as required. These assessments adhered to good practice and demonstrated the provider had improved their approach to assessing people's capacity.

Where people did not have capacity to make decisions, we saw best interest decisions had been recorded. However we were concerned not all best interest decisions had involved appropriate individuals. For example, we saw a best interests decision had been recorded which showed the provider had involved a family member when there was no evidence of that this would be the person's wishes. The provider understood our concerns and told us they would take action to address this.

Staff we spoke with confirmed they had received training in the MCA and DoLS, and were able to tell us how these impacted on the ways in which they worked with people. Staff understood the importance of supporting people to make their own choices wherever possible, for example in using pictorial aids and technology to allow people to communicate their needs and showing people clothing so they could choose what they wanted to wear more easily.

Records we looked at showed the provider and registered manager understood when applications for DoLS should be made, and where DoLS had been approved with conditions, we saw the provider was aware of these and could evidence how they were being met. We saw effective systems were in place to ensure applications to renew DoLS were made in a timely way.

The provider showed us new menus which they explained they had developed following research into nutritional needs of older people. The menus included the addition of nutritious seeds, oils and whole foods such as brown rice. These additions were optional and did not affect people's choices. We saw people who lived at the home and their relatives had been involved in menu planning with their favourite foods included and we saw positive feedback about the new menus.

Care plans contained an assessment of people's nutrition and hydration risks, and we saw people were regularly weighed to ensure their weight remained stable. There was information relating to people's food likes and dislikes, and we saw there was clear guidance in place for people who needed or preferred a specialist diet. We saw one person was diabetic, although preferred not to follow an adapted diet. In order to ensure the person remained safe we saw guidance in their care plan relating to regular testing of their blood sugar levels, and records of contact with the person's GP to ensure the home had the right equipment to enable them to do this. Staff we spoke with had a good knowledge of who needed an adapted diet, for example a pureed diet to ensure safe swallowing or alternatives for people who chose not to eat meat.

People we spoke with were complimentary about the food at the home. One person told us "A lot of things don't agree with me and the staff are very good here at getting me what I can eat."

Visiting family told us they had been invited to eat at the home regularly (with no charge) and that the food was "Very good."

We saw the lunchtime meal consisted of home-made soup followed by a choice of quiche or cottage pie with fresh vegetables. Drinks and snacks were offered to people at various times throughout the day.

Records showed people had access to a range of health and social care professionals when they needed this. These included GPs, Quest Matrons, opticians, mental health teams and social workers. We spoke with a visiting district nurse who told us staff at the home contacted them appropriately, worked well with them and followed their instruction and guidance. We saw that since the last inspection, the home had also installed the Tele-Care system which enabled them to seek medical assistance for people at any time without the person needing to leave the home.

The provider told us when the home first started with the Quest service (a model of care aimed to increase the level of support provided to care homes and their residents); they noticed a lot of confusion with people and their relatives as they had not known this before. The provider made an information letter which was given out to give more information about the Quest Service.

Staff we spoke with told us they felt well supported and had regular supervision meetings with the registered manager. They told us these meetings took the form of meaningful discussions about their experience of working in the home and any challenges they faced. One member of staff said, "We discuss any problems we have, and [name of registered manager] works through these with us."

Staff we spoke with said they had access to regular training which they felt was effective. When training was delivered online staff said they felt able to speak to the home manager to clarify any areas they felt they were not confident with.

We saw new staff without previous experience of care followed the Care Certificate training. The Care Certificate is a set of standards for social care and health workers. Staff with previous experience completed a self-assessment to establish what level of Care Certificate training would be appropriate for them. As part of the induction process, staff developed a personal development programme with the registered manager

or provider to make sure they received training appropriate to their needs. Training records showed that in addition to online training staff had received face to face training in areas including safeguarding training from the local safeguarding team; practical moving and handling training and we saw bookings for continence care training from the local continence advisory service.

Staff involved in managing medicines completed a minimum of annual competency checks.

We noted a wide divergence in temperature in various parts of the home during our inspection. This was not helped by staff having left windows open in some bedrooms after supporting people to get up despite outside temperatures being below freezing. We also found some radiators not to be working efficiently. The handyman had been alerted and was working to try to remedy the issue with the heating and had contacted heating engineers to attend the home. Communal areas were warm but people had been offered blankets if they felt cold. As requested, the provider confirmed with us following the inspection that the heating had been checked and was working efficiently.

There were colourful and detailed murals covering many walls and doors, however, in some areas these made doors and their handles hard to identify, which may have been challenging to people with visual impairments or those people living with dementia.

Other decorations were helpful to supporting people living with dementia, for example seasonal murals on windows, paintings of fire men on fire doors and the addition of street names to bedroom corridors to assist in people's orientation.

We saw record of a meeting held with one person to choose their bedroom décor. This involved looking at on line wallpaper and picture suppliers on the home's tablet. We saw the results of this when we visited the person's bedroom.

Good

Is the service caring?

Our findings

People we spoke with were positive about the care they received. Their comments included "Nearly everybody looks after me well, I don't do anything, the staff do all for me." "I do what I want and the staff are good to me" and "Staff are very good, quite pleased and my daughter is quite pleased as well."

We saw life histories were in place in people's care files. These are important in helping staff to get to know and understand people living at the home, particularly when people are living with dementia or find verbal communication difficult.

Staff we spoke with were able to tell us in detail about the people living in the home, and spoke about them with appropriate familiarity and fondness. We saw staff took the opportunity to sit and chat with people, and we saw people appreciated this.

Care plans contained information which evidenced the provider considered the diverse needs of people who used the service, including those related to faith, sexual orientation, ethnicity and disability. Documents we reviewed contained details of important relationships and friendships, and evidenced people were supported to maintain contact with people where this was possible.

Care plans showed how people were supported to follow their lifestyle choices and meet their religious and spiritual needs, including visiting places of worship and being supported in reading faith based literature such as the Bible.

One person told us, "The priest comes as often as he can manage to celebrate mass." They said that if they wanted to go to mass at church they knew staff would take them as another person goes.

Staff told us about ways in which they were mindful of people's privacy and dignity as they provided care and support. These included being discreet when asking if people needed any personal support, ensuring doors and curtains were closed before delivering personal care. We saw staff discreetly re-arranging one person's clothes in a way to preserve their dignity as they got up from their chair to walk. Staff also told us they encouraged people to do as much as they could or preferred to do when washing or bathing in order to promote their independence and dignity.

Good

Is the service responsive?

Our findings

Information in care plans and risk assessments was reviewed regularly to ensure it reflected people's up to date needs, although we noted there was little evidence to show people or appropriate others were involved in the review process. We discussed this with the provider and registered manager who said they did include people but accepted our feedback about this not being evident. Staff told us they found the care plans easy to read, and said they had time to do this during their working day.

There were a range of activities in the home, and care plans contained records of what activities people had participated in or declined. Staff we spoke with said they felt there was enough for people to do, and we observed a high level of participation in activities during our inspection. A programme of activities was on display in the hallway which accurately reflected the activities we observed. The provider told us they did not employ an activities organiser as they felt it was an integral part of care staff's role to meet people's social and recreational needs. We saw people had access to a large range of equipment to occupy them. This included books, jig-saws, arts and crafts and items specifically aimed at engaging people living with dementia.

There was a range of activity supplied by people from outside the home. This included singers, exercise groups and general entertainers. We observed people thoroughly enjoying two such activities during our inspection.

One person told us that they had planned their funeral, made their will and did not want to be resuscitated but was not sure they had spoken with their GP. We checked this person's care file and found a 'Do not resuscitate' order was in place along with a care plan detailing their wishes for the end of their life.

The provider told us about how they made sure extra staff were made available to make sure people were given support and comfort at all times during their final days. We saw a number of cards and letters from families thanking staff for their support at the time of their relatives' death.

We saw the complaints procedure and associated forms were displayed in the home, and the statement of purpose made clear the provider welcomed and would respond and act on all feedback. The provider made contact details for the local authority and the CQC available in this information.

One visitor told us there had been some issues and believed that "No care home is perfect." However when they had raised issues these had been dealt with quickly and to their satisfaction. They told us "I can say what I don't like and they do something about it."

We saw documentation which showed all complaints received had been investigated and responded to in line with the complaints procedure.

Good

Is the service well-led?

Our findings

There was a registered manager in place who, due to being relatively new to the position was being supported by the provider in various aspects of management.

The provider had a clear business plan in place which detailed their plans for the development of the service. They told us of ways in which they involved people associated with the home to gain their views about planned changes and receive feedback about the current status of the home. This included annual quality questionnaires and requests for feedback about specific topics such as changes to the menu. We saw the provider produced a breakdown of feedback along with an action plan which they shared with people who lived at the home and their relatives.

The provider told us they did not have relative meetings as previous efforts had received no response. However we noted that that feedback from people who lived at the home was included within staff supervisions as a way of staff being aware of people's opinions. The provider also recorded feedback from people who lived at the home and visitors in their monthly provider reports.

Staff meetings were held on a monthly basis. We saw from minutes how these meetings were used to inform staff of any changes, remind them of where improvements were needed, share successes and obtain opinions.

There was a robust system in place for auditing areas including environmental safety, fire safety, staff training, care plans and medicines. Weekly environmental audits were completed by the registered manager and we saw actions had been taken where issues had been identified. We saw monthly provider visit reports which identified any outstanding issues and how they had been addressed as well as recording what improvements had been made within the service.

As a result of previous inspections, feedback and audit, the provider had invested in high quality items such as pillows, duvets and infection control equipment to ensure the comfort of people who used the service. Where an audit of complaints made to the home had identified issues with clothing being misplaced through the laundry system; the provider invested in a new way of discreetly but permanently marking people's clothing.

We looked at the review of accidents and incidents. We saw the provider was collating information monthly and quarterly; however we discussed with them ways in which this could be made more robust. For example in one analysis we saw the provider had recorded, 'We picked up the trend of falls due to health problems," however there was no detail to accompany this. There was no information to show how statistics had been collated to ensure that accidents and incidents were not clustered around specific times of day or in specific areas.

Staff we spoke with gave good feedback about the registered manager. This included, "She is very supportive," "She is hands-on and a visible presence, she's not just locked in the office" and "She has

worked hard." Staff told us they felt the registered manager was approachable and respected confidentiality. Some staff told us that since the appointment of the new registered manager, they felt there had been considerable improvement in the home. They identified improvements in care, people looking cleaner, a better laundry service and a more positive atmosphere as examples of this.