Bupa Care Homes (Partnerships) Limited

Bankhouse Care Home

Inspection report

Shard Road
Hambleton
Poulton Le Fylde
Lancashire
FY6 9BU

Tel: 01253701635

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13 June 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 November and 2 & 9 December 2015. At this inspection breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bankhouse Care Home on our website at www.cqc.org.uk

This focussed inspection took place on the 13 June 2016 and was unannounced. This means we did not give the registered provider prior knowledge of our inspection.

Bankhouse Care Home is registered to accommodate up to 52 people who have nursing needs or people living with dementia. The home comprises of two general residential and nursing units and a unit for people living with dementia. All accommodation is located on the ground and first floor. At the time of the inspection there were 42 people who lived at the home.

There are a range of communal rooms, comprising of three lounges, and two dining rooms. There is a garden area with seating for people to use during the summer months. Car parking is available at the home.

The home has a manager who is registered with the Care Quality Commission. 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.

At the comprehensive inspection of Bankhouse Care Home in November and December 2015 the service was rated as 'requires improvement' overall, with 'requires improvement' ratings in three of the key questions 'is the service safe?' 'is the service responsive?' and 'is the service well – led?' We identified a breach of Regulation 12, (Safe care and treatment) as medicines at the home were not managed safely. We also identified a breach of Regulation 17, (Good Governance) as care records were not contemporaneous, accurate or reflective of people's needs. In addition, quality assurance systems were not operated effectively to ensure risks were addressed and improvements made.

We carried out this focussed inspection in June 2016 to check improvements had been made.

During the focussed inspection carried out in June 2016, we found two occasions where information was not shared promptly with external health professionals to allow timely care planning to take place. This was a breach of Regulation 12 (Safe care and treatment.) During the inspection we became aware of an occurrence at the home. We are considering our response to this.

We noted there were ineffective quality monitoring systems in place as improvements were not being made. This was a continued breach of Regulation 17, (Good Governance.)

We viewed care records to ascertain the care and support people received. We noted care records did not always contain accurate and sufficient information to ensure people's needs were met. The records we viewed did not always contain an accurate reflection of care interventions provided. This was a continued breach of Regulation 17, (Good Governance.)

We found medicines were not safely managed and people did not always receive their medicines as prescribed. This was a continued breach of Regulation 12 (Safe Care and Treatment.)

You can see what action we told the provider to take at the back of the full version of the report.

People told us they were happy living at Bankhouse Care home and they found staff to be kind and thoughtful. They told us if they required support, staff came quickly. However we were also told staff were not always able to meet their immediate needs and would arrange to come back to them in order to help them. This was confirmed by speaking with staff.

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 always safe.

People could not be assured they would receive their medicines safely.

The staffing provision was not arranged to ensure people were supported in an individual and prompt manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Appropriate referrals to external health professionals were not always made.

Documentation did not always reflect the care interventions people received.

Is the service well-led?

Requires Improvement

The service was not well-led.

Quality assurance checks in place were not effective as improvements were not always made.

Bankhouse 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.

We undertook an unannounced focused inspection of Bankhouse Care Home on 13 June 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our November and December 2015 inspection had been made. The team inspected the service against two of the five questions we ask about services: 'is the service safe?', 'is the service responsive?' and 'is the service well-led?' This is because the service was not meeting some legal requirements.

At the comprehensive inspection of Bankhouse Care Home in November and December 2015, the service was rated as 'requires improvement' overall, with 'requires improvement' ratings in three of the key questions 'is the service safe?', 'is the service responsive?' and 'is the service well – led?' We identified a breach of Regulation 12, (Safe care and treatment) as we found medicines were not managed safely. We also identified a breach of Regulation 17, (Good Governance) as care records were not contemporaneous, accurate or reflective of people's needs and quality assurance systems were not operated effectively to ensure risks were addressed and improvements made.

This focussed inspection was carried out on the 13 June 2016 and was unannounced. The inspection was carried out by one adult social care inspector, a pharmacist inspector and a specialist advisor. The specialist advisor had experience and expertise in falls prevention and management.

Following the comprehensive inspection carried out in November and December 2015, the registered manager sent us an action plan. This indicated the actions the registered manager planned to take to ensure improvements were made. We reviewed this as part of our inspection planning. In addition we reviewed notifications the provider had sent us, and reviewed information provided by the safeguarding authorities. This enabled us to plan our inspection effectively.

During the inspection we spoke with three people who lived at Bankhouse Care Home and six relatives. We

spoke with the registered manager and the deputy manager of the home. We also spoke with one registered nurse, two agency nurses and six care staff.

We looked at all areas of the home, for example we viewed the lounges and dining areas, and bedrooms. This was so we could observe interactions between people who lived at the home and staff.

We looked at a range of documentation which included eight care records and a sample of medicine and administration records. We also looked at records relating to the staffing provision at the home.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection carried out in November and December 2015, we found care records were not contemporaneous, accurate or reflective of people's needs.

At the focussed inspection carried out in June 2016 we found improvements were required to ensure records contained up to date and accurate information regarding people's needs.

We viewed one pre-admission assessment which indicated the person had a specific health concern. In the care record we viewed we could see no corresponding risk assessment to evidence the associated risks to the person had been assessed. In addition the corresponding care plan did not contain specific information to instruct staff on how the person should be supported. We discussed this with the registered manager who told us the information within the record was incorrect. Prior to the inspection concluding the registered manager addressed this.

We looked at a falls risk assessment to see how the risk of falls was identified and managed. The falls risk assessment we viewed had not been calculated accurately. Although this had no impact on the risk control measures implemented, this evidenced the documentation was inaccurate.

We reviewed two accident forms which had been completed after people who lived at Bankhouse Care Home had fallen. We saw the form recorded the action to be taken was to observe the people the forms related to. There was no guidance for staff on the frequency or types of observations to be carried out.

These were breaches of Regulation 17 (Good Governance) as the records were not accurate and contained insufficient information to enable staff to provide care and treatment which met peoples' needs.

The registered manager told us the registered provider had recently implemented a new 'falls policy.' This described the actions staff were to take if a person fell. This included the carrying out of vital observations following a fall. We spoke with the deputy manager who told this was not routinely carried out. The registered manager advised us they would ensure this was highlighted to staff.

We asked the registered provider how they monitored accidents and incidents within the home. We were told all incidents and accidents were reported using the registered providers reporting system. This information was then reviewed by the registered provider and the registered manager to identify if trends were occurring. We viewed the documentation provided and saw evidence incidents and accidents were recorded. We spoke with staff who were able to explain measures taken to reduce the risk of reoccurrence. We saw risk control measures had been introduced and were in place. For example we saw alarm mats, and laser alarms were in place. These are items of equipment that are used to alert staff if a person is mobilising. This allows staff to respond and offer support which reduces the risk of falls.

We asked the registered provider how they ensured sufficient numbers of staff were available to meet people's needs. They told us they reviewed the needs of people who lived at the home using a formal

assessment tool. They explained the assessment tool calculated how many staff were required. They also told us if extra staff were required, these were provided. The registered manager told us they also used an agency to provide registered nurses as they were currently recruiting staff. This was in addition to the registered nurses permanently employed by Bankhouse Care Home.

We spoke with six staff to ascertain their views on the staffing provision at Bankhouse Care Home. Four staff told us they considered more staff were required to enable them to meet people's needs. We asked staff to give examples of how the staffing levels at the home impacted on people's care. Staff told us they often had to leave people they were supporting to answer call bells. They explained they did this so the person who had rung their bell did not become anxious. Staff told us they would go to the person, tell them they would attend and return as soon as possible. Comments we received included, "People have to wait, not for long but we want to help people straight away. It happens most shifts and we all try our best to get to people." And, "We have to go and turn the calls bells off and ask them to wait. It's not something I want to do but I've no choice, there aren't enough here to help everyone." Also, "I don't like to think of people waiting for help."

Staff we spoke with also discussed the arrangements for their breaks. They told us when they took their breaks; two staff took a break together. They explained this meant there were less staff available to support people.

People we spoke with confirmed they had to wait on occasion. We were told, "They come back to me when they're busy." And, "If I ring the bell and they can't help me straight away, they ask me to wait. That's fine by me." Also, "Sometimes they turn my bell off but do come back."

We spoke with six relatives. Four relatives told us they were dissatisfied with the staffing provision at the home. Comments we received included, "Care here is good, there's no doubt about it. It's just finding the staff." And, "They need more staff here, [family member] has had to wait for help." Also, "Staff are very sensitive and caring, they just need more of them."

We discussed this with the registered manager. The registered manager told us they would review the deployment of staff at break times immediately. The registered manager took substantive action following our discussion. We received written communication which showed the registered manager had reviewed the staffing provision at the home and extra staff were provided.

At the last comprehensive inspection in November and December 2015 we found that medicines were not handled safely. We told the provider they must take action to improve the safe handling of medicines. We carried out this focused inspection on 13 June 2016 to ensure improvements had been made.

At this focused inspection we looked at how medicines were managed for 16 of the 42 people living at Bankhouse Care Home. We found that medicines were still not handled safely because the provider's arrangements to manage medicines were not consistently followed.

Medicines were not obtained safely. We found two people had missed doses of some of their prescribed medicines for between one and two days. This was because there was no stock available in the home. Missing doses of medicines places people's health at risk of harm.

We saw that medicines rounds took a long time to complete, there was no record of the time people were given their medicines which meant that people were at risk of being given doses of medication with an unsafe time interval between doses.

We saw that people were not given their medicines safely. One person was given out of date eye drops for three days. This placed the sight of this person at risk.

We saw that nurses administering medicines failed to follow the manufacturers' directions. Medicines, including antibiotics, which should have been given before food, were given with food, which means they may not work properly. We saw that nurses had not followed manufacturer's directions about how to use certain pain relieving patches. This placed people at risk of being in pain.

We saw some people were prescribed medicines to be given 'when required. ' We saw that for some people, the information recorded to guide staff when administering these medicines was missing. There was no information to guide staff as to how to select the correct dose of medicines which was prescribed with a choice of dose. We also saw that there was no information available to guide staff help them decide when to commence administration of medicines (anticipatory drugs), used when people were very poorly. If this information is missing, medicines may not be given effectively or consistently and people's health could be at risk or people may be in unnecessary discomfort.

Some people were prescribed thickeners to make sure they could have drinks without choking, we found that staff who prepared and served drinks did not have any written guidance as to how to thicken people's drinks to the correct thickness. Care staff had to rely on their memories to remember how to thicken each person's drinks, which is unsafe practice. We asked staff how they thickened one person's drink. Different members of staff told us they thickened the drink to different consistencies, which could have placed their health at risk of harm.

Records about medicines could not show that medicines were given safely as prescribed. There were gaps on the records which made it difficult to tell if medicines had been given or omitted. Staff failed to make an accurate record of the quantity of medication in the home for some people which meant it was not possible to make checks, by way of audit, to ensure people were given their medicines as prescribed. When stock levels were accurately recorded we found that medicines were not always given properly and safely.

We saw the records about the use of thickeners and creams were poor and did not provide evidence that creams had been applied properly or that thickeners had been used in all drinks. Medicines were stored in a tidy and dedicated clinic room. However the stocks of medicine in the room included medicine which had been discontinued and should have been disposed of.

We saw that tins of prescribed thickeners were kept in people's bedrooms. Care staff told us that they had been told thickeners must be kept in peoples bedrooms. In February 2015 a patient safely alert was issued regarding the need to keep the thickening powder out of peoples reach to avoid accidental asphyxiation if it was inadvertently swallowed. By failing to follow the advice in the safety alert, people were placed at risk of harm.

These were continued breaches of Regulation 12 (Safe care and treatment) as medicines were not safely managed.

Requires Improvement

Is the service responsive?

Our findings

At the comprehensive inspection carried out in November and December 2015, we found care records were not accurate of the care interventions delivered.

During this focussed inspection we found some improvements had been made. In two of the care records we viewed we saw external health professionals instruction had been documented in care records. However we found further improvements were required to ensure accurate records were kept.

We viewed a sample of documentation relating to the support people required to maintain their skin integrity. Staff we spoke with were knowledgeable of people's needs, however care documentation did not reflect that care interventions had been delivered. Staff we spoke with told us they sometimes forgot to complete positional change charts.

We viewed one care plan which showed a person needed support to change their position every three to four hours. We viewed nine of the person's positional change charts and saw several occasions when records indicated support had been given in excess of four hours. For example we saw one occasion when documentation recorded the person had received support in excess of seven hours. A further entry recorded the person had not received support for five hours. This placed the person at risk of care and welfare that did not meet their needs.

We viewed another care plan which recorded the person needed support to change their position every two hours. We viewed three of the person's positional change charts and saw several occasions when support had been recorded in excess of this. For example we saw one occasion which recorded the support was delivered an hour and fifty five minutes after the person had required the care intervention. Care documentation should accurately reflect the care and support provided to ensure care can be delivered which meets people's needs.

We viewed a third person's care plan which indicated the person required support to change position every three to four hours. The documentation we viewed did not reflect this had been carried out. For example we saw one occasion when the documentation recorded the person had not received support for over 10 hours. We spoke with a member of staff who confirmed the person required support to change position every three to four hours.

These were continued breaches of Regulation 17 (Good Governance) as care records were not contemporaneous and contain an accurate reflection of care interventions provided.

We found two occasions when information had not been shared to ensure timely care planning took place. We viewed one person's care file and saw they had been referred to an external health professional. We noted the entry stated the external health professional would visit the home the next day. We reviewed the information within the care file and saw this had not taken place. This was identified by staff 20 days after the initial referral had been made. The care record we viewed recorded the person had been visited by the

external health professional 21 days after the initial referral had been made and they then received the treatment they required.

In a further person's care record we saw a person had lost weight. The care record showed the person had been reviewed by the GP. However we noted the person had continued to lose weight. The records showed the person had not been reviewed again by the GP until this had been requested by the local authority safeguarding team. We discussed this with the registered manager who acknowledged the person's weight loss should have been identified. During the inspection we visited the person and found they were comfortable. Staff we spoke with were aware of the person's individual needs.

The lack of prompt referrals to appropriate health professionals for further advice and guidance was a breach of Regulation 12 (Safe care and treatment) as information had not been shared and timely care planning had not taken place to ensure the health, safety and welfare of people who lived at the home.

Requires Improvement

Is the service well-led?

Our findings

At the comprehensive inspection carried out in November and December 2015, we found quality assurance systems were not operated effectively to ensure risks were addressed and improvements made.

At this inspection the registered manager told us care records audits had been carried out. We were shown care records audits had been completed to identify if care records required improvement. However as the evidence in this report demonstrates, some information in the care records was inaccurate, vague and did not provide clear instruction for staff.

We discussed inaccurate recording on the positional change charts we had viewed with the registered manager. The registered manager told us senior staff within the home had been allocated the responsibility of checking the charts for accuracy. However the charts we viewed had inaccuracies within them. We reviewed 23 positional change charts from 22 May 2016 to 12 June 2016 and found 15 were not signed by senior staff and nine of these had inaccuracies on them. In addition we saw nine of the charts had been signed by senior staff and we noted errors on five of these. This evidenced the quality checking system in place was ineffective.

We reviewed the medicines audit completed in May 2016. We saw it had identified areas of improvement which were still required at the time of our inspection. For example we saw it had been identified that there was no recording of the start and finish times of medicines rounds. In addition we found missing signatures were noted and protocols for 'as required' medicines were not always present. This demonstrated the audit system in place was ineffective as improvements were not being made.

These were continued breaches of Regulation 17 (Good Governance) as quality audit systems in place were ineffective.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe management of medicines. Regulation 12 (2) (g). The registered provider had not ensured timely care planning had taken place when responsibility for care and treatment was shared with other appropriate persons. Regulation 12 (1) (2) (i)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were not contemporaneous, accurate or reflective of people's needs. Regulation 17 (1) (2) (c). Quality assurance systems were not operated effectively to ensure risks were addressed and improvements made. Regulation 17 (1) (2) (a)

The enforcement action we took:

Warning notice