Bupa Care Homes (Partnerships) Limited

Bankhouse Care Home

Inspection report

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Tel: 01253701635

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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 focussed inspection of this service 13 June 2016. At this inspection breaches of legal requirements were found. After the focussed 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 in December 2016 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 was carried out on the 07 December 2016 by one adult social care inspector and a medicines inspector and was unannounced.

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 47 people who lived 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.

We last inspected Bankhouse Care Home in June 2016. We identified breaches of two regulations. We found timely care planning had not taken place when responsibility for care and treatment was shared with other health professionals. We also found medicines were not managed safely. These were breaches of Regulation 12 (Safe care and treatment.) We identified that 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. These were breaches of Regulation 17 (Good Governance.)

At the last inspection on the 13 June 2016 we issued a warning notice for the breaches we found. We did this to make sure the registered provider took action to make improvements. We were provided with an action plan which detailed how the registered provider intended to ensure improvements were made. The action plan recorded improvements would be made by September 2016.

We undertook this focused inspection to check they had followed their plan and to confirm they now met legal requirements. During this inspection carried out on the 07 December 2016 we found some improvements had been made. We saw care records were reflective of the care and support people received. We also found information was shared with other health professionals and care planning documentation reflected health professional's instructions. Staff were knowledgeable of the care people

required and told us the registered provider had made changes to the way documentation was completed. They explained this helped ensure documentation was accurate and up to date.

We found significant improvements had been made in the safe management of medicines, however further improvements were required to ensure medicines were managed safely. During this inspection on the 07 December 2016 we found creams were not always stored safely and further detail was required in 'prn protocols.' These are documents which provide guidance to staff on when and how to administer medicines. We also found two people had not had their medicines administered due to insufficient stock at the home and medicines were being crushed without staff having the authority or information that it was safe to crush specific tablets. In addition we found there was no record of the times each person was given their individual medicines, such as analgesia. This was a breach of Regulation 12 (Safe care and treatment.)

We discussed staffing with people who lived at the home, the registered manager and relatives. People told us they considered there were sufficient staff available to meet people's needs and they received help quickly. One person who lived at the home commented, "Staff always make sure I have my call bell and come very quickly if I need help." One of the relatives we spoke with said they considered more staff were required. They explained they considered there had been no negative impact on the care of their family member and they were discussing their concerns with the registered manager.

We reviewed staff files and found there were processes in place to ensure staff were recruited safely. People we spoke with told us they felt safe and staff we spoke with were able to explain the processes to follow if they believed someone was at risk of harm or abuse. These processes were displayed within the home to support staff to do so.

We reviewed documentation which showed risk assessments were carried out to identify individual risks to people who lived at the home. Written plans were in place to manage these risks.

We saw evidence that audits were carried out to identify if areas of improvement were required. The registered manager reviewed accidents and incidents as they occurred and a report was compiled to identify people who were at risk of falls. This was passed to the registered provider's quality team. Audits were carried out on care records, medicines and the environment. We found the medicines audit was not always effective as it did not always identify when improvements were required. We have made a recommendation regarding this.

We viewed documentation which evidenced people were able to attend 'residents and relatives' meetings. People told us they were able to do so.

Staff we spoke with spoke highly of the registered manager. They told us the registered manager had sought their views regarding the way in which to improve care documentation. Staff explained they considered the registered manager to be supportive and they could approach them to discuss any concerns. Relatives we spoke with also told us they found the manager to be approachable.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Staff were safely recruited, and staffing levels were sufficient to respond to peoples' individual preferences.

Risk assessments were carried out to identify risks to people who lived at the home. Written plans were in place to manage these risks.

Is the service responsive?

Requires Improvement

We found action had been taken to improve how the service responded to meet people's needs.

People received care and support in accordance with their assessed needs.

Documentation reflected people's individual needs and preferences.

There was a complaints policy to address complaints made regarding the service provided.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems were in place to ensure areas of improvement were identified and actioned. However the medicines audit did not always identify if improvements were required.

The registered provider consulted with people they supported and relatives for their input on how the service could continually

improve. People, relatives and staff told us the registered manager was approachable and supportive.

Bankhouse Care Home

Detailed findings

Background to this inspection

We carried out this focussed 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 last inspected Bankhouse Care Home in June 2016. We identified breaches of two regulations. We found timely care planning had not taken place when responsibility for care and treatment was shared with other health professionals. We also found medicines were not managed safely. These were breaches of Regulation 12 (Safe care and treatment.) We identified that 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. These were breaches of Regulation 17 (Good Governance.)

This focussed inspection was carried out on the 07 December 2016 by one adult social care inspector and a medicines inspector and was unannounced.

Prior to the inspection we reviewed information the Care Quality Commission (CQC) holds about Bankhouse Care Home. This included any statutory notifications, adult safeguarding information and comments and concerns. In addition we contacted the local commissioning authority to gain their views of the service provided. This helped us plan the inspection effectively.

As part of the inspection we spoke with six people who received care and support from Bankhouse Care Home and two relatives. We spoke with the registered manager, two quality managers, the deputy manager, two qualified nurses, the activities coordinator and two care staff.

We looked at a range of documentation which included six care records and two staff files. We also looked at a range of audits. As part of the inspection we viewed a sample of medication and administration records.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe. People told us, "I feel very safe here." And, "Yes, I'm safe. Everyone looks after me." Also, "I feel very safe." Relatives we spoke with raised no concerns regarding the safety of their family member. One relative commented, "[My family member] is safe here."

At the last inspection carried out in June 2016 we found documentation was did not contain up to date and accurate information regarding people's needs. At this inspection in December 2016 we found improvements had been made. We reviewed care records of two people who had recently started to live at the home. We saw risk assessments had been carried out to identify any individual risks and written plans were in place to manage these risks. For example we saw recorded that one person required a wheelchair to help them mobilise. During the inspection we saw the person was supported using a wheelchair. We spoke with the person who confirmed this was required by them. This evidenced the documentation we viewed was an accurate reflection of the person's needs. We also saw documentation contained people's preferences and personal routines. For example we saw people were asked if they wanted their family involved in their care planning and preferences regarding social activities. In one record we saw recorded that a person liked to spend time at a specific social event. During the inspection we were unable to talk with the person as they were attending the event of their choice. This demonstrated the documentation reflected the person's wishes.

At the last inspection in June 2016 we saw accident forms did not contain information on the types of observations people required following an accident and there was no guidance for staff to follow if an accident occurred. We also found a falls risk assessment had been wrongly calculated. During this inspection in December 2016 we saw improvements had been made. We noted that following an accident people had specific observations carried out and this was recorded within the person's care record. In addition we noted the registered provider had included part of the homes 'Falls management Policy' within the care record. This provided staff with an easy point of reference to refer to. We also checked the calculation of a person's falls risk assessment and saw this was accurate. This demonstrated improvements had been made.

At the last inspection in June 2016 we found that medicines were not handled safely. We told the registered provider they must take action to improve the safe handling of medicines. We issued a warning notice to make the provider make improvements quickly.

During this inspection in December 2016 a medicines inspector (pharmacist) visited the home to ensure that improvements had been made. We looked at how medicines were managed for 18 of the 47 people who lived at the home. We found that significant improvements had been made in the safe handling of medicines since our last inspection. However we found that medicines were still not handled safely because the provider's arrangements to manage medicines were not consistently followed. Further improvements must be made to ensure people are safe.

We saw improvements were made in the safe administration of medicines. Nurses now dated medicines

when they were opened which meant that people were not given medicines which were out of date. The nurses now followed the manufacturers' directions about giving medicines with regard to food. Arrangements were now made to ensure that medicines which must not be given together were given safely.

However as at the last inspection we found that not all medication was obtained safely. We found that two people missed doses of some of their prescribed medicines for between one and twelve days because there was no stock available in the home. Missing doses of medicines places people's health at risk of harm. We saw that times of medicines rounds were now recorded, but there was still no record of the times each person was given their individual medicines, such as analgesia. This meant that people were still at risk of being given doses of their medication with an unsafe time interval between doses.

We saw that for some people the information recorded to guide staff when administering medicines which were prescribed to be given "when required" was now available for all medicines. However this information was not always sufficient to ensure people with limited communication were given their medicines safely and consistently. There was still no information recorded to guide staff as to how to select the correct dose of medicines which was prescribed with a choice of dose. There was some information to direct nurses to refer to pain and bowel monitoring systems, however we saw that there was no monitoring recorded and nurses could not refer to them when making clinical decisions.

There was now information available to guide staff and help them decide when to commence administration of medication (anticipatory drugs), used when people were very poorly. However this information needed to be more personal.

When medicines had to be given to people through a feeding tubes nurses failed to make clear records to show that the medication had been given properly. Nurses were also crushing medication without having the authority or information that it was safe to crush specific tablets.

There was now information recorded to guide staff as to where and how often to apply creams. Some improvements needed to be made to the quality of this information when more than one cream was prescribed for the same part of the body. But generally creams could be applied safely. There were lockable cupboards in people's rooms to store creams securely. However we saw that staff failed to store all creams properly. We saw that keys were left in the locks and we found creams on bedside cabinets and in bathrooms.

Some people were prescribed thickeners to make sure they could have drinks without choking; information to thicken drinks safely had now been put in the care files. However we found that staff, hostesses, who prepared and served drinks, did not have any written guidance as to how to thicken people's drinks to the correct thickness when they were thickening them. They still had to rely on their memories to remember how to thicken each person's drinks, which is unsafe practice. The information in people's care files and medication administration sheets gave conflicting information as to how thick their drinks should be. Different members of staff told us they thickened the drink to different consistencies, which could have placed people's health at risk of harm. This was an ongoing risk from the previous inspection. During the inspection the manager created a guide for hostesses to refer to when making drinks so they did not have to rely on their memories. The system will need developing so that the information does not go out of date.

Improvements had been made in the records about medicines which now showed that almost all medicines were given safely as prescribed. We saw the records about the use of creams had improved and could show that they had been applied properly. We found that the records still could not provide evidence that drinks had been thickened safely.

Medication was stored in a tidy and dedicated clinic room and was stored safely .However the waste medication was not stored in line with current guidance.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not ensure that nurses and carers followed the systems in place to manage medicines safely.

We reviewed documentation which showed suitable recruitment checks were carried out before a person started to work at the service. We saw evidence that a disclosure and barring check (DBS) was carried out prior to staff being employed. This is a check which helped ensure suitable people were employed to provide care and support. We saw records of the checks were kept and two references were sought for each new employee. We spoke with one newly recruited staff member. They told us they had received a DBS check prior to starting work at the home. This helped ensure suitable staff were employed by Bankhouse Care Home.

Staff told us they had received training to deal with safeguarding matters. We asked staff to give examples of abuse and they were able to describe the types of abuse that may occur. Staff also demonstrated an understanding of signs and symptoms of abuse and explained how they would report these. Staff said they would immediately report any concerns they had to the registered provider, the registered manager, or to the local safeguarding authorities if this was required. We saw details of the reporting processes to follow were available on notice boards within the home. One staff member told us, "I'd report any safeguardings to [registered manager.] She would respond straight away."

We asked people their opinion of the staffing provision. Everyone we spoke with told us they were satisfied with the arrangements in place. They told us staff came quickly if they required assistance. Comments we received included, "If I call someone they come and help me straight away." And, "Staff always make sure I have my call bell and come very quickly if I need help." We discussed staffing arrangements with relatives. One relative told us, "There's no problem with staff here. There's plenty of staff around." A further relative told us they considered more staff were required. They explained there had been no negative impact on the care of their family member and they were discussing their view with the registered manager.

We asked the registered manager of Bankhouse Care Home how they ensured there were sufficient numbers of suitably qualified staff available to meet peoples' needs. They told us the rotas and annual leave were agreed in advance. They explained this helped ensure there were sufficient staff available to support people. We were also told if extra staff were required due to a person's needs or unplanned leave, additional staff were provided. The registered manager told us they were currently recruiting additional staff to ensure staffing was sufficient to meet people's needs. Staff we spoke with confirmed this. All the staff we spoke with told us they considered there were sufficient staff to meet people's needs and maintain their safety. We viewed one weeks rota and saw staffing levels were consistent with the managers explanation and the assessed needs of people who received care and support.

We asked the registered manager how they monitored accidents and incidents within the home. We were told all accident forms were viewed by the registered manager and information was collated to identify any trends. The registered manager was able to explain actions taken to minimise the risk of reoccurrence. For example the introduction of specific equipment and referrals to other health professionals. The registered manager also told us the accidents and incidents audits were also provided to the registered providers quality team to allow further analysis to take place.

We found there was fire risk assessment in place and staff we spoke with were knowledgeable of the action

to take in the event of a fire. In addition we found there was a business continuity plan for staff to refer to. A business continuity plan is a document which instructs staff in the action to take in the event of an unforeseen emergency. For example in the event of a power failure. Staff we spoke with told us that in addition to the advice contained within the business continuity plan, they could access support by utilising the on call system. This was a system which enabled staff to contact members of the management team if advice was required. One staff member commented, "You are only ever a phone call away from a manager."

Requires Improvement

Is the service responsive?

Our findings

People told us they considered the care and support they received met their needs. Comments we received included, "If I need to see a doctor I ask staff and they sort it out." And, "I can do what I want, staff always ask. " Also, "Staff keep a close eye on me. I'm weighed, checked on and if I need a doctor, well that's not a problem." Relatives we spoke with were also positive regarding the care and support their family members received. We were told, "The care is very good." Also, "The actual care people get and the kindness is excellent."

During the last inspection carried out in June 2016 we saw records did not reflect the care and support delivered when people had individual needs. During this inspection we found improvements had been made. We reviewed two people's care plans and saw these instructed that people needed support to change position every three to four hours. This was in order to maintain their skin integrity. We reviewed eight positional change charts relating to these people. These are documents that record the time people are given support to change position. The eight charts we viewed recorded people had received support in accordance with their assessed needs.

During the last inspection carried out in June 2016, we found information had not been shared with other health professionals to ensure timely care planning took place. During this inspection we saw improvements had been made. We viewed one person's care record and noted a referral to a dietician had been requested. We saw the person received a visit from a doctor and the doctor's instructions were documented. We further saw the referral to the dietician had been made and the care record had been updated to reflect this. We spoke with the person who discussed their care with us. They told us the home had consulted with them and had encouraged them to follow the doctor's instructions. They said, "I needed to see a doctor and have antibiotics and drink more. Staff remind me to drink more as well!" This demonstrated information was shared with other health professionals to allow timely care planning to take place.

In a care record for a further person we saw it had been identified the person had lost weight. As a result we saw documentation which evidenced a referral had been made to a dietician and the dietician's instructions had been included within the care record. We saw the person was weighed in accordance with their assessed needs. We spoke with a staff member who was able to describe the needs of the person. This demonstrated action was taken to ensure people received advice and guidance from other health professionals when their needs changed.

Care records we viewed recorded people's routines and preferences. Care plans contained information on how and when people wished to be supported. For example one care record described the way in which the person preferred their call bell to be left. During the inspection we saw the call bell was placed on the person's right hand side as instructed in the care plan. We noted in a further care plan a person had made a specific request regarding their food. We discussed this with them. They told us, "I like my food a particular way and staff remember that."

We discussed the provision of activities with the activities co-ordinator. We saw a programme of events was

planned in advance for people to attend if they wished. During the inspection we did not see any internal activities taking place, but the people we spoke with told us they were aware of the events programme. For example one person told us, "I'm looking forward to the carol singers." A further person said, "I prefer a film. They have them here." One relative we spoke with told us, "They always have something going on. Singers, music, trips, it's very good."

We observed staff interacting with people and supporting them to pursue their own preferred activities. For example we saw one person was supported to straighten tablecloths prior to lunch being served. A further person was helped to put laundry away in their room. We also noted staff spoke with people about the upcoming festive plans. This resulted in a group of people singing carols. We saw this was enjoyed by people who lived at Bankhouse Care Home.

There was a complaints procedure available which described the response people could expect if they made a complaint. People who lived at Bankhouse Care Home and relatives told us they had no complaints but they were confident these could be raised with the registered manager. People told us, "I've no reason to complain, if I did, it would be sorted." And, "I've got a book with how to complain in but I don't need to." One relative commented, "Any complaints would be investigated. If we make any comments someone always comes back to us with a solution."

Requires Improvement

Is the service well-led?

Our findings

People told us they considered Bankhouse Care Home to be well-led. Comments we received included, "I think it's well organised." And, "Everything runs smoothly here." One relative told us, "I'm very confident in [registered manager.] I can go to her at any time about anything." A further relative commented, "[Registered manager] is very professional and easy to talk to."

At the last inspection carried out in June 2016 we found audit systems had not identified when improvements were required. During this inspection in December 2016 we found some improvements had been made. We saw care records audits were completed and an action plan was developed to ensure areas of improvement were identified and actioned. We checked one care records audit and saw the identified actions had been completed. We checked the corresponding care record and found the areas of improvement had been rectified.

We saw checks were carried out in other areas to ensure the home remained a safe and comfortable place to live. For example we saw checks were carried out on window restrictors, water temperatures and lifting equipment. In addition we saw evidence of accident and incident audits, weight monitoring audits and pressure care audits. The registered manager told us these were provided to the quality team to allow further analysis and oversight to take place.

We viewed the medicine audit completed by the home. We saw a monthly and a weekly audit was in place and checked areas such as storage, quantities of medicines within the home and the disposal of waste medicines. The audit had not identified the areas of concerns we had identified during inspection.

We recommend the registered provider seeks and implements best practice in relation to the auditing of medicines.

Staff we spoke with were positive regarding working at Bankhouse Care Home. Staff told us they felt they were consulted in improving the service the home provided. One staff member we spoke with told us the registered manager had actively sought staff suggestions of how to improve the care documentation. They explained the registered manager had implemented staff suggestions of keeping care records in people's bedrooms." They said, "Records are in the rooms and we can complete them. It's more accurate to complete them as you go." A further staff member said, "Morale is high. We've done a lot of work, it's better than it was." Another staff member commented, "[Registered manager] has focused on pulling us together as a team."

We viewed documentation which evidenced staff meetings were held to enable information to be communicated effectively. One staff member commented, "Staff meetings give us a chance to air our views." A further staff member said, "We have meetings and [registered manager] is very good, she listens and responds."

People who lived at Bankhouse Care Home told us they had the opportunity to attend meetings and give

feedback to the manager. However the people we spoke with told us they did not wish to do so. We saw documentation which evidenced meetings took place. In addition we saw a notice board which displayed "You said" and "We did" comments and actions from the meetings. For example we saw a suggestion had been made regarding people having personal pets at the home. In response to this the home was currently exploring the possibility of having 'pet a pet' sessions at the home. The activities coordinator explained this would enable people to have contact with pets as they had requested.

We asked the registered manager how they enabled people to give feedback regarding the quality of the service provided. We were told that in addition to verbal feedback, surveys were provided to obtain the views of people who received care and support and their relatives. We did not review these at this inspection as no surveys had been carried out since our last inspection in June 2016.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that nurses and carers followed the systems in place to manage medicines safely. 12 (1) (2) (g)