Mr Sariff Jomeen

West Bank Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of West Bank Care Home took place on 12 December 2016 and was unannounced. At the previous inspection in March 2016 we found the provider was not meeting the regulatory requirements in relation to respecting people's dignity, training, maintaining a safe environment, medicines management of 'as required' medicines and having systems and processes in place to assess, monitor and improve the quality of the service. We took enforcement action and this inspection was to check improvements had been made.

West Bank Care Home is is registered to provide nursing and personal care for a maximum of ten people who have mental health needs. At the time of our inspection there were seven people living at the service.

At the time of our inspection, the service was managed by two care managers. Due to the provider being registered as an individual, the service does not require a registered manager to be in place. 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 found the service had made improvements since our last inspection. However, we would need to see these sustained over a period of time and other improvements made before reviewing our rating above 'requires improvement'.

People told us they felt safe with the care and support they received. Staff had received safeguarding training and understood how to report any concerns.

Medicines were safely managed and 'as required' medicines protocols were in place.

Accidents and incidents were minimal. However these were appropriately documented with actions taken and included in the audit process.

The premises was well maintained and clean; daily audits were in place with actions seen to be taken where required. However, we noted radiator covers still needed to be put in place.

Risk assessments were present in people's care records to mitigate risks to people living at the service. Care records were detailed, up to date and pertinent to the person's care and support needs. People had signed consent to their plans of care.

The service was acting within the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS).

People told us they enjoyed living at the service and staff were kind and caring. Sufficient staff were employed to keep people safe and staff were recruited in a safe manner. Training was mostly up to date.

The atmosphere at the service was calm and relaxed and staff knew people's care and support needs well.

The service was supporting people's health care needs and we saw a range of multi-disciplinary team involvement.

People told us they enjoyed the food. We saw people's nutritional needs were met, appropriate referrals made and action plans put in place when someone was assessed at nutritional risk.

Activities were planned according to individual preferences and people were looking forward to the planned Christmas festivities.

Evidence was in place of improvements to the audit process with actions seen to be taken as a result of these.

Staff meetings had taken place and staff told us they were happy working at the service.

Resident meetings had been held as well as quality questionnaires completed by people living at the service.

The provider needed to have better communication systems in place in case of emergency as well as increased provider support to the service.

The service had not displayed the rating from the previous inspection at the premises or on its website. This was a breach of regulation.

You can see what 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.

Although improvements had been made to the environment, further improvements were required.

Medicines were managed safely.

Robust recruitment processes were in place and there were sufficient staff deployed to meet the care and support needs of people living at the service.

The service needed to demonstrate sustained improvements to the safety of the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was up to date but more detailed training would evidence better practice.

The service was meeting the legal requirements of Deprivation of Liberty Safeguards (DoLS).

People enjoyed the food at the service. Those assessed at risk nutritionally had appropriate referrals made.

People had regular access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People's independence was supported and encouraged.

Staff were kind and caring and knew people's care and support needs.

There was a relaxed atmosphere in the home and people were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People living at the service had input into their plans of care.

People followed their own daily routine although an activities programme was available if people wished.

An effective complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audit and quality assurance systems were in place.

The provider had not displayed the rating from the previous inspection.

Continued provider oversight and support was required to demonstrate sustained improvement.

West Bank 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.

Our inspection of West Bank Care Home took place on 12 December 2016 and was unannounced.

The inspection team consisted of one adult social care inspector and one specialist advisor (SPA) who had experience of working in the field of mental health.

Prior to the inspection we gathered and reviewed information we held about the service. This included reviewing notifications we had received from the provider and information received from the local authority contracts and safeguarding teams. We had not requested a Provider Information Return (PIR) from the provider on this occasion. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

During our inspection we spoke with four people who use the service, two care managers, one care worker and a cleaner. We reviewed four people's care records, some in detail and others to look at specific information relating to the person's care and support, three staff files, staff training information, audits and other records relating to the management of the service. We looked around the building including communal areas, bedrooms and bathrooms and spent time in the lounge and dining room, talking with people and observing care and support.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at West Bank with one person saying, "I've lived here for 21 years and have always felt safe and well cared for." Training records and supporting certificates showed staff had completed training in safeguarding and had access to information and guidance about how to report any concerns. Staff had the knowledge to identify safeguarding concerns and acted on these to keep people safe. For example, staff we spoke with demonstrated they understood the signs of abuse and how to act on any concerns. Safeguarding referrals had been made appropriately.

We saw where accidents and incidents had occurred appropriate information had been recorded with actions taken as a result.

We completed a tour of the premises as part of our inspection and found improvements had been made since our previous visit. We inspected four people's bedrooms, bath and shower rooms, the laundry, kitchen and various communal living spaces. We saw fire-fighting equipment was available, emergency lighting was in place and all fire escapes were kept clear of obstructions. Upstairs windows had tamper-proof opening restrictors in place and the back door had been replaced with a secure, lockable door. During our previous inspection in March 2016 we saw radiators were not covered and this was still unresolved at this visit. However, we saw people living at the service had capacity, the service was completing their own action plan and this was listed for attention with the provider sourcing bespoke covers due to the radiator sizes. We saw the action was due for completion within three months. We spoke with the care manager who confirmed they had spoken with the provider to ensure plans were in place for work to be done and we saw this was documented in their provider communication book. Since we saw other actions had been undertaken we had confidence this would be undertaken.

During our last inspection we saw many items of furniture in communal areas and people's bedrooms were dilapidated and the call bell system was not working. On this occasion we found many of the items had been replaced and were in good working order and the call bell system was fully functional. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant. The service had a maintenance book in place which listed all required jobs. We saw these had been ticked when completed and the care manager told us they were now dating when a task had been completed for audit purposes. The care manager had also introduced a provider meeting book in which they itemised areas of concern, such as maintenance issues and the provider signed this to agree these had been discussed.

However, although we recognised the service had made improvements in the environment, we would need to see evidence of sustained improvement before rating the service above 'requires improvement'.

People told us they were involved in reviewing their care plans and risk assessments. Whilst care plans contained generic risk assessments to guard against poor nutrition and falls management, our review of care plans evidenced risk assessments were also highly specific to people's individual needs. Many people

living at the home were at risk due to long standing mental health issues or due to leading chaotic and risk laden lifestyles. Where risks to people had been identified, specific staff requirements for action were recorded. For example, one person was most vulnerable when their mental health declined. The risk assessment recorded the person may become isolated or display certain repetitive actions when their mood was becoming low which had in the past resulted in behaviour that challenged others. The risk assessment recorded the actions staff were required to take to mitigate the risks. We also saw risk assessments designed to prevent harm to others. We saw one person had a history of being a risk to others whilst in the community. The risk assessments identified how staff should act to reduce the known risks. Our observations of incident reporting and records of daily living demonstrated the approach to risk management was successful.

We saw people's care records contained personal emergency action plans (PEEPS) which included information on what support people would need if the home had to be evacuated in case of emergency.

We saw Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances. All cleaning materials and disinfectants were kept in a locked room out of the reach of vulnerable service users.

Safe recruitment procedures were completed to ensure people were assisted by staff who were of suitable character. The provider requested full application forms with details of past employment history. Two references from previous employers evidenced good conduct in previous health and social care employment and a Disclosure and Barring Service (DBS) check was completed. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff unsuitable to work with vulnerable people. We saw where people were employed from other countries checks were conducted to ensure staff had a right to work in the UK. Copies of visas and passports were retained in staff files.

We reviewed the staffing levels at the service and found these were appropriate to the current care and support needs of the people living at the service. People we spoke with told us there were enough staff deployed and staff were skilled in their roles.

Medicines were administered to people by trained care staff. From care records we saw people had been given the opportunity to administer their own medicines. All people had declined the opportunity with care records containing a signed consent for staff to administer medicines. We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete.

The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. We conducted a sample audit of boxed medicines to check their quantity and found all to be correct. Our review of MAR sheets and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed.

We observed staff supporting people to take their medicines in line with their individual prescriptions. People were not hurried and staff demonstrated they knew people's individual preferences.

We saw all 'as required' (PRN) medicines were supported by written instructions which described situations, frequency and presentations where PRN medicines could be given. We saw evidence people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on MAR sheets were signed. We looked specifically for the use of antipsychotic, anxiolytic or

antidepressant medicines as interventions for challenging behaviours. We found functional analysis had taken place to identify what appeared to trigger untoward behaviours and trends in behaviour to enable staff to de-escalate situations, commonly without the need for PRN medicines.

Allergies or know drug reactions were clearly annotated on each person's medicine records.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection no people were receiving controlled medicines. The care manager told us during their six years of working at the home no controlled medicines had been prescribed and therefore no facility existed. The care manager told us that if the need arose they would liaise with the dispensing pharmacy and ensure the medicines were safely stored. We noted the date of opening was recorded on all liquids and creams that were being used and found the dates were within permitted timescales. Medicine storage temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures. The home did not have a medicine fridge nor had they found the need to store medicines in a fridge in the recent past. The care manager told us they had discussed this with the dispensing pharmacy and had received assurance a fridge would be provided if the need arose.

Whilst no person was receiving their medicines by covert means the care manager had a good understanding of the legal framework which applied.

We reviewed the procedure for handling people's monies and saw this was managed safely and appropriately. Only two members of staff had access to people's money, transactions were fully documented, signed by the person and the member of staff and receipts obtained. We found accounts tallied with what was recorded in the accounting book.

Requires Improvement

Is the service effective?

Our findings

People were all complimentary about the staff. We were told they thought staff were very good and met their needs. One person said, "It's good living here and much better than some places I have lived at." They also said, "It's Christmas soon and we have a really good time with a party and presents from the owner; last year I got a pair of slippers."

We looked at the supervision arrangements for staff. We saw staff files contained records of regular supervision meetings. Whilst the supervision meetings followed a set format we saw the record was specific to each member of staff.

We looked at the training plan for the current year. Training was delivered in a number of formats and settings. Some training was computer based, some internal and some provided by external trainers. We saw three members of staff had completed advanced training in health and social care to NVQ levels three and four. Whilst the training programme was complete and mostly up to date, we noted one day's face to face training included a large number of subjects, including practical moving and handling training. We were concerned about the detail this training could include and if this was sufficient for the needs of the service. We also noted three members of staff had yet to receive 'person centred approach' training.

Throughout our inspection we saw people who lived at the service were able to express their views and make decisions about their care and support. People's care plans were underpinned by a mental capacity assessment to identify if they were able to consent to their planned care and treatment. We saw staff sought consent to help people with their needs. For example, when staff were administering medicines we observed people were asked if they would prefer their medicines at a particular time rather than medicines being administered at a time convenient for staff. People who were prescribed PRN medicines were asked if they required the medicine.

We saw two people shared a bedroom. Care records contained evidence of a discussion with both people detailing how their shared interest in music and film could best be supported by sharing a room. We saw where disputes between the two people had arisen a detailed record was kept including a safeguarding referral on one occasion. We spoke with both people who confirmed they were happy to share a room with each other.

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). We checked whether the service was working within the principles

of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found no DoLS were in place. We looked at three records to satisfy ourselves people were not being deprived of liberty. Our observations of care plans showed people had the mental capacity to make their own decisions. Our discussions with the care manager showed they regularly reviewed people's mental capacity as all people had a diagnosis which may affect their cognitive ability and there already existed evidence some people had fluctuating capacity with loss of short term memory.

The service used the Malnutrition Universal Screening Tool (MUST) to assess people's nutritional status. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. We saw one person had lost five kilograms in two months. We saw this had been brought to the attention of the GP and district nurse who had instructed the issue should be monitored and any further reductions brought to their attention. We saw records showed the person had a good appetite and during the day we witnessed the person eating a good diet.

People were complimentary about the food provided in the home. A person told us "There is always plenty to eat and you can make a coffee or a mug of tea whenever you want." Another person was complimentary about the proposed Christmas menu and said they were looking forward to it. We saw mealtimes were informal and relaxed with some people choosing to eat in their rooms and others in the dining room.

We saw evidence in people's care records of staff working with various agencies and making sure people accessed other services in case of emergency or when people's needs changed. This included GPs, hospital consultants, community psychiatric nurses, opticians and dentists. This showed us people's health care needs were being met.

Good

Is the service caring?

Our findings

We observed staff and people in communal areas and noted there to be a calm and settled atmosphere. This helped people who had identified problems with anxiety which could result in aggressive and disruptive behaviours. Staff spoke quietly and gave encouragement for people to participate in conversations.

It was clear from our observations and discussions staff knew people well including their care and support needs. We observed affectionate and caring interactions between staff and people living at the service. One staff member told us, "It's like your family." People living at the home appeared happy and relaxed. One person commented, "I like living here. Lovely staff," and another said, "They look after us."

Staff told us people were encouraged to be as independent as possible and their decisions were respected. We were told people were encouraged to participate in carrying out domestic tasks to help them maintain involvement in the home and help create an inclusive homely environment. Staff told us people, under supervision, did their own laundry and helped to keep their rooms tidy. We were also told people undertook certain daily tasks on a rota system. This included washing up and keeping the dining area tidy. We spoke with three people who all enthusiastically told us of their involvement. One said, "I've done the vacuuming in this lounge today," and also said it was their turn to dry up the dishes after lunch. We asked all three people if they liked doing these tasks to which one person said, "Yes it's OK and I would rather keep my bedroom clean than ask someone else to come in to do it for me." We saw people making themselves hot drinks in the dining room and some people told us they sometimes liked to help prepare the food for the main meal. People were supported to go out during the day, some with a member of staff and others by themselves.

All people who lived at the home had mental health needs and were at risk of harm and self-neglect. As such, some people's care was coordinated under a Care Programme Approach (CPA). This approach ensured a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw written evidence CPA meetings took place with all relevant health and social care professional in attendance. We saw outcomes of CPA meetings had been translated into current care planning records. For example, one person had been judged to be able to move out of West Bank into a more independent living arrangement. The person had declined as they liked living at the service. The outcome of the CPA meeting recorded the home should formulate care plans to encourage greater independence. We saw care plans had reflected this requirement and our discussion with the person demonstrated they were living more independently as a result.

During our inspection tour of the property we noted staff knocked on doors before entering people's rooms, thus demonstrating staff respected people's need for privacy. We saw evidence the service had acted upon the previous inspection regarding privacy and dignity concerns. For example, two people shared a bedroom and we saw the service had purchased a dividing curtain between the beds following concerns raised at the previous inspection. However, when the curtain was delivered it was found to be the incorrect length and the service was re-ordering. An interim measure was in place but neither person said they wished to use a privacy curtain.

We saw all personal information about people receiving care was only accessible to staff involved in care.

We were told the provision of care at the service was developed around the individual choices of people living at the home. This included choices around how people liked to have their bedrooms and the communal areas. We saw evidence of personalised bedrooms. People we spoke with confirmed they were offered the opportunity to personalise their bedrooms. We saw people had the opportunity to have pets which clearly gave their owners great pleasure.

Care plans and daily records of care given demonstrated triggers for anxiety or behaviours which challenge were well documented. Documentation in people's care plans showed practical interventions were carried out by staff to ensure people were not distressed or subject to stressors which would have a detrimental effect on their mental health. For example, we saw one person would shout and swear when mentally unwell which caused distress to them and other people. We saw the person's increased desire to be alone was a precursor to these bouts of shouting. Staff were aware of the need to ensure the person remained active in the home and not become isolated in their room.

Our inspection of care records and a discussion with the care manager showed some people were without any family or close friends. We saw people had accessed advocacy services in the past to help them make decisions about their care. Our previous inspection showed advocacy services had not been accessed for five years. On this occasion we saw people had been supported by advocates as recently as August 2016.

Where people had chosen to do so we saw end of life care plans were in place. People with potentially diminishing mental capacity had recorded their wishes whilst they were able to do so.

Good

Is the service responsive?

Our findings

The care manager told us the service had a complaints procedure, which was provided to people and their relatives. Staff were aware of the complaints procedures and how they would address any issues people raised in line with them. We looked at the complaints register to find all complaints were responded to in an appropriate way. The complaints register recorded the investigation into the complaint and indications to prevent reoccurrences. With the exception of a complaint from a neighbour regarding a person's behaviour all other complaints were one person against another. We saw there was a pattern to the complaints as most were about people using another person's property without permission. We saw care plans recorded practical solutions to minimise the occurrence of these complaints, which included re-enforcement of the need to respect people's property and advising people to keep their bedroom doors locked.

We saw up to date care plans were in place which had been reviewed since the last inspection. Information in people's care records contained life histories including a pen picture of their lives, people important to them and their medical history.

Individualised plans of care were in place which contained risk assessments and identified needs specific to the person. For instance, we saw where one person was identified at risk nutritionally, a needs assessment was in place with detailed information about their dietary requirements and how to encourage their intake, including their likes and dislikes. We saw an input/output chart had been put in place which had been completed on a daily basis.

People we spoke with told us they had been involved in the planning and review of their care. We saw people had signed updated information contained in their care records, such as important dates, consent to care and treatment and managing finances, and their plans of care. This showed the service was taking a person-centred approach to care and support.

We saw activities were organised on a one to one basis although some group activities such as meals out had taken place. Although an activities programme was in place, we saw most people preferred to follow their own daily routine. We saw some people went out during the day by themselves and others were accompanied by a member of staff. The service had organised a Christmas party and a Christmas meal out for all staff and people living at the service which people told us they were looking forward to. One person told us they had been involved with decorating the home for Christmas, including the Christmas tree.

We saw people's personal preferences were respected. For example, some people preferred to spend time by themselves and eat their meals in their rooms and we saw staff respected this.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager since it was run by a sole provider. The provider employed two care managers, both of whom were present during our inspection. The provider was present during the morning of our inspection and we saw they were checking the maintenance of the premises and meeting with one of the care managers about required work. We saw this was recorded in a provider meeting book which the care manager had implemented and a record of the meeting was signed by the provider.

We spoke with the care manager about the support they received from the provider. They told us they felt this still required improvement since they found communication with the provider difficult. For example, although the provider was now calling in to the service each day, they did not carry a mobile phone or use email. They did not remain at the service all day. This meant once they had left the premises staff would have to try to contact them at their home which was sometimes difficult. We were concerned the provider had not considered how they could be quickly contacted if an emergency situation arose.

We saw the provider and the care managers had worked to improve the service following the previous inspection and had implemented an action plan. However, we would need to see continued improvement and for the service to have implemented all actions before rating above 'requires improvement.'

The service had failed to display the rating from the previous inspection at the service. We spoke with the care manager who told us they were aware of the requirement to display and had forgotten to do so.

This was a breach of Regulation 20a (1)(2)(3) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

We saw a range of quality assurance audits were in place including monthly audits on cleaning and infection control, the nurse call system and accidents and incidents. We saw comments and tasks identified as a result of these audits. In addition, the provider completed a daily audit regarding the premises and maintenance. This included identified work needing to be done and this information was transferred to the maintenance book for completion. Once the work had been completed a tick was made against the job, and we saw the care manager had started to record the date of completion. An infection control inspection was carried out in July 2016 with the score of 93.4%, evidencing the service had made improvements in this area. In addition, the care manager had introduced a formal system to raise concerns about the service with the provider.

Following concerns raised at our last inspection, we saw the provider now provided disposable gloves and aprons for staff to wear.

We saw six monthly satisfaction surveys were in place in people's care records as well as evidence of residents' meetings. In addition, people had monthly one to one meetings with their key worker to discuss any concerns or issues.

Staff morale seemed good and staff we spoke with told us they felt supported by the care manager. During our inspection, we saw the staff supported each other and worked well as a team. One staff member told us, "Staff are good. There is support for me."

Staff meetings were held. We saw two had been held since our last inspection in March 2016 which included action points about concerns raised, although the care manager told us they would like to see these occurring more frequently.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the most recent rating by the Commission of the service provider's performance that related to those premises at the premises or on their website. Regulation 20a(1)(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

FPN