Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Bankhouse Care Home

Bank House Nursing Home
Llangynidr Road
Beaufort
Ebbw Vale
NP23 5EY

Date Inspection Completed

22/02/2024

About Bankhouse Care Home

Type of care provided	Care Home Service Adults With Nursing
Registered Provider	Bankhouse Care Ltd
Registered places	54
Language of the service	English
Previous Care Inspectorate Wales inspection	23 November 2022
Does this service promote Welsh language and culture?	This service is working towards providing an 'Active Offer' of the Welsh language and demonstrates a significant effort to promoting the use of the Welsh language and culture.

Summary

People at Bankhouse do not receive consistent, good quality care to help them achieve wellbeing. Care standards vary depending on the care workers on shift. Personal plans do not accurately reflect people's current needs, meaning care workers do not have up-to-date information to help them deliver the best care possible. People are not safe from harm and abuse. Significant safeguarding concerns have not been reported to the relevant agencies. Care workers are not safely recruited or sufficiently trained to equip them with the skills and knowledge necessary to deliver safe care. People are often deprived of basic care needs, such as sufficient food and fluid and timely personal care, meaning they are not as safe and healthy as possible.

The Responsible Individual (RI) does not have sufficient governance arrangements in place to allow effective oversight of the service. Whilst RI visits and reports have been completed in a timely way, they have failed to identify poor care standards. This means poor care standards have continued without any improvement action taken.

We acknowledge immediate improvement action was taken by the RI following our inspection.

Well-being

The service provider does not deliver consistent standards of high-quality care to ensure people achieve wellbeing. People do not always get the right care and support, as early as possible, to keep them safe and healthy. Basic care needs are not always met. This includes people not having access to sufficient food and fluids and timely personal care. We saw people's personal plans are not always updated to reflect changing needs. This means care workers do not have up-to-date information to let them know exactly how to support people. In addition, inaccurate information risks people receiving incorrect or unnecessary care which may impact their well-being.

People do not always have control over their day-to-day lives. We observed and were told nearly all people have not got access to a nurse call alarm. This means people are dependent on waiting for safety checks or calling out to staff. We noted the reasons, why people could not use a nurse call alarm, were not recorded in their plans. We observed people at times being ignored for long periods resulting in them becoming distressed. People's individual circumstances are not always considered; some care decisions are made to benefit the service provider and not people. This is not in-keeping with the ethos of dignified and person-centred care with people not having their voices heard or encouraged.

People are not always treated with dignity and respect. We observed mixed standards of care delivery. Some people were treated in a warm and respectful manner where care workers used tactile support and comfort to make people happy. People responded well to this. Other care workers ignored people and delivered care in an undignified manner. We observed care workers carrying out manual handling in an unsympathetic manner and care workers did not always speak about people in a dignified way. Mealtimes were not a pleasurable experience for people due to low numbers of staff. People were rushed to eat their meals placing them at risk of choking, and others waited a long time to be given their food which had turned cold. People nursed in bed were left without support, meaning they did not get sufficient food and fluids. We observed some people in unclean clothes and bedding with offensive odours present at the time of our inspection. This does not promote dignified care and may impact people's emotional and physical wellbeing.

People are not safe from harm and abuse. The service provider has failed to report a number of significant safeguarding incidents to the relevant agencies. This means people are at risk of ongoing abuse or neglect. Care workers are not recruited safely. Most care workers have not completed Safeguarding of Vulnerable Adults training, meaning they may not know how to recognise the signs of abuse or report a safeguarding concern. People are not routinely reminded of their right to make a complaint or raise a concern.

Care and Support

The service provider does not have robust processes to ensure care and support is delivered in line with people's current needs to help them achieve wellbeing. People's personal plans are not always accurate or updated in line with changing needs. This means care workers do not have access to up to date information to provide appropriate and safe care. Personal plans are reviewed regularly, but inaccuracies we identified indicate reviews are not meaningful or diligent.

We received mixed feedback about the service. Some people offered positive feedback. One person's relative praised the staff for the care delivered. A visiting clinical professional offered positive feedback about the standards of care. Some people raised concerns about insufficient staffing numbers and poor care delivery.

Daily care recording is inconsistent and sometimes inaccurate. Gaps in recording indicate people may not receive sufficient care to keep them healthy and safe. People are not consistently supported with basic health needs. We observed insufficient fluid available to people, particularly those nursed in bed. The food is varied, plentiful, and a good quality, but people needing support to eat are not always provided this in a timely way. Appropriate care is not continually delivered to mitigate the risk of skin damage as far as reasonably practicable. Some people needing regular re-positioning do not get the correct care in line with their personal plans and people go for long periods without sufficient personal care. Observational safety checks are not consistently undertaken to ensure people are safe. These poor levels of care and support are placing people's health and well-being at immediate risk, and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

Environment

The service is undergoing some renovation and redecoration. People's bedrooms are personalised and offer a comfortable environment if they want to relax. The downstairs areas are welcoming and homely. The conservatory offers a light and spacious area where people socialise and relax. A bar area hosts regular events, such as cheese and wine evenings, which all people are welcome to attend. The upstairs areas require some maintenance and redecoration to provide the same homely and positive feel. We acknowledge further work is planned to improve the aesthetics of the service as a whole.

We identified several health and safety concerns during our inspection. The service does not comply with current fire safety regulations. Fire alarms are tested regularly, but doors are often propped open without the use an appropriate fire door retainer posing a risk in the event of a fire. An upstairs emergency exit is sometimes blocked with large furniture and people's emergency evacuation information is not always accurate. This means people may not be able to escape quickly in the event of emergency.

We identified some trip hazards, including manual handling aids which had been inappropriately stored in bathroom areas and clutter left behind from maintenance workers. At the time of our inspection, some areas of the home were not clean and offensive odours were present. While no immediate action is required, health and safety is an area for improvement, and we expect the provider to take action.

Leadership and Management

The service provider does not have clear arrangements for the oversight and governance of the service to establish, develop, and embed a culture which ensures the best possible outcomes for people. The service does not consistently operate in line with its Statement of Purpose (SoP), meaning people cannot be assured of the service provided. Some key policies that underpin the service are out of date and the service is often not aligned to these. This is placing people's health and well-being at risk and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

The service provider does not utilise existing quality and auditing systems to review standards of care. Audits are not always completed in a diligent way and the service provider has failed to address poor standards of care to ensure people are safe and achieve wellbeing. Significant safeguarding concerns have not been reported to the relevant agencies. Accurate records of these safeguarding events have also not been maintained or been adequately investigated.

The RI does not have effective quality and governance processes for monitoring the overall running of the service to offer people assurance it is providing high quality and safe care to people. This means people may not be safe or achieve wellbeing. The RI does not regularly consult with people to gather feedback on the service or undertake detailed reviews of documentation. This has prevented the RI from identifying deficits in the service and improvements required. This is placing people's health and well-being at risk, and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

New staff do not undergo safe or thorough recruitment checks to ensure they have the right character or skill to undertake the role. We identified some missing safe recruitment documentation, including proof of identity, full working histories, and appropriate employment references. One staff member was working at the service without an up-to-date Disclosure and Barring Services check. The service is not always sufficiently staffed. Unsafe staffing numbers mean the appropriate ratio of staff are not always available to safely support people. We observed care workers taking breaks at the same time which impacted the quality and timeliness of care people received.

The service provider does not offer sufficient ongoing support and development opportunities to care workers. Care staff do not consistently receive core training for their role. This means most staff do not have the appropriate knowledge, skills, and experience to provide people with safe, person-centred care. Staff do not receive regular supervision to help them reflect on their practice or discuss developmental needs.

New staff members do not consistently complete a sufficient induction programme to equip them to be confident and competent in their new roles.

We received mixed feedback from staff. Some staff told us they enjoy their roles and feel supported by the RI. Other staff members raised concerns about staffing numbers.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
21	The service provider does not have safe and effective standards of care and support which protects, promotes, and maintains the safety and wellbeing of people receiving a service.	New
6	The service provider does not have effective governance processes in place to ensure people are provided with sufficient care by staff who have the correct competence, experience, and skills.	New
26	The service provider has not ensured people are safe and protected from abuse, neglect, and improper treatment.	New
80	The Responsible Individual (RI) does not have suitable arrangements in place to establish and maintain a system for monitoring, reviewing, and improving the quality of care and support provided by the service.	New

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
57	The service provider has not managed and reduced health and safety risks as far as reasonably practicable to keep people safe.	New

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