We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Prior Bank House

74 Cherry Tree Road, Sheffield, S11 9AB

Date of Inspection: 28 August 2013

Date of Publication: September 2013

We inspected the following standards as part of a routine inspection. This is what we found:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to care and treatment</td>
<td>✓</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>✓</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>✓</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Anchor Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Prior Bank House is a converted Victorian House with a purpose built extension to the rear. The home is registered to provide residential care for a maximum of thirty-two older people (male and female). It is part of a group of care homes operated by Anchor Trust. Prior Bank House is set in a quiet location, surrounded by a mature garden. It is situated in the residential area of Nether Edge in Sheffield and is close to local shops and public transport.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Care home service without nursing</td>
</tr>
<tr>
<td>Regulated activity</td>
<td>Accommodation for persons who require nursing or personal care</td>
</tr>
</tbody>
</table>
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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<td>Requirements relating to workers</td>
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

Some people living at the home were not able to verbally communicate their views and experiences to us. Due to this we used a formal way to observe people at this inspection to help us understand how their needs were supported. We call this the 'Short Observational Framework for Inspection (SOFI).

Records checked showed that before people received any care or treatment they were asked for their consent and the staff acted in accordance with their wishes.

People that we could communicate with told us that they were happy living at the home and that they were very satisfied with the care they received. People said, "They [care workers] are very kind to me. They are all kind with a sense of humour. Some of them are friendly which makes life easier. We all have choice, we listen to music and watch TV and choose what time to get up."

The provider had a satisfactory recruitment and selection procedure in place to ensure that staff were appropriately employed.

The provider had an appropriate system in place for gathering, recording and evaluating information about the quality and safety of care the service provided.

You can see our judgements on the front page of this report.
More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Consent to care and treatment</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before people are given any examination, care, treatment or support, they should be asked if they agree to it</td>
<td></td>
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</tbody>
</table>

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We found that the home had policies and procedures in place relevant to this standard. These included the medical consent policy and a policy and on the Mental Capacity Act 2005 (MCA).

On the day of the visit we spoke with the business manager and the care manager for Prior Bank House. We asked the managers about the systems in place to gain consent from people about their care and treatment. They said consent was covered during the person’s care planning process. The provider had sent a letter to people who used the service and their next of kin asking them if they would like to be involved in their or their family member's personal plans and the frequency of involvement. People had the choice to opt in or out in the involvement of their or their family members care and treatment.

The business manager also showed us a record called ‘care plan for decision making and involvement.’ This listed people’s everyday decisions such as when to get up, where to sit, declining to eat and drink, what to wear and declining medication. The manager told us that care staff would discuss this with people and use the information to update their personal plans. This demonstrated that the provider had systems in place to gain and review consent from people who used the service and act on them.

The managers told us that where people lacked capacity, a capacity assessment would be undertaken to determine the person's capacity to make decisions and the family of the person would be involved.

We looked at four care plans that had consent and decision making documents, which had been signed and dated by the person using the service to either request or decline support and assistance with such things as medication and personal planning. This demonstrated that consent to people's care, treatment and support options was discussed by staff, with people, to enable people to make informed decisions.
People told us that they were able to make choices in the way they were supported. People told us that they chose what time to get up. People also told us that they were able to choose how to spend their day and what activities they would like to participate in.

Staff that we talked with had an understanding of the MCA and DoLS (Deprivation of Liberty Safeguards) and recognised that people using the service had the right to make their own decisions.

We viewed the staff training records which showed that six out of 28 staff working at Prior Bank House had received combined mental capacity act and deprivation of liberty safeguard training in 2012. We discussed this with the business manager who gave assurances that training would be organised as a priority for the staff who had not received this training.
Care and welfare of people who use services

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.
Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People who could communicate with us told us, "They [care workers] are very kind to me. They are all kind with a sense of humour. Some of them are friendly which makes life easier. We all have choice, we listen to music and watch TV and choose what time to get up." "I'm satisfied, I can't fault anything they [care workers] do. Staff are nice. I choose what time to get up. They [care workers] look after me."

During our SOFI observation we saw that the atmosphere within the home was very quiet. There were 25 people living at the home and there were six people sat in the communal lounge. Three people that spent a large proportion of the time asleep.

We observed four people who used the service for a period of one hour 30 minutes in the lounge. We recorded their experiences at regular intervals. This included people's mood, how they interacted with staff members, other people who used the service and the environment.

We saw that there was not always a member of staff present in the lounge. Different staff entered the lounge briefly and frequently and appeared to be rushed. However staff were quick to respond to people's needs.

We observed basic interaction between the staff and two people that spent a large proportion of their time asleep or gazing around the lounge. We looked at their personal plans which recorded that they liked to talk to people. When a staff member asked if they would like a drink, they became alert, smiled and enjoyed the company. This showed that contact with other people increased their engagement with the world around them. We discussed this with the manager who acknowledged that an 'Anchor' dementia champion who had previously visited and undertaken an assessment had identified similar areas for improvement. The manager said an action plan was being developed and would be discussed at the team meeting.

There were occasions during our observations where staff would sit and talk to people that were awake. Staff were observed asking people their choices of food and drinks and checking that they were comfortable. Staff treated people in a kind and caring manner.
Within the lounge the television was on with the volume very low. This meant that people with a hearing impairment would not be able to hear the television.

The provider may find it useful to note that on one occasion we saw staff members carry out care tasks with minimal communication. These tasks included placing cups down for drinks. We observed that a drink was placed without explanation to a person that was awake and was not within their reach. Approximately 15 minutes later we observed that a care worker assisted the person with their drink. This meant care was not always delivered in a timely way for people.

At this visit we also spent a period of time walking around the other areas of the home and sitting with people in the lounge. We were able to observe people's experiences of living in the home and their interactions with each other and the staff. We noted that the atmosphere in the home was different in the afternoon to the period of observation during the SOFI over the lunch period. In the afternoon the home had music and dance session. We saw and heard staff asking people their choices and preferences about what activities they would like to do in the afternoon; they were asked if they would like to sing. The majority said yes, people started singing, and there was laughter between the staff and people living at the home. We observed positive interactions between staff and people who used the service. We observed staff talking with people, making eye contact and being tactile in a friendly and professional manner.

When we spoke with staff they were able to give us detailed information on or about how people they were providing care for were assisted with their needs.

The manager told us that people had regular contact with their GP and they visited on a weekly basis. We saw evidence that people had contact with their GP in their personal plans.

We checked the personal plans for four people that lived in the home. The provider was in the process of implementing new care plan documentation. The personal plans contained good information about each person's needs and their medical and support needs. Risk assessments were included within the documentation and included moving and handling and other risk factors, for example use of bed sides, fire and mobility. The personal plans seen had been updated and reviewed appropriately.

The provider may find it useful to note that the personal plans reviewed did not contain information on people living at the home in the 'all about me' section and one person's personal details had not been completed. The business manager gave assurances that personal plans would be completed as a priority.

The home employed two activity workers. The activity workers provided activities each morning and afternoon. The programme of activities was on display in the reception area.

We observed that call bell systems were located in communal areas, bathrooms and toilets. During the inspection we heard the call bell system and noted that people's needs were responded to quickly. This demonstrated that people who lived at Prior Bank House were able to get help when their mobility was limited.

We spoke with the manager and two members of staff who said that there was a formal contingency plan in place to advise staff on how to deal with an emergency. We saw evidence of this. People and staff we spoke with were clear on what to do in the event of
an emergency.
Safety and suitability of premises

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

Throughout the inspection we moved around the home making observations the safety and suitability of the premise and speaking with people. The business manager told us that redecoration for communal areas was due to be completed by the end of the financial year. During our observations we noticed that all fire exits, stairs and corridors were clear of equipment and clutter.

We spoke with two people who lived at Prior Bank House, they told us that the building was well maintained, with sufficient toilets and bathroom facilities to maintain and promote people's privacy, dignity and independence.

We viewed four people's rooms which had a wash basin and toilet facilities. The rooms were spacious, personalised, had storage facilities for private belongings and were a comfortable temperature. We found that people who lived at Prior Bank House had their rights to privacy, dignity, choice, autonomy and safety maintained.

We viewed the bathroom facilities within the home. We observed that there weren't any grab rails next to the toilets.

The provider may find it useful to note that the bathrooms were not designed and adapted to enable people to move around and be as independent as possible.

There was an unused bathroom on the ground floor. We were told by staff that the toilet was used by people living in the home. We observed that the room was cluttered and there were five pieces of equipment stored in close proximity to the toilet. We spoke with the business manager who told us that the room was not used as a toilet and they were looking to transform the room into storage or an office.

The provider may find it useful to note that the toilet facilities in the unused bathroom were not appropriate for people who used the service.

We viewed the sluice room on the ground floor. The provider may find it useful to note that we observed that the floor was sticky and had several visible spillage stains. Behind two washing machines there were high and thick levels of dust on the floor, wall and pipes.
Clean mops were stored against the wall. We discussed this with the business manager who said they had identified cleaning behind the washing machines as an issue and they would discuss with their health and safety advisor. It was agreed that the clean mops would be relocated.

We saw that the provider had a Control of Substances Hazardous to Health (COSHH) Regulations policy and procedure in place with appropriate assessments. We found that substances hazardous to people's health were securely stored in a room which was locked. We looked at the staff training matrix which showed that 19 members of staff had not completed the COSHH training. The manager gave us assurances that this would be organised as a priority.

We spoke with the maintenance staff who explained what weekly premises and security checks were undertaken which included checking that external doors were closed, temperatures of communal rooms and en-suites and checking paths and grounds for debris. We saw evidence of these checks.
## Requirements relating to workers

<table>
<thead>
<tr>
<th>Met this standard</th>
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### People should be cared for by staff who are properly qualified and able to do their job

#### Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

#### Reasons for our judgement

The staff we spoke with said that they felt supported by their manager and able to speak with them confidentially about any issues.

The service had a recruitment policy and procedure that the provider followed when employing new members of staff.

The service had a recruitment system in place to show that all staff had undergone the appropriate checks, for example, Disclosure and Barring Service (DBS) checks (formerly Criminal Records Bureau Checks (CRB)), submitted an application and two references. We viewed three staff files that contained an application form, job description, two references, interview records, certificates and a DBS check.

We spoke with two members of staff who told us they had been recruited by submitting an application form and attending an interview. The manager confirmed staff were recruited by interview and appropriate checks were undertaken before staff began work.

All staff that we spoke with were clear about their responsibilities and had the relevant qualifications, knowledge, skills and experience to carry out their role.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

| Met this standard |

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

During our inspection visit we reviewed how quality of care was monitored and safety maintained. We found the manager had responsibility to ensure a range of quality audits and checks were undertaken each month and/or quarterly. These covered areas such as personal plans, excellence audits (customer experience), infection control, medication and health and safety. We reviewed the completed audits and found these audits had been undertaken accordingly and had identified areas for improvement with completion dates.

We looked at a sample of the services policies and procedures. We found the policies and procedures to be detailed, clearly written and easy to understand. The policies and procedures had been reviewed and updated as necessary.

A complaints procedure was in place so that people could voice any concerns. All of the people spoken with said that they had no worries or concerns, but that they could talk to the manager or the staff if they had any. We viewed the complaints record and saw that there was an audit trail of steps taken and the decisions reached.

The home had accident and incident reporting processes in place. These recorded the lessons to be learned from the investigation and signed by the manager. The manager explained that these were discussed at staff handovers and at team meetings.

The provider had introduced new departmental staff meetings. The manager explained that they held monthly staff meetings for domestics, care staff, team leaders and kitchen staff. They would then hold a full staff meeting monthly. All staff told us that the meetings were an effective method of communication and they were minuted. We saw copies of the minutes. Areas discussed included cleanliness, record keeping, training, personal plans and policies.

We saw evidence that Prior Bank House held monthly resident meetings. Areas discussed at the meetings included summer menu and activities.

The manager told us that they planned to send out a survey to people who used the service and their relatives in September 2013. They showed us a copy of the planned
survey. We requested a copy of the survey results from the previous year, these were unavailable. The business manager presented an email to us from the customer research manager at Anchor which stated that the survey results from 2012 were positive.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th>✔ Met this standard</th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td>✗ Enforcement action taken</td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
</tr>
</tbody>
</table>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

**Essential standard**

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Outcome</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>5</td>
<td>14</td>
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<tr>
<td>Cooperating with other providers</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>11</td>
<td>16</td>
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<tr>
<td>Requirements relating to workers</td>
<td>12</td>
<td>21</td>
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<tr>
<td>Staffing</td>
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<td>Supporting Staff</td>
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<td>Assessing and monitoring the quality of service provision</td>
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<td>Complaints</td>
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<td>Records</td>
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**Regulated activity**

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.