Excel Care Homes Limited

Aniska Lodge

Inspection Report

Brighton Road
Warninglid
West Sussex
RH17 5SU
Tel:01444 464130
Website: aniskalodge@gmail.com

Date of inspection visit: 30/04/2014
Date of publication: 27/08/2014

Contents

Summary of findings

Overall summary

Aniska Lodge is a care home for up to 49 people. It provides care and support to older people with nursing care needs, dementia or physical disability. At the time of our inspection there were 40 people living at the service. People we spoke with spoke positively of the service. One person told us, “It’s lovely here.”

The service was spread over three floors. The ground and top floor provided nursing care support and treatment while the middle floor was for people living with dementia. We spent time observing the delivery of care and treatment for people receiving nursing and dementia care.

The service had a registered manager in place and they provided good leadership and support to the staff. Throughout our inspection, staff spoke positively about the service and commented that they felt supported in their role.

People looked happy and content. People spoke positively of the service and the registered manager. A relative told us, “It’s like a hotel here.”

Although some people spoke positively about the range of activities in the home, not all the activities met everyone’s individual needs and preferences. We brought this to the attention of the registered manager and found that the service needed to make improvements in this area.

During the course of the inspection we found that staff treated people with dignity, kindness and compassion. However, we observed one staff interaction which was undignified and was reported to the registered manager immediately. The registered manager informed us this would be addressed immediately with the care staff involved. We found the service needed to make improvements in this area.

We found that, for people living with dementia, staff did not always enable them to make choices about day to day decisions. We found the service needed to make improvements in this area.

For people living with dementia, we found that the design and layout of the service did not enable people’s wellbeing and independence. People could not freely access their bedrooms and were dependent upon care staff to assist them when needed. We found the service needed to make improvements in this area.

The delivery of care and treatment was recorded and each person had an individual care plan which detailed the support required to maintain their health and wellbeing. Risk assessments were reviewed on a monthly basis but did not always reflect the current situation and the support required to minimise the risk of harm. We found that care plans were not always being followed which therefore placed people at risk of harm and meant that their needs were not always met effectively. We found the service needed to make improvements in this area and we informed the local authority of our findings.

We found that not all people were safely supported to transfer from a chair to a wheelchair. We observed one transfer where inappropriate equipment was used. This placed the person at risk of harm. The registered manager was informed immediately. We found the service needed to make improvements in this area and we informed the local authority of our findings.

People received care from a consistent team of care staff who were clear about their roles and knew people well. Staff received appropriate training which was continually on-going.

We observed staff interaction throughout the course of the inspection. Staff respected the individuality of the people using the service. For people receiving nursing care, staff enabled them to make day to day decisions.

People looked content and happy in the company of care staff. We observed that people were dressed in accordance with their lifestyle choice. For example, one person was seen wearing smart clothes. Documentation we reviewed recorded that this person had always dressed smartly and this had been an important aspect of their life. People were wearing their glasses and hearing aids.

Emergency plans were in place and understood by staff. These included personal evacuation plans for all people, to ensure they would be safe in the event of an emergency.

Summary of findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found that people living with dementia could not freely move around the service when they wished to. We found the service needed to make improvements in this area.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Risk assessments such as manual handling, were reviewed monthly. We found that risk assessments did not record the current measures required to keep people safe. One person using the service now required the support of a hoist to move from bed to a chair but their risk assessment recorded they were mobile with a walking aid. This showed us that risk assessments did not document the measures required to safely support people and reduce the risk of harm.

Staff had received training on manual handling. Throughout the inspection we observed three transfers where people were being supported to move from a chair to a wheelchair with the aid of a hoist or stand aid. One transfer we observed was seen to be unsafe and placed the person at risk of injury and harm.

We looked at recruitment records for six care staff. Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home.

Training records confirmed that staff had received safeguarding training. Staff we spoke with demonstrated an understanding of safeguarding, the identification and reporting of any suspected abuse. We found that although staff spoke of safeguarding and demonstrated an understanding of safeguarding we identified practice during the inspection that placed people at risk of harm.

Staff were aware of the requirements of the Mental Capacity Act 2005. Staff had received training and the registered manager demonstrated a sound understanding. Documentation demonstrated that mental capacity assessments were being undertaken but it was found that the assessments did not clearly record how the decision on capacity was reached.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). In order to understand the legislation, staff had completed training which developed their knowledge and understanding of dementia care.

We saw that staff had regularly tested safety equipment such as fire alarms and emergency lighting. Floors and carpets were in good condition, which minimised the risk of people tripping.

Are services effective?

People had their needs assessed and individual care plans were devised. Care plans included detailed information on how best to support the individual and meet their identified care needs.

Summary of findings

During the inspection, we identified that care staff were not following individual's care plan and therefore placing people at risk of harm or abuse.

Staff we spoke with clearly knew the people they were supporting and caring for. They were able to tell us about people and their support needs. During the inspection we found that a care task had been delegated to a member of staff whose role was housekeeping and who should not have been providing care to people as their English language speaking skills were poor. We found this member of staff supporting someone with nutritional intake. We raised concerns as the person was found to be making choking like sounds and was being fed while lying flat on their back, therefore placing them at risk of aspiration. We raised concerns with the registered manager immediately as this person was placed at risk of harm.

Care plans were in the process of being personalised which included key information on the person's life history which included information on their childhood, adulthood and memories which were of importance to them.

People received appropriate support from healthcare professionals when required. Examples seen, included referrals to other professionals such as General Practitioner's (GPs), speech and language therapists (SALT) and the tissue viability nurse.

People were assessed to identify the risks associated with nutrition and hydration and were involved in discussions about their nutritional needs. People also had access to dietary and nutritional specialists and were regularly assessed by dieticians and SALT.

Training was up to date and staff received further training specific to the needs of the people they supported. For example, staff were trained in dementia awareness and end of life care.

Staff received regular supervisions and appraisals which developed and enabled their knowledge base, skills and understanding.

People told us they felt confident in the skills of the care staff.

Are services caring?

We spent time observing staff interaction for people living with dementia. We found that people's ability to freely move was restricted. People could not freely access their bedroom or patio and were dependent upon care staff to do so. This showed us that the design and layout of the service was not promoting people's wellbeing.

Summary of findings

People spoke positively about the staff and felt that their privacy and dignity was maintained. They said staff were respectful. Staff demonstrated a kind and caring approach when we heard them discussing people's needs and wishes.

People's preferred names were recorded in their care plans and people told us that staff always used these names. People were wearing hearing aids, glasses and foot wear of their choice. We saw that clothing was freshly laundered and people had their hair neatly styled.

Throughout the day we saw that people looked happy and relaxed in the care of staff at Aniska Lodge.

Care staff demonstrated patience and understanding. We saw that care staff responded to people's care needs promptly when required.

Staff spoke with fondness about the people they supported.

Are services responsive to people's needs?

People who received nursing care were encouraged and supported to make their own decisions. Staff were able to recognise non-verbal communication and recognised specific gestures that people used to communicate when they were not able to speak due to their individual needs.

We found that people living with dementia were not always enabled and supported to make day to day decisions. We observed examples of where people were given choices but this was not consistent and we found that care staff made choices for people without asking them. This demonstrated that people living with dementia were not supported to live independent lives.

We saw there were a number of activities arranged for people who used the service. Feedback about the activities was mixed. People told us they felt the activities offered were childish at times but enjoyed the games and puzzles offered.

Staff had received end of life training and spoke positively of the care people received when providing end of life care and support.

All rooms had call bells to enable people to summon assistance. We saw that some people had been provided with pendant call bells. On the day of the inspection we heard that someone had pressed their emergency call bell. We observed that staff responded within seconds.

Information was available on how to make a complaint and people who could communicate told us they would feel happy approaching the registered manager with any concerns.

Summary of findings

Feedback from people who used the service, relatives and staff was continually being sought to develop and improve the service.

Are services well-led?

Throughout our inspection, staff spoke positively about the culture of the service and commented they thought it was well-managed and well-led.

Care staff, people and their relatives, said they found the management team were approachable.

Staff had a clear understanding of why they were there and what their roles and responsibilities were. During the inspection we found that one care staff had delegated a care task to a member of staff who should not have been providing care to people as it was not their role. This meant that care tasks were not always undertaken by care staff whose responsibility it was.

We saw from records that, before a person came to live at the home, their staff support levels had been agreed. We saw from staff rotas, and our observations, that there were enough staff on shift to meet the needs of people who lived there.

Qualified care staff had the necessary knowledge, skills and experience to meet the needs of people at all times.

Incidents and concerns were recorded in a way that allowed staff to identify patterns. The service had systems in place to identify and manage incidents effectively.

The service had a business continuity policy in place. This made sure that the service had a plan in place to deal with foreseeable emergencies. This reduced the risk of people's care being adversely affected in the event of an emergency such as flooding or a fire.

Summary of findings

What people who use the service and those that matter to them say

We spoke with six people who lived at the service and three relatives who were visiting on the day of the inspection. People who were able to express their views told us they were happy with the care and support they received. One person said, "The food is lovely, staff are lovely and I'm very happy."

Many people who lived at the home were unable to express their views. We used various forms of communications throughout the inspection, including observations of care and written communication with people. For people living with dementia we used the short observational framework (SOFI), which is a specific way of observing care to help us understand the experiences of those people.

Comments from people living at the service included; "I feel safe here." and "I was a body in a bed when I got here six years ago. Now I can get about with the help of others and my electric wheelchair I am so much better". Another person told us, "I just tell them when I want to go to bed; they help me to the bathroom. Then I can manage to clean my teeth and have a wash myself and whilst I do that they straighten my bed for me and make me a drink. Then help me back to bed and I can use the remote to turn off the TV when I am ready."

Relatives we spoke with were very complimentary of the service. A relative told us, "I'm very happy with my relatives care." Another relative told us, "I'm very impressed with the place so far. They have been so supportive."

We spoke with four care staff and one nurse. Staff spoke positively of the service and said that the service was well-led with management extremely approachable. One care staff told us, "People come here and we help them to improve, people are very happy here."

Aniska Lodge

Detailed findings

Background to this inspection

We visited the service on the 30 April 2014. 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

The inspection team consisted of a lead inspector, a second inspector and an Expert by Experience who had experience of dementia care. We spent time in each part of the service. We talked with staff and people who used the service. We observed the delivery of care. We used the short observational framework (SOFI), which is a specific way of observing care to help us understand the experiences of people who could not talk with us. We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms, lounges and the dining room.

During the inspection we spent time reviewing the records of the service. These included quality assurance audits, staff training and policies and procedures. We also reviewed care plans and other relevant documentation to support our findings. We spoke with six people living at the service, three relatives, one nurse, four care workers, the registered manager and the operational manager.

Are services safe?

Our findings

We looked at the policies and procedures for safeguarding and whistleblowing. We found that these were up to date and appropriate for this type of service. For example, we saw that the safeguarding policy corresponded with the Local Authority and 'No Secrets'. 'No Secrets' is the "guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse". The guidance demonstrated best practice to follow and included information on the definition of adult abuse. This showed us that the service had the relevant government research and guidance in place.

Staff records confirmed that all staff had received training in safeguarding and this training was refreshed annually. We spoke with five members of staff about their understanding of safeguarding. The majority of staff were clear about their role and responsibilities and how to identify, prevent and report abuse. One member of staff we spoke with was unclear of the importance of safeguarding and was unaware of whom to report any concerns of abuse. This was brought to the attention of the registered manager during the inspection. We were informed that the member of staff would receive further safeguarding training. We saw that the service had information available on safeguarding including the contact details for the local authority and alert forms if a safeguarding referral needed to be made. The registered manager told us that the service had not needed to make any safeguarding alerts since December 2013.

As part of the inspection, we reviewed the service's policies and procedures on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We saw that, where people did not have the capacity to make more complex decisions, the service had policies in place which enabled staff to act in accordance with legal requirements. The registered manager told us that in order to understand the legislation staff had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of developing their knowledge of dementia. Most staff confirmed they had received MCA and DoLS training.

We looked at seven care plans and in four of them, we saw that the staff were completing mental capacity assessments in line with current legislation. For example, we saw that concerns had been raised about the ability of one person to safely administer their medication. A mental capacity assessment had been completed which deemed the person to lack capacity and for medication to be administered by a nurse in their best interest. It was clear how this decision had been reached and the assessment was underpinned by the principles of the MCA. When looking at the other three care plans, we found that each person had a generic form within their care plan which included the question "has he/she got capacity". Whether the person had capacity or not was recorded against an area of care such as medication and personal hygiene. We could not see how these decisions had been reached. The registered manager acknowledged that these assessments did not identify and record how the decision was made and agreed that this needed to be changed. The Mental Capacity Act 2005 (MCA) says that reaching a decision on capacity is based on the two stage assessment. The assessments completed by Aniska Lodge did not record the two stage assessment; therefore the assessments were not completed in line with the requirements of the Mental Capacity Act 2005 (MCA). Observations throughout the day found that this did not impact upon the delivery of care and treatment and was an issue with recording only. This has been identified as a breach of legal regulation (Regulation 20 (1)(a)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). The action we have asked the provider to take can be found at the back of this report.

Before a person moved into the home, a pre-admission assessment took place. People could visit or stay overnight. This determined the care needs of the person, dietary requirements, religious beliefs and the support required to ensure their safety. We saw that people's preferences and views on what they wanted from the service had been recorded. The registered manager told us, "The pre-admission assessment allows us to meet with the person and ensure that we can confidently meet their needs." This showed us that before someone moved into Aniska Lodge, staff had assessed they could safely meet their individual care needs.

We looked at seven risk assessments and found they were reviewed regularly. We saw that risk assessments included an assessment of the need and then detailed on the monthly review the changes to the person's health and care needs. For example, one risk assessment for manual handling recorded that the person now required the support of a stand aid (mobility aid) or hoist to move from

Are services safe?

or into their chair or bed. The assessment of need on the risk assessment did not reflect that the person's ability to move independently had deteriorated and recorded their mobility as only needing a walking aid. This meant that information on the risk assessment was not accurate. During the inspection, we observed care staff were using the appropriate mobility aid to support the person's transfer from chair to wheelchair. We found that the delivery of care and treatment was not affected and this was a recording issue only. This meant there had been a breach of the relevant regulation (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). The action we have asked the provider to take can be found at the back of this report.

Throughout the course of the inspection, we observed the delivery of care and treatment. We observed three people being moved throughout the course of the day. Most people were supported to move from a chair to a wheelchair using the appropriate equipment. During one observation we saw one person who was supported to move but care staff were using inappropriate equipment. The person was unable to safely weight bear and required the support of a hoist to move. Care staff supported this individual by using a stand aid. This is a manual handling aid which should only be used if the person can weight bear. During the move, we saw the person was being pulled up by their arms as they had no ability to support themselves with their legs. We brought this to the attention of the registered manager immediately who confirmed this was not safe practice and acknowledged our concerns. The registered manager said that they would talk with the staff involved and organise further manual handling training. This showed us that the person could have been at risk of injury from inappropriate use of equipment for care. This meant there had been a breach of the relevant regulation (Regulation 9 (1)(b)(ii)). The action we have asked the provider to take can be found at the back of this report.

Most people who lived at the home had an air mattress (inflatable mattress which could protect people from the risk of pressure damage) as they had been assessed as high risk of skin breakdown (pressure sore). At the time of the inspection we were told that no one had a pressure sore. We were informed by the registered manager that air mattresses were checked daily to ensure they were on the right setting for the individual needs of the person. We checked six air mattresses. On two instances we found that the air mattress setting was not correct for the individual need of the person and could have potentially placed them at risk of skin damage or developing pressure sores. Care staff were informed and the issue was rectified immediately.

We found that recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. We looked at six staff files which confirmed that staff had completed an application form, references were obtained, forms of identification were present and a disclosure and barring check had taken place. This showed us that the provider had checked that people had no record of misconduct or crimes that could affect their suitability to work with vulnerable adults.

The premises were safe and well maintained. Floors and carpets were in good condition; which minimised the risk of people tripping. Regular audits were completed by staff to check the house was safe. These included checks on electrical equipment, trip hazards, fire safety and cleanliness of the house. We saw that all the hoists had been serviced and were safe to use. The service employed a dedicated maintenance worker who was responsible for the servicing and maintenance of the house on a weekly basis. Staff we spoke with confirmed that any faulty equipment was repaired promptly. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. This showed us that people received care and treatment in an environment that was well maintained and safeguarded them from faulty equipment.

Are services effective?

(for example, treatment is effective)

Our findings

People told us they were usually involved in decisions about their care and were kept informed of any changes to their care plans or medication. One person said, “My care plan changes a lot but we do it together.” A visiting relative told us that they found the service extremely supportive and were kept updated about their loved one’s health and care needs.

We looked at seven care plans. Care plans demonstrated that people’s needs were assessed and plans of care were developed to meet those needs. Each section of the plan covered a different aspect of the person’s life, for example personal care, medication, communication, continence, mobility, nutrition and weight, mental health and cognition. The general care and support plans provided clear guidance to staff about how people wished to be supported, including details of their personal care needs. For example, one person preferred to go to bed in their night clothes and sometimes chose not to change their clothes. The care plan provided clear guidance for staff about what to do whilst respecting the person’s individual preferences.

We found that care plans were not followed effectively by care staff which placed people at risk of harm. For example, we overheard a choking like sound from a person’s room. Upon entering the room, we found care staff supporting a person with eating but the person was lying flat on their back placing them at risk of choking. We reviewed the person’s care plan and found it clearly documented that the person should be sitting upright when being supported with eating and drinking. We raised our concerns with the registered manager. We were informed that this member of staff should not have been providing care as it was not their role. The registered manager spoke with the nurse in charge immediately to understand why this member of staff was providing care. It was identified that the member of staff was delegated the task by another care worker but should have declined as their role was purely domestic. The above issue meant that there had been a breach of the relevant legal regulation (Regulation 9 (1)(b)(ii)). The action we have asked the provider to take can be found at the back of this report.

We observed staff supporting people with eating and drinking in both the dining room and people’s own bedrooms. We found that appropriate staff members were supporting people in line with their individual care plan. We found no further incidences where people were placed at risk when being supported with eating and drinking.

We saw that the service was implementing a ‘This is about me’ document for all people. ‘This is about me’ was a personalised document which recorded the person’s life history, aspirations, goals, daily living routine and support required to maintain their health and wellbeing. It was designed to help someone who may not be able to communicate their feelings or wishes at a time of need. We saw that staff and families were supporting the service to complete them. This showed us that the registered manager and staff understood the principles of personalised care and were incorporating this into their care documentation.

Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, tissue viability nurses or dieticians and when referrals had been made. These showed that people's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Staff worked closely with healthcare professionals such as occupational therapists and physiotherapists to promote movement and quality of life. One person told us, “A physiotherapist comes to see me once a week which I really enjoy.” This showed us that people were supported to maintain good health and received ongoing healthcare support.

People were protected from the risks associated with insufficient or nutritionally deficient food and drinks and enjoyed the food provided. People told us, “The food is lovely” and “The food is so good we could have a full English breakfast every morning if we wanted it.”

The chef told us the service had a weekly menu with options such as fisherman’s pie or chicken curry. We saw that staff went round each day asking people what they would like for the following day. Two options were always available but we found that people could also make additional requests. This information was then fed back to the chef. Within the kitchen, we saw that the chef had information available on the dietary requirements of each person using the service. For example, whether a pureed or soft diet was required. This showed us that staff were aware of individual preferences, needs and nutritional requirements.

Are services effective?

(for example, treatment is effective)

Staff told us how they monitored people's food and fluid intake and met any special needs people had. “We weigh people monthly and this may indicate that we need to weigh people every two weeks if required.” Staff members described the importance of fluid and food charts and the MUST score (malnutrition universal screening tool). Staff demonstrated an understanding of the importance of hydration and nutrition and monitoring for any signs of dehydration and weight loss. We saw that, where concerns over nutrition had been raised, referrals to the dietician and speech and language therapist (SALT) had been made. For example, one person’s MUST score had been calculated as 2 which meant that their nutritional intake was low. We saw that action was taken which included a referral to the dietician.

We observed lunch being served. Where required, we saw staff provided one to one support to people in the dining room and in people’s bedrooms. Staff were seen sitting next to people and talking with them whilst providing support. We saw one person who was reluctant to accept help. The staff member moved away but kept returning and asking the person if they would like any help. We saw that the staff member supported the person to cut up the food but promoted their independence by placing the cutlery in the person’s hand. People had the choice of eating in the dining room or in their bedrooms and this choice was respected by staff.

For people living with dementia we found that, during lunch time, care staff were seen placing protective clothing (bibs) on each person. We did not see any interaction or communication as to whether the person wished to wear the bib or not. This could be seen as infantilisation and was brought to the attention of the registered manager. We were informed that care staff would be spoken with immediately to address the situation. The above issue meant that there had been a breach of the legal regulation (Regulation 17 (1)(a)). The action we have asked the provider to take can be found at the back of this report.

Most people received effective care from staff that were appropriately trained. We looked at the induction and training programme for staff. We saw this was comprehensive and ensured all staff had the knowledge and skills necessary to carry out their roles. Records showed that the training the provider required them to do was up to date or on going for all staff. Staff told us that the training opportunities were “excellent” and they felt supported within their role. In addition to the required subjects, they said they could request additional training courses. These included; end of life care and stroke awareness.

We saw that staff had regular supervisions. Supervision is a formal meeting where training needs, objectives and progress for the year were discussed. Staff confirmed they found supervision a useful tool and could discuss any concerns. We found that the registered manager was seen as approachable and helpful by staff. Staff we spoke with commented they felt well supported by the registered manager.

Are services caring?

Our findings

We spoke with six people about how they found the care and treatment they received. People spoke highly of the service and the care and support they received. For example, one person commented, "Even though I can't get out and about much I live a very good life here."

The service provided care and support to people living with dementia. Due to the communication needs of the people living with dementia we were not able to get detailed responses to our questions. We conducted a SOFI observation in the main lounge used by people living with dementia. We observed that staff showed patience, understanding and treated people with kindness. During our observations we saw care staff supporting a person to move from a chair to a wheelchair. We saw that this move was undertaken in an undignified manner. A screen was pulled around the person to provide some privacy. But the screen was not large enough to ensure total privacy in that people sitting next to the person, or people walking into the lounge, could see what was happening. During the move, we heard staff talking to the person. However, it was clear that the person did not understand as care staff were not clearly communicating with the person and the person was therefore becoming agitated. We saw that during the move, the person was wet from urine. We saw that the person was not wet from urine before the move and this may have occurred during the move. Care staff did not promote the person's dignity by placing a towel or blanket over the person and other people were able to see this. We reviewed the person's care plan and found that it was documented for staff to "clearly" ask permission before moving the person and to "clearly explain to the them, step by step what was happening". The above issue meant that there had been a breach of the legal regulations (Regulation 9 (1) (b) (ii) and Regulation 17 (1)(a)). The action we have asked the provider to take can be found at the back of this report.

During the rest of our inspection, we observed two other situations where care staff supported people to move from a chair to a wheelchair. We found that staff supported in a dignified manner, explaining to the people what was happening and keeping them involved. We did not observe any other people being moved in an undignified manner.

Observations of care reflected that staff had built rapport with people living at the service. For example, one person was becoming distressed and agitated during the course of the afternoon. Staff recognised the signs of agitation and sat with the person providing reassurance and comfort. This showed us that staff had the skills and understanding of how best to support this person.

People were supported to maintain their personal and physical appearance. We saw that people were dressed in the clothes and in the way they wanted. We saw that one gentleman was wearing a shirt, jumper and trousers. Care documentation recorded that this was how he enjoyed dressing when he was at home and maintaining a smart appearance was important to him. People were wearing hearing aids and glasses along with footwear of their choice. We saw that people had their hair neatly done and we observed staff offering to paint someone's nails.

People could bring their own furniture into the home if they so wished and staff encouraged people to bring objects and pictures of importance. People decorated their rooms according to their wishes. For example, pictures were displayed on the walls and people had brought their own bed spreads and items of importance. Staff and the registered manager commented that Aniska Lodge should feel like home and people should be able to bring whatever they want. This showed us that the service was taking into account the emotional needs of people.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). A deprivation of liberty application should be made by the service "if a person was continually under supervision and control, was not free to leave and lacked capacity to consent to these arrangements".

Part of the home provided care to people living with dementia. People were not able to move around the home freely because a wooden gate restricted them from going to their bedrooms and to the patio garden. The wooden gate was placed in front of three steep steps and its purpose was a safety feature to prevent people from falling. We could not find any specific risk assessments within care plans about people's ability to use steps safely. But, during the course of the day, we saw that most people required support from staff to walk up and down the steps. To open and close the gate, we saw that a key code was required which meant people were reliant upon care staff opening and closing the gate. During the course of the inspection we observed staff supporting people to their bedrooms from the lounge but saw that one person did become

Are services caring?

distressed when they could not freely move independently from the lounge to their bedroom due to the presence of the gate. We saw that staff immediately supported them to go through the wooden gate to access their bedroom and provided reassurance. The wooden gate was found to impact upon people's ability to move freely but we saw that once people asked to be supported through the wooden gate, staff provided assistance immediately. We identified that the design and layout of the service did not promote people's wellbeing. The operational manager told us that they would contact the local DoLS team and begin work to improve the design and layout for people living with dementia. The above issue meant that there had been a breach of the relevant legal regulations (Regulation 15 (1)(a)). The action we have asked the provider to take can be found at the back of this report

Continued observations of the delivery of care to people living with dementia found that people continually had a tray (table) placed in front of them. Throughout the day we saw that, as soon as someone sat down, a tray was placed in front of them. The operational manager informed us that the purpose of the trays was so people could easily reach food and drinks and was also needed so they could take part in some activities. We observed throughout the course of the inspection that the trays were used for this purpose but not always. One person was seen sitting down with a tray in front of him (no items were present on the tray) and his walking aid was not present. The person had to ask staff for his walking aid and for the tray to be pulled away. We observed that the staff immediately gave him his walking aid and removed the tray. Our observations throughout the day found that care staff responded immediately to the requests of people if they wished to go to their bedrooms.

In light of recent Supreme Court Ruling, people living with dementia should be empowered to make decisions and given choices to enable them to live autonomously. We found that people's ability to make choices were limited at times. We saw evidence that people were given choices such as what they would like to drink but this was not consistent. For example, a care worker accidently knocked over a person's drink. The member of staff did not apologise for knocking over the drink. The person was brought another drink but care staff did not talk with the person to ascertain what drink they would like or whether they wanted another drink. We heard a member of staff comment, "I'll just get them squash." It was not clear whether squash was the person's favourite drink or whether they just made that decision for the person. This demonstrated that people were not always enabled to make day to day decisions. This meant that there had been a breach of the relevant legal regulation (Regulation 17 (1)(b)). The action we have asked the provider to take can be found at the back of this report.

People who received nursing care were encouraged and supported to make their own decisions. For example, staff told us how they provided choice and promoted people to be independent and make decisions. One staff member told us how they offered people the choice of a shower or bath whilst also respecting their decision if they declined any assistance. During the course of the inspection, we heard staff offering choices on what to eat and drink and what activities to take part in.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People were encouraged to make their views known about the service and the care they received. We saw that 'residents meetings' were held every two months. These provided a forum where any concerns, issues or ideas were discussed. Records of meetings confirmed that issues were discussed and action was taken. For example, we saw that a residents meeting had been held following the feedback from a recent survey. Concerns around the menu had been raised. During the meeting, the registered manager explored the concerns and options on the menu were changed.

We saw that 'relatives meetings' were held every three months which provided a forum for relatives to raise concerns and discuss ideas. We found that the service listened to the feedback of relatives and acted on their concerns. For example, feedback included further involvement from relatives in care planning around end of life wishes. We saw that care plans had been amended to include end of life wishes and what should happen in the event of deterioration of health.

The registered manager told us they had information available on advocacy services but that currently no one was using the support of an advocate. The registered manager commented that advocacy services had been used in the past with good effect and they were aware of how to make a referral when required.

Staff demonstrated an understanding of non-verbal communication needs and how to interact with people who could not verbally communicate. Staff told us, when offering choice to people who could not verbally communicate; they used facial expression, body language and gestures to communicate. For example, one person was being offered their lunchtime meal. The care staff explained what it was and then used hand gestures to ask if the person was happy with the meal. The person responded with hand gestures, confirming they were happy. This showed us that people's communication needs were met.

The service employed two activity co-ordinators. On the day of the inspection, only one activity co-ordinator was present. We were informed that the second activity co-ordinator was assisting in the kitchen. The registered manager commented that staff had been trained to offer activities and therefore the opportunity for people to take part in activities should not be limited. We observed a wide range of activities throughout the course of the day including bowls, puzzles and exercise games. People living with dementia experienced a range of activities in the morning and people who received nursing care were encouraged to participate in activities in the afternoon.

During the morning we observed that people living with dementia were offered activities but people who required nursing care were not provided or offered any activities. During the afternoon, we observed that activities were being undertaken in the communal lounge for people who required nursing care. During the inspection, we found that activities were offered for people with dementia in the morning and for people with nursing needs in the afternoon. Activities for all people were not offered throughout the day. People appeared to be enjoying the activities and the social stimulation provided. We noticed that people who preferred spending time in their room did not receive any quality time with the activity co-ordinator. We observed whether care staff spent one to one time with people in their own room to provide social interaction. We found that people who preferred spending time in their room did not receive regular social interaction from members of staff.

Within the entrance of the home was an activity timetable. We could see that people were supported to attend the local church every two weeks or local ministers visited the service. The activity co-ordinator told us that the timetable is a "rough guide, people can request activities and we can do what people feel like at the time." We found that the service had dedicated patio and garden areas but during the course of the inspection we did not observe anyone going into the garden. One person told us that they would like to go out more and that they thought the activities were childish at times and wished to do more meaningful activities. Other people spoke positively of the activities offered but this showed us that the activities did not meet everyone's individual needs and preferences. We brought this to the attention of the registered manager and found that the service needed to make improvements in this area.

All rooms had call bells to enable people to summon assistance. Bedrooms included an emergency call bell which people could press if they required urgent attention and a call bell to press if they required assistance. We saw that some people had been provided with pendant call

Are services responsive to people's needs?

(for example, to feedback?)

bells they could wear round their neck. We found that call bells were answered promptly by staff. During the inspection, the emergency call bell was pressed. Staff responded in seconds and attended to the needs of the person. People we spoke with confirmed that their call bells were answered in a timely manner. One person told us, "I have two bells right here, one if I feel unwell and boy do they come running if I press that one." For people living with dementia who were unable to use their call bell to summon assistance. We saw that care staff regularly checked on people throughout the day. The nurse told us, "For people in their room, we go round and check on them hourly." This showed us that staff were able to provide care and support in a timely and responsive manner.

People were involved in planning for the future. Care plans recorded people's future and end of life wishes. For example, one person wished to stay at Aniska Lodge and not to be admitted to hospital. Staff had received end of life training and staff we spoke with felt that Aniska Lodge provided the care and support people deserved when receiving end of life care. Staff spoke about providing dignity, privacy, respect and support for relatives during this time period.

Care plans recorded when people had Power of Attorney. This provided the service with details on who to contact when decisions relating to finance or care were needed to be made. We saw that people had DNARs (do not attempt resuscitate) forms which were completed. Three DNARs we looked at had been completed by the person's GP but did not evidence that the decisions had been discussed with the person or their relative. This was brought to the attention of the registered manager to review. We were informed that the registered manager would be contacting the GP to get them reviewed and completed correctly.

We saw that information about how to make a complaint, or give comments on the service was available in the reception area, and in the service user guide. The service user guide was provided to all people when they moved into the home. It provided information of the service including information on how to make a complaint. Staff we spoke with felt confident in supporting someone to make a complaint. People who were able to verbally express their views commented that they felt the registered manager was approachable and would listen to them.

The service had a clear complaints policy in place. This detailed how complaints would be dealt with. The complaints procedure contained timescales so people were informed about how and when a complaint would be handled and responded to. Aniska Lodge had not received any complaints since the last inspection in December 2013.

Are services well-led?

Our findings

People who lived at the home, their relatives and staff were regularly asked to complete satisfaction surveys. Results were then reviewed by senior management for any trends or patterns. We saw that, following satisfaction surveys, meetings were called with 'residents' to discuss and explore the results found and identify a way forward. This showed us that the service consulted with people for their views on ways to improve practice.

Staff and people who used the service spoke positively of the registered manager and during the inspection, the registered manager continued to be available to staff for advice and guidance. Throughout our inspection, staff spoke positively about the service and told us they thought it was well-managed and well-led.

Staff demonstrated a clear understanding of their roles and responsibilities. In between, each shift we saw that staff had a handover which provided staff coming onto shifts with the information they required to do their job safely. During the inspection we found that a member of care staff providing care to people with dementia had delegated a care responsibility to a member of staff who should not have been providing care to people as it was not their role. This meant that a person received care from a member of staff who was not appropriately trained and therefore this person was placed at risk of not having their care needs met. We discussed our concerns with the registered manager. We questioned why the care staff responsible delegated their responsibilities and why the member of staff accepted. The registered manager agreed that the member of staff should not have delegated their responsibility. We found that this was an isolated incident and people received care from staff who were trained and competent to do so. As a result of this incident, a person was placed at risk of not having their care needs met and we identified that the service needed to be make improvements in this area.

Staff we spoke to had a firm understanding of the whistleblowing policy and that they could contact senior managers or outside agencies if they had any concerns.

Staff we spoke with commented that they felt compassionate and motivated. Staff told us they found the role rewarding and supporting. One care worker told us, "I find it very rewarding working here." Another care worker told us, "People come here and we help them to improve, people are very happy here."

We found that the registered manager had been supported by the provider. The operational manager told us, "We have shifted our culture of blame and indifference to one of honesty and transparency over the past year and this has had a tremendous impact." Staff told us there were regular team meetings which provided an opportunity to discuss concerns and suggest improvements. Staff told us that the service had improved over the past year. Staff commented that the service learnt from any mistakes and wished to continually improve the standard of care.

We saw records of audits and meetings that had taken place. The registered manager completed a monthly audit tool which covered the running of the service, including infection control; medication, dignity, financial, care documentation and health and safety. We saw that this audit was then shared with senior management for any action points to be addressed.

We found incidents and concerns were recorded in a way that allowed for any patterns to be identified. A recent audit had highlighted that one person was experiencing recurrent falls. We saw that measures were implemented to reduce the frequency of falls. These included a referral to the falls prevention team and the implementation of a falls sensor mat in the person's bedroom. The falls sensor mat would alert staff in the event the person suffered a fall or stepped into the mat therefore alerting staff to provide assistance with moving.

The registered manager monitored the frequency of 999 calls made and following a high number of 999 calls made by the home, a referral to the integrated response team was made. The integrated response team provided support to care homes to reduce un-necessary hospital admissions and for the home to be able to safely support the person without attendance to accident and emergency. This showed us that the service had implemented measures to reduce people's attendance to accident and emergency and safely manage their needs at the home.

There were sufficient numbers of suitably skilled staff to meet people's needs. Before a person moved into Aniska Lodge their support needs had been agreed. We saw from care documentation that each person using the service had

Are services well-led?

a 'dependency tool'. A 'dependency form' was a form used to calculate the support required to meet the person's individual needs. We saw that from this form, the registered manager could calculate the staff required to meet the needs of people using the service at all times. From the 'dependency tool' the staff rota was calculated. We saw from staff rotas, and our observations, that there were enough staff to meet the needs of people who lived at Aniska Lodge.

During the inspection we saw that people's opportunities for social interaction and activities were limited at times. The registered manager told us that care staff were trained in social activities and if the activities coordinator was not present, they should be providing activities for people. We commented that we had not seen this happen. The registered manager informed us they would discuss this with staff and inform staff of the importance of providing social interaction.

Emergency plans were in place and understood by staff. We saw that the service had a business continuity plan which detailed what to do in the event of an emergency such as a fire or gas leak. Each person using the service had a personal evacuation plan which included detail on their level of mobility and the allocated place of safety in the event of a fire. Records showed fire safety equipment was maintained appropriately and fire drills were held regularly. The registered manager commented that she or senior management could be contacted in the event of an emergency. This meant that there were clear instructions for staff to follow, so that the disruption to people's care and support was minimised in the event of an emergency situation occurring.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Respecting and Involving people who use services. Suitable arrangements were not always in place to ensure the privacy and dignity of service users. Service users were not always enabled to make or participate in decisions relating to their care or treatment.

Regulated activity	Regulation
	Regulation 9 (1) (b) (ii) HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare of service users. Care was not delivered in such a way to meet the service user's individual need.

Regulated activity	Regulation
	Regulation 15 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Records. The provider had not ensured that all areas of the home were of a suitable design and layout to promote people's well-being

Regulated activity	Regulation
	Regulation 20 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Records. The provider had not taken steps to ensure that people were protected from the risks of unsafe or inappropriate care and

This section is primarily information for the provider

Compliance actions

treatment because not all care records were accurate and fit for purpose.