

Anchor Trust Keswick

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

Keswick provides care and accommodation for up to 51 people. On the day of our inspection 51 people received care and support in seven different living areas of the home, some people had a range of physical health needs and some of the people were living with dementia.

The inspection took place on the 17 March 2016 and was unannounced.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive safe care and treatment. Any risks people took were not always minimised. Risk assessments had not always been completed for people and staff were not always aware of people's needs. We observed several incidents where staff were supporting people to move or transfer from chairs in an unsafe way.

People did not always receive their medicines as prescribed. During the inspection we found that people had not always received their prescribed medicine. The registered manager raised a safeguarding with the local authority regarding this and started an internal investigation. People were prescribed as required medicines (PRN); however protocols to describe to staff how, why and when the person should have these medicines were not robust. Topical creams had not been applied as directed by the person's doctor.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We did not consistently see the code of practice being applied in the service and accurate documentation being undertaken by staff. We have made a recommendation to the provider regarding this.

People were not always treated with kindness, compassion and respect. Staff did not always take time to speak with the people who they supported. We observed both good and not so good interactions between staff and people.

Staff recruitment processes were robust and helped ensure the provider only employed suitable staff to care for people. Permanent staff had the specialist training they needed in order to keep up to date with care for people.

People were able to see their friends and families as they wanted and there were no restrictions on when

relatives and friends could visit. The activities on offer to people were varied. One person said, "The pianist is excellent."

Incidents and accident were fully investigated by the registered manager, and actions put in place to reduce the risk to people of accidents happening again such as people falling.

Care was provided to people by a sufficient number of staff who were appropriately deployed. People did have to wait to be assisted. One person said, "Staff come when you want them."

People and their relatives gave positive feedback about the service they or their family member received. People were very happy. One person said, "Staff treat me very well." People and their families had been included in planning the care provided. We saw that people did not have an individual plan, detailing the support they needed and how they wanted this to be provided. Staff ensured people had access to healthcare professionals when needed.

People were provided with a choice of freshly cooked meals each day and facilities were available for staff to make or offer people snacks at any time during the day or night. Specialist diets to meet medical or religious or cultural needs were provided where necessary. One person said, "It's nice here and the food is good."

People knew how to make a complaint. One person said, "I have not needed to make a complaint." Complaint procedures were up to date. The policy was in an easy to read format to help people and relatives know how to make a complaint if they wished.

The registered manager undertook quality assurance process, including regular audits on health and safety, infection control and medication. The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People were not always supported in a safe way and assessments were not always reflective of the risks to people.

Medicines were not consistently stored, managed or administered safely.

The provider ensured there were enough staff on duty to meet the needs of people. Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

People told us they felt safe. Staff knew how to keep people safe and protect them from abuse.

There were processes for monitoring accidents and incidents to reduce the risk of them happening again.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People's rights under the Mental Capacity Act were not always met. Assessments of people's capacity to understand important decisions had not always been recorded in line with the Act.

Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were not always met.

Staff said they felt supported by the manager, and had access to training to enable them to support the people that lived there.

People had enough to eat and drink and had specialist diets where a need had been identified.
People had access to health care professionals for routine check-ups, or if they felt unwell.

Is the service caring?

Good ●

The service was caring.

People told us they were well cared for.

People's privacy was respected by staff and they were cared for by staff who knew them as individuals.

People's relatives and friends were welcomed into the home.

Is the service responsive?

The service was not always responsive.

Care plans were not person centred and did not reflect clearly the support needs of people.

People had access to wide range activities. People chose activities and events within the home.

There was a clear complaints procedure in place. Staff understood their responsibilities should a complaint be received. The registered manager responded openly to complaints received.

Requires Improvement 

Is the service well-led?

The service was well led.

The service had a registered manager in place.

The registered manager had regularly checked the quality of the service provided and worked towards driving improvements.

Staff felt supported and able to discuss any issues with the manager. Senior managers regularly visited to speak to people and staff to make sure they were happy.

The registered manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Good 

Keswick

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR to see if there was any particular area we needed to focus on when we carried out our inspection. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience (a person who has personal experience of using or caring for someone who uses this type of care service) also took part in the inspection.

During the inspection we spoke with seven people, eight staff members, three relatives, the registered manager, and one health care professional. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the different floors within the building and the main lounge and dining area.

We looked at a variety of documents which included six people's care plans, five staff files, training programmes, medicine records, four weeks of duty rotas, maintenance records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

The last inspection was undertaken on 9 July 2014 where no areas of concern were identified.

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel safe living here; I can lock my door if I want."

Although people told us they felt safe potential risks were not always assessed and information was not always available for staff to help keep people safe. Risk assessments were not informative or reflected people's current needs. One person's risk assessment for mobility stated the person had previously suffered a 'hip fracture' however it did not state which hip or how this had happened. The risk assessment instructed 'staff supervision' to transfer, however there were no further details to guide staff on how to support the person. We asked staff if they had received information specifically about this person's needs and they told us they had not. This showed staff did not understand the person level of need and risks associated to their care.

Another person's falls risk assessment stated that they were at high risk of falls. They had experienced previous falls. However the risk assessment did not give any guidance to staff in how to support the person and reduce the risks of falling throughout the day. Staff we spoke to were not aware of the risks to this person or how to reduce them.

We observed throughout the inspection several incidents of staff not using best practice techniques when supporting people to mobilise. On one occasion a staff member supported a person to complete a sit to stand transfer from their bed to a wheelchair. The staff member did not put the brakes on and as a result the wheelchair moved backwards with the person calling out. We had to intervene and put the brakes on the wheelchair immediately for the person's safety. On another occasion a member of staff put their hand under someone's arms to move them from their chair. This is called a drag lift and is not best practice as can cause pain and or further injury to a person.

An agency staff member told us that they did not want to work at Keswick again as they felt there was a risk of unintentionally causing harm to someone due to poor induction." We spoke to the registered manager about this and they said that all agency staff received a short induction into the care needs of people.

People did not always receive their medicines safely. We identified that one person had not received their medicine for a period of 14 days in January and a further 15 days in March. Staff had continually logged on the medicine administration records (MAR) chart 'out of stock'. Staff responsible for the medicines had not followed up on the person not receiving the medicines or informed the registered manager that this person had not received medicines prescribed to them. We spoke to the registered manager who immediately raised a safeguarding alert and initiated an internal investigation.

People, who were prescribed 'as required' (PRN) medicines, did not have robust protocols in place to show staff when the medicines should be given. In addition records for people who required topical medicines (creams) were not completed fully by staff which meant it was not clear whether people had received the creams as prescribed. For example, one person required a gel to be applied twice a day; however the

application had not been recorded. The registered manager and staff were unable to confirm to us whether or not this was a records issue or if staff had not followed application instructions for people.

We observed staff giving people their medicines in one living area; staff left the medicines trolley doors open with medicines on the top of the trolley whilst they went to give another person their medicines on the other side of the room and had their back to the trolley. The only time they put all medicines away and locked the doors was when they went out of the unit to give someone their medicines who was eating their lunch in the day centre. This could put people at risk of accessing or taking medicines that were not prescribed to them.

The above evidence demonstrates that action was not always taken to reduce risks to people's health and safety and to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff had taken steps to help protect people from avoidable harm and discrimination. They were able to describe what they would do if they suspected someone was being abused or at risk of abuse. Staff told us they had received safeguarding training. People told us they would approach the registered manager if they had any concerns. Staff members were able to give us examples of what would constitute abuse. One said, "I would report any concerns to the manager or use the numbers available to the staff in the office to report outside of the organisation."

Incidents and accidents were reported appropriately and in a timely manner. The staff described to us the action they took to respond to each incident. They showed us examples of outcomes of investigations; this included an accident where a person had fallen. One staff member said, "If a person has a fall, I will press the call bell, make sure the person is safe and call the paramedics."

People said that there were enough staff deployed to meet their needs. The provider had recently introduced increased staff on each of the living areas. One person said, "I don't have to wait for staff. I just press my bell." Staff also said there were enough of them on duty to meet people's needs. One member of staff said, "Now with two carers it's less stressful." We saw people being attended to promptly. The registered manager said that the staffing levels were two team leaders, two staff on each living area, and one floating member of staff to provide support where needed throughout the day. The rotas for a four week period confirmed the staff levels described by the registered manager were maintained. An external healthcare professional told us, "There are always staff with people in the lounges."

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff members confirmed they had to provide two references and had a DBS check done before starting work.

There were emergency and contingency plans in place should an event stop part or the entire service running. Both the registered manager and the staff were aware and able to describe the action to be taken in such events.

Is the service effective?

Our findings

Staff did not have a good understanding of the Mental Capacity Act 2005 (MCA) and they did not always follow the full legal procedures in relation to it. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments were completed for people in relation to Deprivation of Liberty Safeguards (DoLS). However we found some MCA assessments and best interest meetings had not been undertaken for people in relation to decisions regarding general care and treatment.

We discussed the MCA with the registered manager and Anchor area manager's at the end of our inspection. They explained there had been conflicting guidance from the provider and information circulating in relation to the MCA which had meant registered managers in all of their homes had followed different processes. An Anchor wide initiative was taking place to address this shortfall and area managers were working with registered managers to ensure the necessary processes were followed and paperwork completed.

The registered manager was not always meeting the requirements of DoLS. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called DoLS. The registered manager understood when an application should be made and how to submit one. Applications had been made for people who lived at the home as coded locks were in place and some people did not have the capacity to consent to their use. We read evidence that a relative who had the legal right, had been involved in a best interest decision in relation to their family member who wished to leave the home. A DoLS application had been submitted in this case.

However DoLS applications had not been submitted for other types of restrictive practice such as bed rails, or for people who were unable to decide on actions needed for health issues such as surgery. One person standard DoLS authorisation had expired in December 2015 and had not been reviewed by staff. The registered manager stated that further training for staff in the MCA and DoLS had been organised. We recommend the registered provider reviews and implements the MCA and DoLS code of Practice to ensure their services are adhering to legal requirements.

People and relatives told us they thought permanent staff were trained to meet their needs or their family member's needs. One relative said "Staff know how to look after my relative." One member of staff said they had a two-week induction shadowing an experienced member of staff when they first started in the role. Since then they had completed the Anchor mandatory training and had supervisions. They had also undertaken an NVQ Level 2 in Health and Social Care. One staff member said, "I have enough training to do the job. I have had safeguarding, data protection, dementia awareness, health and safety."

The provider ensured that permanent staff undertook an effective induction and training to understand their roles and responsibilities to provide care and support people. The induction process for new staff was robust to ensure they had the skills to support people effectively. This included shadowing more experienced staff to find out about the people that they cared for and safe working practices. Staff were trained before they started to support people and received regular ongoing training to ensure their skills were kept up to date. Training was given based on the support needs of the people that lived at the home.

The registered manager told us some staff were trained to an NVQ level in health and social care and that all new staff employed undertook the care certificate as part of their induction.

Staff said they had annual appraisals. Staff also had regular supervisions which meant they had the opportunity to meet with the registered manager on a one to one basis to discuss their work or any concerns they had.

People liked the food at Keswick. One person said, "Food is excellent." Another person said, "Can't fault the food. I've had the best porridge ever this morning." Another person said, "It's nice here and the food is good." A further person said, "The food is lovely."

People's individual dietary requirements were met. We saw a list in the kitchen of people's dietary requirements. The chef was able to identify those people who were on specialist diets. Staff told us if a person had lost weight or staff reported a change in their dietary/fluid intake or a healthcare professional requested it, they recorded a three day food/fluid chart and always referred to the GP if the person's health deteriorated. They told us they offered the person fortified meals or drinks and this would continue until the GP reviewed the person (if required). The Chef Manager told us they were involved, if the person was agreeable, when speech and language therapists (SaLT) assessed a person's swallowing needs. This helped ensure recommendations to minimise the risk to the person were put in action.

We observed lunch in three areas. We were told by the registered manager that lunch was served between 12.30pm and 1pm. In one unit we saw the hot trolley with lunches arrived late and staff did not start giving people their meals for a further 10 minutes. Some people did not receive the meal they had requested. The staff had to go to the kitchen to get people their choice of lunches, delaying people eating for a further period of time. Other people waited long periods of time to get drinks served.

In another unit the three people in wheelchairs were not pushed close enough to the tables and could not easily reach their meals. We also observed one staff member tried to take a person's plate away without asking if they had finished. The person said "I haven't finished that." Another person told us they had asked staff if they could invite their family member to lunch and they had been told that they were not able to do this.

People said that they were happy with the help they received to maintain good health. One person said, "Yes, I see the doctor if I need to." A healthcare professional told us that staff followed any guidance they left. A relative said, "The team leader always contacts me if my relative is ill. They are trying to get the right treatment from the GP."

The registered manager said that they promoted collaborative care (supporting people to access healthcare professionals and provide a person centred approach). Staff responded to changes in people's health needs quickly and supported people to attend healthcare appointments, such as to the dentist, doctor or optician. We saw in individual care plans that staff made referrals to other health professionals such as the SaLT team, the falls team, district nurse or the dementia nurse when required.

Is the service caring?

Our findings

People told us the staff were caring. One person said, "The best thing is that everyone is very kind. They help you. If you have any problems you can ask them (staff)." Another person told us, "I love it here. The staff are lovely. I have a laugh with staff and staff always speak to me nicely." They added, "I stay in my room but that is my choice as I can watch people going past. Staff come in and chat to me. Nothing could make things better."

People told us they were treated with dignity and respect. One person said "We can spend time on our own if we want to. Staff always knock on my door." People looked well cared for, with clean clothes, tidy hair and were appropriately dressed for the activity they were doing. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. Permanent staff were knowledgeable about people and their past histories. A member of staff said they would always ask people what clothes they wanted to wear each day and encourage them to do things for themselves if they could. They said, "I would also ask them how they would like their room tidied and how they wished their bed to be made." A healthcare professional said, "I come in every day. I really like it. The staff are really friendly, they notice things and are always asking questions and taking an interest." We heard staff speaking very kindly to people.

We saw staff treat people in a caring way. One person got upset and said, "I am never going to recover from this." A staff member comforted them and reassured them in a very caring way. The staff sat chatting with the person for some time. When another person came back from the day centre, staff greeted them with a huge smile and welcomed them back. They asked them if they'd had a good time and what they had got up to.

We watched staff support one person to get up from their chair into a wheelchair. It took almost quarter of an hour to achieve this because the person was quite weak. Throughout the whole process the two staff showed patience, they gently prompted and encouraged the person, telling them to take their time and only try again when they felt they could. Another person became a bit agitated at one point and wouldn't stand up from their wheelchair to allow staff to support them to sit in a comfortable chair. After a short while staff suggested they take her for a "walk" in the wheelchair around the home in order to calm them. A relative told us, "Staff are brilliant."

People's rooms were personalised which made it individual to the person that lived there. There were as photographs on the walls of family and items of furniture from their own homes. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to services in the local community so they could practice their faith.

We asked people and family members if they had been involved by the staff in their care or the care of their relative. They confirmed that were included and kept up to date by the registered manager and the staff at the home. One person said, "I have read my care plan; I am surprised about what I read. I agree with the care plan."

Is the service responsive?

Our findings

People did not always receive responsive care. Staff did not always respond to people in a way people required. We observed during the morning another person becoming upset they repeatedly said "Just take me away to die." The staff did not approach the person or try to provide reassurance in any way. The person became more agitated. We spoke to staff about how they reacted to the person and we were told "They are always like this." This showed staff lacked the understanding to provide support to this person. Another person's care plan stated they were visually impaired and needed to wear their glasses at all times. We saw during the inspection this person was not wearing their glasses and were continually asking for them. We asked staff about the person's glasses but they did not know they were visually impaired. Staff did go and find the person their glasses. Which enabled them to feel less anxious and take part in activities.

Peoples individual care plans did not always contain information which related to their needs. For example people who lived with dementia did not have care plans to show staff how this affected them or guide staff in how to support the person. Care plan for specific health conditions that people experienced were not in place such as diabetes or osteoporosis. There were also no details about how people would wished to be looked after if they became unwell. One person had a diagnosis of anxiety and depression. The care plan did not direct staff how to provide support for this person or reduce their anxieties. We observed the person was noticeably anxious throughout the day and staff did not support the person to become less anxious. We asked staff if they had any training in supporting people with anxiety and they told us they had not.

Another person told us they had asked the night staff to assist them going to the toilet. The night staff did not support this person until an hour after the person asked for support. We reported this to the manager who told us they would undertake an investigation.

The lack of person centred care and lack of person centred care planning is a breach of regulation 9 Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to activities that they enjoyed. One person said, "I went to the day centre for the first time today and I really enjoyed it." Another person said, "I will go downstairs if there is something on I fancy." Another person said, "I go out on my own. I go into the garden and when the weather is nice, I go into town." And another person said "I still go to my evening clubs."

The registered manager told us their aim was to have activities staff present seven days of the week which supported the Anchor Inspires programme (Anchor Inspires is an internal accreditation awarded to Anchor care homes that deliver the highest quality and standards of dementia services, where person-centred care is embedded into every element of a resident's life.) We spoke to the Dementia Advisor who told us their role was to promote dementia awareness throughout the provider's homes and supporting staffing working with people living with dementia. People at the service were not aware of the Dementia Adviser's role.

People told us they knew how to make a complaint if they needed to. One person told us, "I have nothing to complain about." We saw how the registered manager had dealt with previous complaints and had

identified improvements or actions that needed to be taken. For example, one person had complained their clothes had been misplaced in the laundry. The registered manager acted on this promptly. The complaints policy was displayed in the foyer of the home and each person had a copy of it in their service user guide. There was a 'We welcome feedback' poster on the noticeboard on one floor and a complaints policy. Which showed the registered manager sought the views and feedback from people and visitors to the service.

Is the service well-led?

Our findings

People and relatives we spoke with all knew who the registered manager was and felt that they could approach them with any problems they had. One person said, "The home is well led and the team leaders are approachable." A relative said "The manager is always available." The registered manager told us, "I have an open door policy."

The registered manager had been in post for six months. They were working effectively to identify where improvements were needed in the service. The registered manager told us about the systems the provider had to ensure the delivery of high quality care. We saw the quality assurance systems in place were always completed. We saw evidence of audits for health and safety, care planning, and infection control that had been undertaken. The systems had ensured that the registered manager identified where improvements were needed in the service.

They told us once they identified an area for improvement an action plan was put in place. The registered manager gave the example of the increased staffing. They explained to ensure that two staff are on every unit they have had to use agency staff whilst recruiting. They told us that continuity of the same agency staff was essential to ensure that they got to know people and their needs. The registered manager said that by "Identifying and solving the problems it will lead to a good quality service."

We observed that the registered manager interacted well with people. They were walking about the home talking to people and speaking to them by name and there was a friendly rapport with people. This gave people the opportunity to talk with them and allowed them to observe staff practice was of a good standard.

Staff were positive about the management and the support they gave to them. They told us they felt supported and could go to them if they had any concerns. One member of staff said, "She walks around. I am very happy here. I love my job."

Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings and any concerns that staff had. Staff told us they attended staff meetings and felt comfortable to speak up in these. A staff member said, "We have regular staff meetings, talk about locking things away, decorating the home, we can raise ideas."

The registered manager told us about the homes missions and values. Which were responding to the individual and supporting what they can do with a personalised care plan, looking for opportunities to build on their strengths and abilities. Staff we spoke to understood and followed the values to ensure people received kind and compassionate care. This was implemented during the staff induction process and reviewed regularly. We saw that the values were promoted in the 'Residents Guide', which anyone wanting to find out about the home or who lived there could read.

The registered manager held regular meeting with people to ensure they were involved in the running and improvements of the home. The registered manager sent us minutes of the last meeting held in march which showed discussions with people about the use of agency, the breakfast menu and the introduction of snack trays throughout the service.

The registered manager had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely within the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The lack of person centred care and lack of person centred care planning is a breach of regulation 9 Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The above evidence demonstrates that action was not always taken to reduce risks to people's health and safety and to ensure the safe management of medicines.</p>