Make-All Limited

Annefield Grange

Inspection report

85 George Street
Ryde
Isle Of Wight
PO33 2JE

Tel: 01983617327

Date of inspection visit:
13 March 2017
17 March 2017

Date of publication:
25 April 2017

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 13 and 17 March 2017 and was unannounced. Annefield Grange provides accommodation and personal care for up to 18 people, who do not require nursing care. There were 17 people living at the home when we visited.

Shortly before this inspection the registered manager for Annefield Grange had submitted an application to CQC to cancel their registration as, although still employed by the provider, they were no longer working in a management role. The provider had arranged for the manager of a nearby home, also owned by them, to provide management oversight whilst a new manager was appointed. 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.

The provider's formal quality assurance systems had not been consistently followed. Some key management tasks had not been completed and the home had received a low food hygiene rating. Records relating to care and incidents were not completed fully or in a timely manner. People whose needs may make the home unsuitable for them had been admitted placing them and other people at risk. The provider was now more actively involved and was taking action to ensure improvements in the way the home was managed.

Not all environmental risks were safely managed. These included the stairs where audible safety alarms were ignored by staff who also failed to notice when these were not working. Fire escapes were fitted with alarms however, these could be turned off and keys to do this had been left in place on all alarm boxes located beside the fire exits. Risks posed by the garden had not been assessed or action taken to ensure the garden was as safe as possible. Where people placed themselves or others at risk there was a lack of detailed and prompt recording of incidents meaning information could not be used to reduce the risk of further incidents.

Some medicines were not stored securely and there was insufficient information to guide staff when they should give people some as required medicines. Staff had failed to notice that a review was required for one person who was receiving a medicine to reduce their risk of developing a blood clot.

A training programme was in place although not all staff had completed all essential training in a timely manner.

The manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded.

People received the personal care they required and were supported to access other healthcare services

when needed. People received a varied diet and were supported appropriately to eat.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Individual risks to people were managed and staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect and choice, dignity and independence were promoted. People received mental and physical stimulation in the form of organised and ad hoc activities.

There was a complaints policy in place and people knew how to raise concerns. Where issues had been raised the provider had acted to the satisfaction of the person raising the concern.

We found one breach 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 this 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.

Medicines and risks to people were not always managed effectively. Risks posed by the stairs, garden and fire escapes were not safely managed. Some medicines were not stored securely and there was insufficient information to guide staff about when they should give people some medicines.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Individual risks to people were well managed and staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

A training programme was in place although not all staff had completed all essential training in a timely manner.

The manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded.

People received the personal care they required and were supported to access other healthcare services when needed. People received a varied diet and were supported appropriately to eat.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect and choice, dignity and independence were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Where people placed themselves or others at risk there was a lack of detail when recording incidents meaning information could not be used to reduce the risk of further incidents.

People received mental and physical stimulation in the form of organised and ad hoc activities.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's formal quality assurance systems had not been consistently followed and shortly before the inspection there had been changes to the home's management. Some key management tasks had not been completed and the home had received a low food hygiene rating.

Records were not completed fully or in a timely manner.

People whose needs may make the home unsuitable for them had been admitted placing them and other people at risk.

The provider was now more actively involved and was taking action to ensure improvements in the way the home was managed.

Annefield Grange

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.

This inspection took place on 13 and 17 March 2017 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has experience of caring for an older person.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The registered manager completed 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 spoke with 14 people living at the home and two visitors. We spoke with the manager, six senior and junior care staff and ancillary staff including, the cook, administration and housekeeping staff. We also spoke with two visiting health and social care professionals and three other professionals visiting the home. We looked at care plans and associated records for seven people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

This was the first inspection for Annefield Grange following its registration in October 2015.

Requires Improvement

Is the service safe?

Our findings

Not all environmental risks were safely managed. Bedrooms were provided over four floors with a turning/spiral staircase in place which could be accessed and used by people, visitors or staff to reach all floors. The risks presented by the staircase were known to the provider and sensor/audible alarms had been fitted at the top and bottom of each flight. The audible part of the alarm was plugged in to an electric socket at a low level and could be manually removed or turned off. During the inspection we heard these alarms consistently however, we did not see staff responding to them. One staff member said, "They just go over my head", meaning they no longer heard them each time. On the second day of the inspection we were on the top floor of the home, with a senior care staff member, we saw another care staff member walk up the stairs to a person's room. The stair alarm did not sound and neither of the care staff noticed this. When we pointed out that the alarm had not sounded both staff tried the stairs and agreed the alarm was not working. We identified that on the second day the alarms to the top two floors were not working meaning staff would not be alerted to people accessing the stairs. We discussed the alarms and staff response to them with the manager. They agreed the alarms would not ensure the safety of people as staff were not responding to them and intended discussing other options with the provider. Following the inspection the manager wrote to us and said that another senior member of staff had deactivated the alarms during the day and they would be reactivated at night. They said this was because people had complained about the noise disturbing them and the risks to people were low as people were aware they should not use the stairs. However, staff on duty and the manager had not been informed of this change in the procedures to manage the risks relating to the stairs.

The home had fire exits and external escape stairways from all upper floors. These were fitted with an audible alarm to notify staff if anyone opened the fire exit doors. These alarms could be turned off using keys which we saw had been left in place on all alarm boxes located beside the fire exits. This meant people or visitors could turn off the alarms and open fire doors without alerting staff, placing people at risk of falling down the fire escape. The manager took immediate action to remove the keys meaning alarms could then only be deactivated by staff. The home had an enclosed rear garden. We identified that some areas may present a trip hazard to people as the concrete paths had cracked and moved making an uneven surface. In other areas there were uneven steps to a bungalow located in the garden and a drop from the lawn to the patio of several inches which would also provide a trip risk. There were no handrails for people to use if they wished to walk around the garden. The manager said a risk assessment of the hazards had not been completed. Following the inspection the manager informed us the provider was arranging for a gardener to undertake work to make the garden paths safe and install safety rails prior to the warmer weather when people may begin to access the garden.

Emergency information detailing which people were in the home and where they were accommodated was not up to date. One room listed as empty was now in use and another person listed as in the home was no longer accommodated there. This meant that emergency staff would not have accurate information and may waste time looking for a person not in the home and not evacuate a person who was living there. The manager immediately updated this information.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014

The manager had put in place an emergency grab bag containing items such as a torch and equipment to keep people warm should they need to be evacuated. Staff were aware of how to respond to other emergencies and had access to relevant information and procedures for managing a variety of potential emergency situations such as severe weather, loss of power to the home or a missing person. Records showed essential checks had been completed on the environment such as fire detection, although there had been a gap in these prior to the current manager commencing overseeing the home.

Other environmental risks were assessed and managed appropriately. Supplies such as gas, electricity and equipment such as hoists were regularly serviced and safe for use. Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Staff told us they received fire training which was confirmed by records.

Not all medicines were stored securely. The provider was storing some medicines that required to be kept at lower temperatures. A refrigerator was available but was not locked and the key to the room this was kept in was located on a hook outside the room. This meant that people not authorised to access the medicines in the fridge would be able to do so. The manager took immediate action to remove the key and ensure this was no longer available to anyone other than staff. Records showed the medicine refrigerator temperatures were monitored. This meant that any fault with the refrigerator would be noticed in a timely manner and the safe storage of any items stored could be assured.

Some people needed 'as required' (PRN) medicines for pain, constipation or anxiety. There was information as to what each PRN medicine was for. However, there was insufficient individual information to guide staff as to when this should be given to a person. For example, one person was prescribed two forms of PRN pain relief medicine but there was no guidance for staff explaining when and why which one should be administered. Staff told us that the person was not able to say if they were in pain but they would determine the need from the person's facial expressions. A formal pain assessment tool was not in use which would help ensure consistency in determining the need for pain relief and help ensure people received this when required. The manager initiated the use of a formal pain assessment tool following the inspection. One person was prescribed medicine for when they were agitated. There was no specific guidance for staff as to the actions they should take as part of a behaviour management approach before deciding to give the medicine. Where people had received PRN medicines there was a good system to record the accurate time these were administered meaning these would not be given too close together. Medicines administration records showed people had received PRN medicines for pain throughout the day and at night when required.

Other medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Some medicines must be stored in a special way and additional records held about their use; these are called controlled medicines. We found that safe systems were in place to ensure these were stored and recorded correctly. Medicine administration records (MAR) documented that people had received their medicines as prescribed. Training records showed staff were suitably trained and had been assessed as competent to administer medicines. All staff undertook basic medicines management training whilst those responsible for administration undertook further training including observation of their practice.

Staff administering medicines did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. One person said, "I keep my own puffer [inhaler] in case I get short of breath, but the staff keep my pills". Another person told us, "They [care staff] come around and give them to you and wait while you take them". Safe systems were in place for people who had been prescribed creams and these contained labels with opening and expiry dates. This meant staff were aware of the expiration of the item when the cream would no longer be safe to use.

People gave mixed views about the availability of staff. One person told us, "You have to wait sometimes", another person said, "You can wait a while for the toilet". However, a third person said "It's not too long a wait". During the inspection we saw that staff were not rushed and responded promptly and compassionately to people's requests for support. One staff member told us, "[I] Feel there are enough staff on duty." Other care staff also reported that they felt they had enough time to meet people's needs.

Staffing levels took into account the people who were living at the home and the level of support they needed. The manager completed a monthly dependency assessment tool which identified the number of care staff hours required to ensure people's needs could be met. The manager told us that all staff, regardless of their role, undertook the same basic training and could therefore respond to people's needs. We saw a member of the housekeeping staff responding to a call bell and informing the person that they would get a care staff member to assist them. One person had been assessed by the local authority as requiring additional individual support. We saw that a named staff member was allocated to provide this on a daily basis. Absence and sickness were covered by permanent staff working additional hours which meant people were cared for by staff who knew them and understood their needs. A named off duty member of staff was designated as 'on call'. This meant that, should the need arise such as to accompany a person for an unplanned hospital or doctor's appointment, they could be called in to support the person. This would mean the home would not be left short staffed in an emergency. We saw this process had been followed the day prior to the inspection when night staff had required additional support following a change in a person's needs.

People told us they felt safe. One person said, "I feel safe with the staff". Without exception all the people and visitors we spoke with were sure they or their relative was safe at Annefield Grange. Staff said they would have no hesitation in reporting abuse and were confident the manager would act on their concerns. One care staff member told us, "We have done safeguarding training, I would tell the manager or could report to safeguarding". Another care staff member said, "I've not seen anything to cause me concern but if I did I would know what to do". All staff were confident senior staff would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. There were notices for staff about the procedures, including contact numbers for the local authority for reporting safeguarding matters. The manager overseeing the home was aware of the action they should take if they had any concerns or concerns were passed to them. They followed local safeguarding processes and had responded appropriately to allegations or concerns of abuse.

Staff showed that they understood people's individual risks and we saw that people's health and wellbeing risks were assessed, monitored and reviewed regularly. Individual risk assessments that identified potential risks for people had been completed and provided information for staff to help them avoid or reduce the risks of harm although the level of individual detail was minimal. People were supported in accordance with their risk management plans. Risk assessments were in place for moving and handling, mobility, fluid and nutrition, skin integrity and falls. Moving and handling assessments set out the way staff should support each person to move and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed support being provided in accordance with best practice

guidance. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, and people were assisted to change position to reduce the risk of pressure injury.

People were supported to continue some activities which carried a risk where this was their choice and would enhance their lives. For example, one person wished to continue to smoke cigarettes. This was documented in their care plan and staff supported the person to go outside whenever the person wanted a cigarette.

The provider had safe recruitment procedures in place, which included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed before new staff started working with people. New care staff confirmed that these recruitment procedures had been completed prior to them commencing employment at Annefield Grange.

Requires Improvement

Is the service effective?

Our findings

A training programme was in place although not all new staff had completed all essential training in a timely manner. The training programme included a mixture of on line computer training and practical training with a tutor. The manager was able to monitor training staff had completed on line. We viewed the individual training records for new and some existing care staff. Whilst many staff had undertaken all training, including updates as required, some newer care staff members who had been employed for over a month and were included in shift numbers, had not completed some essential training such as moving and handling training. This meant they would not be able to assist people who required support to move and may mean a delay in people receiving help.

We were told that new care staff completed an induction which covered a range of training including the Care Certificate if they did not already have a qualification in care. The Care Certificate is awarded to care staff who complete a learning programme designed to enable them to provide safe and compassionate care for people. Most care staff had obtained a care qualification. A care staff member told us, "We have lots of training; some of it is on line and some practical with a trainer". Other care staff also confirmed that they received plenty of training. A person told us staff used moving and handling equipment to help them get out of bed and told us they felt safe and, "They [staff] know what they are doing with it".

Staff were supported in their work through the use of one to one supervision and received an annual appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. The provider had identified a number of key skills such as medicines management or record keeping and developed a supervision programme for the coming year. This identified a specific area of practice to be assessed and reviewed with the staff member every two months. We saw that some supervisions had been completed however, not all staff had yet had a supervision during 2017. The manager was aware these were overdue and identified it as an area they were working on. We were subsequently informed that all staff had now received at least one supervision for 2017. We saw new staff had received frequent recorded supervisions throughout their first few weeks at the home. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One staff member told us, "If I had a problem, I would not need to wait for supervision I could go straight to the manager or owner." We saw staff were able to approach either senior staff or the manager to discuss any concerns on an informal basis in addition to the formal supervision sessions.

Most staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to 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. Most people at Annefield Grange did not have a cognitive impairment and were able to make all decisions themselves. Where people had some cognitive needs care plans contained information about what decisions they could make e.g. around where to sit and what meals to have. Where people may have lacked capacity to make some decisions this had not always been formally assessed and best interest decisions about their care made and documented,

following consultation with family members and other professionals, where relevant. For example, the decision to use bed rails or pressure relieving equipment which the person lacked the cognitive ability to understand and consent to. The manager overseeing the home was aware of the need to undertake assessments and best interest decisions and stated these would be undertaken where needed.

People told us they received the personal care they required in a way that met their preferences. One person told us, "I'm able to walk with a frame, the care staff are very helpful when you need it". At 11.30 a person said, "I had a lie in until now, I don't like getting up early". We heard care and other staff seeking verbal consent from people throughout our inspection. We saw staff offering day to day choices and making suggestions verbally to which most people were able to respond. Where people did make decisions these were supported. For example, one person had made a decision that they did not wish staff to use equipment to support them with moving and getting out of bed. The home had consulted with an Occupational Therapist to identify the most suitable equipment to use however, the person had decided not to use the equipment and therefore were cared for in bed.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met. We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary.

People received the personal care they required. One person told us "I'm due a shower; I'm looking forward to that". We saw that although people were allocated a bath or shower 'day' each week they did not have to keep to this. If they declined they were offered again at another time or day. Where requested people were able to bath or shower as frequently as they wished. Staff recorded the personal care they provided to people including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. For example, staff had identified a new medical concern for a person and ensured this was treated. The person told us about this and said, "I hadn't realised that it had become so bad". People were seen regularly by doctors, opticians and chiropodists as required. For example, care staff noted a person had a sore eye and arranged for them to see a doctor. The manager was aware of how to contact health professionals including home visiting opticians and dentists should these be required and people not be able to go out to clinics or surgeries. Should people require to be transferred to other care settings, such as hospital, the manager stated that a member of staff would always accompany the person. They explained this was to ensure essential information was provided to hospital staff and support the person in the unfamiliar environment. The manager said that copies of care plans and medicines information would be taken to the hospital by staff. This meant the person was supported and individual information which would be helpful to others who may be required to provide care could be passed on. We spoke with two visiting healthcare professionals who were complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

People received the appropriate amount of support and encouragement to eat and drink. Where people required full assistance we saw they were supported to eat and this was done in a kind, unhurried way. The staff member providing the support was talking with the person, encouraging them and asking them if they were ready for more. Staff were attentive to people and noted when people required support. We saw staff encouraging a person who was reluctant to eat and suggesting alternatives they may prefer. At lunch time

the dining room tables were nicely laid providing an inviting place to eat. People could choose where they sat and with whom. Lunch looked appetising and potion sizes were generous. Most people ate a good proportion of their meals. Individual food choices had been met, for example, some people had requested bread and butter with their salads and other people had a hot meal. The atmosphere of the dining room was relaxed and unhurried.

People were supported to have a meal of their choice. When asked about the food served at Annefield Grange people were all positive and confirmed choice was provided. One person said "I like the food here, its home cooked. I've put on some weight since I came in here". Another person said, "You can have a fried breakfast if you want". Whilst a third person said "I like ordinary food, its good here". Records showed people were provided with food when they wanted it and staff had provided people with food such as cereals, toast and sandwiches during the evening and overnight. Hot and cold drinks had also been provided. Staff told us they could provide people with food any time it was requested or required. Staff told us they had all the information they needed and were aware of people's individual dietary needs and preferences which were recorded in their care plans. People received varied and nutritious meals including a choice of fresh food and drinks. Snacks were available throughout the day including a bowl of fresh fruit people could help themselves from in the communal room.

Prior to registration of the home the provider had ensured that it was redecorated and adapted to meet the needs of people who would be living there. One person said, "It's a bit plain here, no homely touches". We saw the home was pleasantly decorated but there were no ornaments and many corridor walls were bare although others did have pictures and wall art. The home provided all bedrooms as ensuite and these were seen to be spacious and suitable for the person occupying them. Communal rooms, bathrooms and bedrooms were set over several floors with a platform lift or stairs providing access around the home. One person told us, "I can do the stairs to go down, but the lift's there if I need it". Another person said, "I use the lift, I can do stairs but stay safe". People were able to access external spaces and fresh air if they wanted to do so.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "We've got some very nice girls here helping us". Another person told us "My key carer is on nights, she's lovely". Whilst a third person said "I've got a favourite carer, she's very good". These comments were echoed by other people and visitors we spoke with. A visitor said, "The staff are always very nice to me when I visit". A visiting health professional told us, "They [care staff] seem caring and compassionate".

Interactions between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff did not rush people when supporting them. We heard good-natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. Staff spoke warmly about people and knew how to relate to them in a positive way. At handover staff were describing how a person had become upset when unpacking items relatives had brought in from the flat they had previously lived in. Staff described how they had encouraged the person to talk about the items and helped place these around the person's bedroom. They said the person had cheered up and staff understood why the person had become upset.

People's privacy was respected at all times. A person told us, "Staff knock on the door and ask if they can come in". Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. All bedrooms were for single occupancy and had ensuite facilities. This meant personal care could be provided in private. People were provided with a choice of the gender of care staff who supported them with personal care and specific preferences were recorded in care plans. Confidential care records were kept securely and only accessed by staff authorised to view them.

Staff treated people with dignity and respect and described the practical steps they took to preserve people's dignity when providing personal care. This included keeping people covered as much as possible and telling people what they were about to do. People told us staff always remembered to close curtains and doors before providing care. Staff were seen to respect people during interactions and people were offered the choice and informed before clothing protectors were used at lunch time.

People were supported to make choices and their decisions were respected. One person told us, "I like to stay in my room, but also like company so sometimes I'll go to the lounge". Another person said, "I prefer to eat my meals in my room". A third person commented "I like to stay in my room but it can be a bit lonely in here". We saw they were later encouraged to join an activity in the communal rooms. We heard staff asking people what they would like for their evening meal. One person requested an alternative not on the list and we saw this was provided. This showed people felt comfortable telling staff what they wanted.

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over. Plates with slightly higher sides, but which still looked like routine dinner plates were provided where necessary. This supported people to eat independently without appearing to be using specialist equipment. Care plans specified what people could do for themselves and what they needed help with. For example, in

one care plan we saw a reminder for care staff that the person could wash some parts of themselves but would require verbal prompts to do so.

When people moved to the home, they and when appropriate their families were involved in assessing, planning and agreeing the care and support they received. We saw one person had signed their initial care plan although others had not done so. Family members told us they were kept up to date with any changes to the health of their relatives.

Care files contained information about people's lives, preferences and what was important to them. Staff were able to tell us about people's life histories, such as their previous occupations. Annefield grange supported people to maintain family relationships. Staff responded promptly when a relative who was being cared for in another care facility requested a visit from a person living at the home. Staff rearranged things to enable the visit to occur. They later told us that the visit had gone well and they had informed the relative they would do this again if the relative was feeling well enough for a further visit. Care plans detailed any spiritual beliefs or needs a person may have and how they liked these to be met. The home had links with nearby churches and people were supported to attend services and social events there. The manager was aware of how to access religious leaders if required.

Requires Improvement

Is the service responsive?

Our findings

Care plans lacked clear and specific information as to how people who had behaved in a way that placed themselves or others at risk should be supported. We looked at the care plans for people who staff identified as placing themselves at risk. We saw risk assessments around behaviour were all similar and lacked specific detail or individual management plans. For example, there was no detail as to what may increase the person's risk of placing themselves or others at harm or how staff should respond. When incidents had occurred these had been documented but not in a format which would help identify future management plans. For example, there was no information about what had happened before the incident, or the outcome of staff interventions. One person was described in daily records as being agitated, on another occasion aggressive and in another entry as angry. However, there was nothing to explain how they were showing this, what may have led to this or what action staff had taken.

The lack of detail and recording of incidents meant that clear, individual plans for the assessment and management of incidents could not occur. This would lead to inconsistent responses by staff placing the person, other people and staff at risk. When we spoke with staff they were able to identify some of the higher risk times where individual people may become more unsettled. However, this information was not being recorded or used to support the people. For example, staff told us one person became unsettled during staff handovers in the evening as new staff arrived for duty and day staff went home. The person would sit in the home's foyer and therefore saw staff arriving and leaving. Action had not been taken to use the information about the person to formulate a planned intervention to reduce the risk of incidents. Action such as distracting the person from this area at this time such as taking them to the dining room or lounge for refreshments or an activity may have reduced stress for the person and prevented incidents.

When accidents occurred these had been recorded by staff however, it was not always clear what action staff had taken to monitor people for signs of deterioration. For example, one person had fallen and sustained an injury to the side of their head. Staff had correctly recorded this including a body map showing the site of the injury. However, there was no record of contact with external health professionals or monitoring of the person to ensure early detection of complications occurring following the injury. The provider had a specific form and short term care plan for such incidents although this had not been used. A senior care staff member who regularly led shifts told us they were unaware of these forms and that they had observed the person but no records of this had been completed. One person's care plan identified that they were at high risk of falls. We saw that they had had falls since living at the home however, there was no guidance in the care plan as to what action was being taken to manage or reduce the risk of falls.

The failure to ensure all reasonable action is taken to manage individual risks relating to the safety and welfare of people using the service is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014

Assessments were undertaken to identify people's individual support needs and care plans were developed, outlining how these needs were to be met. Care plans provided information about how people should receive care and support to meet physical health and mental health needs. The manager was in the process

of reviewing care plans and we saw that there were some inconsistencies between different parts of care plans. For example, one plan stated a person was fully continent; however their continence risk assessment stated that they were incontinent and aids were in use. However, people experienced care that was personalised and staff were aware of the care people required. Care staff described how they supported people which reflected the information in people's care plans and risk assessments. In some sections of care plans, such as personal care, there was a good level of individual detail as to how the person liked to be supported and what mattered to them. We saw one person had signed their care plan however, other people were less aware about their care plans. Each month named keyworkers reviewed the person's records for the month and wrote a monthly summary which included, for example, any medication changes or contact from health professionals. Keyworkers were a named member of the care staff team who had particular responsibilities for named people.

Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift, including, information about a person who had not eaten and drunk well. Visiting health care professionals told us staff noted changes in people's needs and contacted them appropriately. There were systems in place to respond to changes in people's prescribed medicines. The manager told us that they were able to obtain medicines promptly by collecting these from out of hours pharmacies meaning there would not be a delay in the person commencing treatment.

People received mental and physical stimulation in the form or organised and ad hoc activities. Staff had time to spend with people providing individual and group activities. Each morning and afternoon a designated staff member was responsible for organising an activity. There was a general plan in place but we saw this could be changed to suit the needs and wishes of people. For example, we heard one person had wanted to play scrabble and the planned activity was a reminiscence session. Staff responded by providing a scrabble game and then continuing with a reminiscence discussion. We also saw staff and people planting seeds and playing table top games. In addition to activities provided by staff an external music entertainer visited the home each fortnight. A person said, "You should have been here yesterday, we had a man singing, he was good, he's coming again". Another external activities provider also visited the home weekly providing a range of small group and individual activities. People were supported to go to the local supermarket, shops or café's and we saw several excursions with staff supporting people when this was requested. Two people were also supported to go swimming in the town's swimming pool each week. People commented that they would like to go out more and the manager said this was something that they would be looking to do in the warmer weather.

Each month the manager met individually with some people or, where more appropriate, with relatives to discuss their views about the service they were receiving. We saw the records of these meetings and people were all positive about the service they were receiving. Other formal systems to seek the views of people were not in place such as resident meetings or surveys. This was confirmed by people who were unaware of any resident meetings or surveys and a relative said, "I'm not aware of any meetings here".

People and visitors said they would make any complaints to the manager or senior staff. One visitor told us they had verbally complained to the previous manager about the cleanliness of some carpets. They told us, "The home owner had the carpets cleaned". We were told by one relative that they intended to raise a concern with the manager. This showed they felt able to discuss concerns. No one else we spoke with had ever had cause to formally complain. The manager told us people and relatives were informed about the complaints procedure when they undertook a pre-admission assessment and written guidance was also provided within the 'service user's guide' given to people or relatives. The complaints log was reviewed and

showed that no formal complaints had been received however, there were systems in place to deal with complaints if these occurred.

Requires Improvement

Is the service well-led?

Our findings

Shortly before this inspection the registered manager for Annefield Grange had submitted an application to CQC to cancel their registration as, although still employed by the provider, they were no longer working in a management role. The provider had arranged for the manager of a nearby home, also owned by them, to provide management oversight whilst a new manager was appointed. 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.

The management changes had occurred three weeks prior to the inspection and had resulted in the provider identifying that some management tasks had not been completed. This had included the home receiving a low food hygiene rating following an inspection by the environmental health inspectors. The manager providing oversight told us they had identified further areas where key tasks had not been completed such as weekly checks of fire detection equipment. The provider was acting to address these and other concerns. For example, we saw action had been taken to address the key areas within the kitchen where action had been required. However, there remained areas where further improvements were required. Risks posed by the stairs, garden and fire escapes were not safely managed. Some medicines were not stored securely and there was insufficient information to guide staff when they should give people some medicines. A training programme was in place although not all new staff had completed all essential training in a timely manner. The manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded. Where people placed themselves or others at risk there was a lack of detailed and prompt recording of incidents meaning information could not be used to reduce the risk of further incidents.

Records were not consistently maintained. Staff were recording the food and drinks received by some people. We saw that on several days immediately prior to the inspection these had only been completed in the morning. The failure to ensure these records were made promptly and fully meant other staff or health professionals would not be aware if the person had not received sufficient food or drink. The delay in writing records means staff may forget specific details and reports may therefore lack accuracy. When people are prescribed some medicines, such as for blood thinning due to a risk of blood clots there is a need for the person to have regular blood tests to determine if the person is receiving the correct amount of the medicine. Staff had failed to note that one person's blood test and prescription should have been reviewed one month prior to the inspection. The date for review was clearly written on the form which staff were using to determine the dosage they were administering on a daily basis. The person was therefore at risk that they had received the incorrect amount of medicine for the preceding month. We alerted the manager to this who took immediate action.

When the home was registered by CQC in October 2015 an assessment of the home was completed and this identified that the stairs may present a risk to some people due to their design as the treads narrowed when they turned corners. The provider had written to the registration team and agreed not to admit people living

with dementia to the home. However, we found that some people living with dementia and other cognitive impairments had been admitted by the previous registered manager. The provider told us they had been unaware that these people had been admitted and would ensure the new manager was fully aware of the need to ensure people were suitable prior to their being admitted.

Formal quality assurance systems were in place, however these had not always been completed by the previous management team. The manager was now reviewing and completing audits and told us they were identifying further areas for improvement. When we identified areas which could be improved the manager was receptive to these and where necessary took immediate action. A staff meeting had taken place at the start of March 2017. This had informed staff about management expectations and sought their views where necessary. Minutes of the meeting were seen and were available for any staff who had been unable to attend.

Staff were positive about the changes to the management of the home and told us the provider was now more often at the home and stayed for longer periods of time when they visited. Staff confirmed they felt able to raise concerns with the manager and the provider and said they had direct phone numbers if they needed to use these. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were informed about this and other staffing policies in a handbook provided to all staff. Staff felt able to make suggestions to the management team for the benefit of people. Links had been developed within the local community including primary schools from where local children had visited at Christmas to sing carols and churches.

People were positive about the home and care they were receiving. They said they would recommend the home. One person said "I would recommend it; you could get much worse than this". Another person said "I would recommend it here". Staff also said they would recommend the home and would be happy if a relative received care there.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to ensure risks relating to the safety and welfare of people using the service are assessed and managed and that all reasonable action is taken to ensure people's safety. Regulation 12 (1)(2)(a)((b)