Croftwood Care Ltd

Ancliffe Residential Care Home

Inspection report

Warrington Road
Goose Green
Wigan
Lancashire
WN3 6QA

Tel: 01942230439

Date of inspection visit:
03 December 2015
04 December 2015

Date of publication:
20 January 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 03 and 04 December 2015 and was unannounced. At our last inspection of Ancliffe residential home on 01 July 2014 we found the home to be meeting all standards that were inspected.

Ancliffe Residential Home is located in Goose Green, a residential area approximately one mile from Wigan town centre. It is situated in close proximity to bus routes, local shops and other public amenities. The home provides personal care to up to 40 older adults. Bedrooms are located on one level and the home is arranged around two courtyard gardens. At the time of our visit there were 40 people living at the home.

At the time of our visit there was a registered manager 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.

Staff and the relatives of people we spoke with told us they thought the service had a 'family atmosphere'. We received positive feedback about the staff and the registered manager from people living at Ancliffe and their relatives. Staff told us they would be happy for a friend or relative to move in to the home, and several people told us they had either recommended the home to others, or had had a family member stay at the home in the past.

Prior to the inspection we received positive feedback from the relative of a person formerly living at the home about the caring approach of staff and in relation to activities. There was an activities co-ordinator employed by the service and we saw a large number of people during the inspection were engaged in the activities that had been arranged.

We saw that people living at the home had formed friendships with each other and staff supported social interaction between people. For example, we saw a small group of people chose to eat together in a separate area of the home where they could look out onto one of the garden areas. On the day of the inspection it was one person's birthday and we saw people celebrate the occasion.

We found there were sufficient numbers of staff to meet people's needs in a timely manner on the day of the inspection. However, one staff member told us that not all the shifts were covered, and the rotas we looked at confirmed this. The registered manager told us on these occasions other staff, such as domestics would help provide staff cover if required, as they were trained to do so. Staff confirmed this was the case, although this was not recorded on the rota.

People had risk assessments in place to help ensure any risks were minimised. We saw appropriate actions had been taken to help ensure people's safety following falls. However, one person's file was missing a falls risk assessment, and another person's falls risk assessment had not been updated following a fall. The

registered manager told us these documents had been reviewed prior to the end of the inspection.

People told us they felt safe at the home. Staff had received training in safeguarding and were able to tell us how they would identify any safeguarding concerns. Medicines were stored and administered safely.

Some adaptations had been made to the environment to make it more 'dementia friendly'. This included pictorial signage and themed corridors. Staff were able to tell us how they would support people living with dementia effectively, despite only approximately half the staff being recorded as having received dementia training.

Staff had received training in a variety of areas such as infection control and first aid. However, no staff were recorded on the training matrix as having received training in the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). Staff showed a reasonable understanding of MCA and told us they had received training. The registered manager confirmed training had been provided in the past but was not recorded on the services' training matrix. They confirmed that further refresher sessions had been booked to cover this area.

We saw people's preferences; including preferences in relation to food were recorded. People we spoke with said they enjoyed the food provided. During the inspection we saw some people requested alternatives to what was recorded on the menu, and these were provided.

We saw people visiting throughout our inspection. Visitors told us they were always welcomed and said that communication with the service was good. There was a dining room, two quiet lounges, a main lounge and a separate visitors' lounge at the service. People we spoke with commented that the home was always very clean and was homely.

Staff talked to us about having a person-centred approach to providing care and support to people. Staff were able to give examples of how they accommodated individual needs and preferences of people.

People's care plans had been regularly reviewed and contained the information staff would need to support them effectively. This included information about social history and preferences.

Relatives and people living at the home told us they thought the home was well-led and that the registered manager was approachable. We received positive feedback about the service from a social care professional.

The service had not submitted notifications to CQC about safeguarding incidents as is required. This was due to a misunderstanding about when these notifications were required. This meant we would not be able to accurately monitor the home.

A range of audits were undertaken to help monitor and improve the quality and safety of the service. This included audits of infection control procedures, medicines and a provider audit.

Records did not always accurately reflect the current position of the service. For example, rotas did not always demonstrate if care shifts were covered, and training records did not show what training around MCA and DoLS had been undertaken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of staff to meet people's needs in a timely manner on the day of the inspection. Although rotas did not consistently demonstrate that all shifts were covered, the registered manager told us domestic staff were trained to cover care roles if required. Staff confirmed this was the case.

Medicines were stored safely and staff were aware of the correct procedures for administration.

Staff were aware of how to identify and report any safeguarding concerns. The registered manager had made referrals to the local authority safeguarding team when required.

Is the service effective?

Good

The service was effective.

People told us they liked the food and we saw individual preferences were catered for.

Staff had received training in a variety of areas including safeguarding, first aid, medicines and infection control.

There were some adaptations to the environment to make it more 'dementia friendly'. This included themed corridors and pictorial signs on doors. Approximately half the staff had received training in dementia, however all staff we spoke with demonstrated a reasonable understanding of how to support people living with dementia effectively

Is the service caring?

Good

The service was caring.

Relatives and staff we spoke with told us the home had a 'family atmosphere'. People living at the home told us they liked the staff.

There was a separate visitors' lounge with tea and coffee making facilities, where people could meet privately if they wished to do so. Visitors told us they were always welcomed, and family members said there was good communication from the home.

Staff we spoke with said they would be happy for a friend or relative to move to the home. Several staff said they had either recommended the home to people or had had a relative stay at the home.

Is the service responsive?

Good

The service was responsive.

There was an activities co-ordinator, and we saw a large number of people were engaged in activities.

We saw people had formed friendships whilst living at the home and staff encouraged social interaction between people.

Care plans contained the information staff would need to support people effectively, including information about people's preferences and social history. Care plans had been regularly reviewed to ensure the information was up to date.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Relatives and staff told us they thought the home was well-led, and said the registered manager was supportive and approachable.

The service had not submitted notifications to the CQC in relation to safeguarding as is a requirement.

Audits were carried out to help monitor and improve the quality and safety of the service. However, some records including; training and deployment of staff were not always accurate.

Ancliffe Residential Care Home

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.

The inspection took place on 03 and 04 December 2015 and was unannounced.

This inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service including notifications the service is required to send us about significant events, such as safeguarding and deaths. We also looked at any information we had received in the form of feedback left through 'share your experience' forms on the CQC website, or submitted to us by email.

Before the inspection, the provider 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 contacted the local authority quality assurance (PMMD) team for feedback as well as the local authority safeguarding team and a social worker with recent experience of the home.

During the inspection we spoke with eight staff. This included four care staff, the registered manager, the area manager, the activity co-ordinator and a domestic. We spoke with three relatives who were visiting at the time of our inspection and six people who were living at the home. 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.

We looked at documents relating to the care people were receiving. This included six care files and five medication administration records (MARs). We looked at other documents relating to how the service was run, including audits, rotas, training records, records of servicing and maintenance and five staff personnel files.

Good

Is the service safe?

Our findings

Everyone we spoke with living at Ancliffe Residential home told us they felt safe. One person said; "For me everything is alright and everything about the home makes me feel safe. They look after me and that is all that matters."

We asked people whether they thought there were sufficient numbers of staff on duty to meet people's needs. One person told us; "There are always enough staff about." One relative told us they visited regularly and always found there were sufficient numbers of staff. Another relative we spoke with said; "Sometimes they don't seem to have enough staff on, they've got too much to do." Three of the four staff we asked about staffing told us they thought staffing levels were fine, although one staff member said that some shifts were not always covered.

We looked at the staffing rotas and saw there were occasions where it appeared not all shifts had been covered. The registered manager told us all shifts would have been covered. They said many of the staff worked in dual roles, which allowed the service to use staff such as domestics, who were also trained carers, to provide support if required. Other staff members we spoke with confirmed this was the case.

The service was had not used a dependency tool to help determine how many staff were required to meet the needs of people living at the home at the time of our visit. However, we saw this was in the process of being implemented, and the tool had been partially completed. During our inspection we saw people's needs were met in a timely manner. There were periods when the lounges were left for short periods without staff cover, however we did not see this negatively impact on anyone living at the home. At one point we observed a person asleep in one of the smaller lounges that were less frequently visited by staff. We asked staff how this person could request assistance if it was required. Staff told us remote call bells would usually be made available, although this was not the case in this instance.

Care plans we looked at contained risk assessments, which would help the service keep people safe. These covered areas such as mobility, nutrition and pressure sores. Where people had been identified as being at risk, we saw there was clear guidance for staff to follow about how to keep people safe.

Where people had sustained falls, we saw the incident had been risk assessed and appropriate actions had been taken. This included post incident observations, immediate medical attention where required, referrals to other professionals such as the falls team, and the identification of strategies that may help reduce the risk of further falls. The area manager told us a falls risk assessment tool had been introduced and we saw this was in place in most people's care files. However, the falls risk assessment tool was missing in one care file of a person who had fallen. In another care file the falls risk assessment had not been reviewed following a fall. Other records indicated appropriate actions had been taken in relation to these incidents, and the registered manager confirmed actions had been taken to rectify the issues with these risk assessments during the inspection. We spoke with a relative who told us their family member had sustained several falls. They told us they had been kept informed of the incidents, and were satisfied with the actions taken by the home, which included re-assessment of this person's support needs.

We saw there were environmental risk assessments in place to help ensure that the building was safe. This covered areas such as the patios, which were often used by people living at the home, and the staircase leading to the first floor. These were reviewed at regular intervals and as recently as August 2015. A fire risk assessment had also been recently reviewed in October 2015. This took into account fire alarms, fire doors, fire exits and the use of oxygen. We saw that where any hazards had been identified, there were control measures listed about how to keep the building safe. There were also individual emergency evacuation plans (PEEPs) in place that would help ensure staff were aware of individual's support requirements in the event that an emergency evacuation of the building was required, such as in the case of a fire. We spoke with a staff member about evacuation procedures and they were able to provide a good level of detail on the procedures in place.

We looked at records of servicing and maintenance and saw the required checks had been completed and were satisfactory. This included checks of the gas, electrical installation, water system and lifting equipment. There was an up to date contingency plan in place that covered steps to be taken in the event of any emergencies that could prevent the provision of a safe service.

People told us they received their medicines as required. We saw medicines, including thickening agents and controlled drugs were stored safely. Controlled drugs are certain medicines that are subject to additional legal requirements in relation to their safe storage, administration and disposal. We looked at records of medicine administration and saw administration had generally been consistently recorded, although we saw there were two missing signatures on one person's record. We spoke with the team leader who told us they were aware of this and would be investigating this with the staff member. There were 'when required' (PRN) protocols in place, although we found these contained limited detail. When required protocols provide staff with information on when they should administer when required medicines. We asked a member of staff who administered medicines to talk us through the processes they followed. They were able to demonstrate an understanding of safe practices in the administration of medicines.

We reviewed staff recruitment records to determine if the provider had taken adequate steps to ensure staff were of suitable character to work with vulnerable adults. There were records of interviews, copies of application forms and references from former employees in staff files. Other required documents including identification and a record of a DBS (Disclosure Barring Service) check were in place. DBS checks highlight whether the applicant has any known criminal record or is barred from working with vulnerable people, which helps employers make safer recruitment decisions. There was not always documentation in place on staff files to evidence how the service had reached a decision to offer a position of employment where the application process had raised possible concerns. However, following the inspection the registered manager sent us evidence that demonstrated thorough consideration had been given to all information received in the recruitment process.

The registered manager kept a record of safeguarding referrals that had been made to the local authority. This demonstrated appropriate actions had been taken to ensure people's safety in the event of any concerns. The home had a copy of the local authority safeguarding policy and staff we spoke with were aware of how to identify potential signs of abuse or neglect, and how to report any concerns appropriately. Staff told us they would raise concerns with their manager or they could contact the area manager if needed. We reviewed training records and saw the majority (32 of the 37 staff) had completed safeguarding training in the past three years.

Good

Is the service effective?

Our findings

All the people living at Ancliffe Residential Home told us they liked the food and said they received ample amounts to eat and drink. One person told us; "The food suits me down to a tee and I have no complaints," and another person said; "You can always get something if you want it, the meals are very nice." A relative we spoke with told us; "[My family member] eats very well and gets plenty to drink."

We saw signs displayed advertising the availability of snacks for people living at the home. There was a regular drinks trolley that went round and people were offered a choice of drink and fruit or biscuits. We observed the mid-day meal and saw people were offered an alternative if they did not want what was on the menu. One person requested a strawberry mousse for dessert, and another person requested egg instead of what was on the menu and these were both provided. We also saw people were given a choice about where they wanted to eat and food preferences had been recorded on pre-admission assessments and in care plans. Staff we spoke with were aware of people's dietary needs and we saw people who required soft diets received these. People's dietary needs and allergies were displayed on a board in the kitchen to help ensure kitchen staff prepared people's food appropriately and in line with their dietary requirements.

We saw people received the support and encouragement they required to eat and drink during meal times. We reviewed the care plan and risk assessments in place for one person who staff told us had been identified as being at risk in relation to their nutrition. We saw their food and drink was prepared as detailed in the guidelines, and this person was supported. This person also required a member of staff to sit with them whilst they ate their food to ensure this was done safely. We observed this person at lunch time and saw this was provided for them. This persons care plan and risk assessment indicated this person's food and fluid intake should be monitored. We found this was not being done and raised this with the registered manager. The registered manager confirmed this would be put in place immediately. We did not see any evidence that this had impacted on this person's care and the service had taken other appropriate steps such as involving the individual's GP in reviewing their nutritional care.

We saw evidence of involvement with health professionals recorded in people's files. This included visits from the memory service, GP's, podiatrists and speech and language therapists (SALTS). Staff told us people's weights were recorded weekly. The records we reviewed showed weights were monitored frequently but were not consistently recorded on a weekly basis.

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 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.

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 were being met.

We found the registered manager was making applications to the supervisory body as required where it was identified that restrictive practice was required to ensure a person who lacked capacity was able to receive care and treatment in their best interests. We saw there was a prompt on the pre-admission assessment to ensure any requirement for a DoLS application was considered. Three of the applications submitted had been authorised by the supervisory body and we saw it was clearly identified on the front of these people's care files that there was a standard authorisation in place. Despite this, the staff we spoke with were unable to identify who had an authorised DoLS in place. This would make it difficult for staff to ensure they were providing lawful care in accordance with the DoLS and any conditions.

Staff we spoke with had a reasonable basic knowledge of the MCA and DoLS, although one member of staff told us they would benefit from MCA training more frequently. We looked at the training matrix and found no record of MCA or DoLS training, although staff told us they had received training. The registered manager told us an in-depth training session had been carried out around three years ago although this was not recorded. They also said the topic was discussed with staff. Following the inspection the registered manager confirmed dates had been scheduled to provide MCA and DoLS training in January 2016.

We asked staff how they would obtain consent from people before providing care to people. Staff told us they would always ask someone before providing care and would listen to what people told them. During the inspection we observed a person becoming upset and showing signs of anxiety when being supported with a hoist. Staff communicated clearly with this person and respected their wishes not to be hoisted at that time. We saw people's care plans contained consent forms, and some files contained two different copies of the consent form. The area manager told us that a new form had been introduced that prompted more frequent review to ensure it was up to date.

People spoke positively about the environment at the home. People told us they found the home to always be very clean. On the day of our inspection we found the home was clean and there were no-odours present. At the time of our inspection the home was decorated for Christmas celebrations, which along with decorations such as ornaments round the service, created a homely feel. A number of the residents commented on the Christmas decorations with one saying they were 'lovely'. Each person had a decoration on their door and we were told each section of the home had been separately themed. We were told relatives would be judging the decorations and that there would be a prize for the winners.
We saw some adaptations had been made to the home to make it more accessible to people living with dementia. This included pictorial signs on doors to bathrooms and communal areas and a large pictorial board informing people of the day, date and time. There were four areas of the home where people's bedrooms were located. These areas had been made more distinctive by each area having different colour bedroom doors, and a distinct theme. For example, one area was themed on the colour red and poppies. We saw some people's bedroom doors had their names on; however, other aides to help people locate their rooms such as memory boxes or photos were not in place. The home had two courtyard gardens, which we saw were accessible to people.

Staff we spoke with told us they had completed dementia training. They were aware of the ways in which dementia could affect the people they provided support, and were able to tell us techniques they could use to help provide effective support to people living with dementia. We looked at training records, which showed 18 out of 37 staff had completed dementia training (48%). Staff were able to tell about the techniques they would use, such as distraction and activities, to help provide effective support to people who may demonstrate behaviours that challenged the service. We received positive feedback from a social

care professional who told us the service had been particularly effective at supporting people with behaviours that challenged whilst more specialist long term placement had been sourced.

We reviewed the training matrix, which showed staff had completed training in; infection control, food hygiene, fire safety, medicines, moving and handling, and first aid. Four staff had completed training in end of life care and two people had completed challenging behaviour training. The registered manager told us senior care staff received additional training as it was more applicable to their role and they would cascade the learning to care staff. A large proportion of the staff also held a care qualification. Three of the staff we spoke with were satisfied with the training they received, although one staff member said they would benefit from more training.

We asked two people living at Ancliffe, and two visiting relatives whether they thought the staff were competent and able to meet people's needs. Everyone told us they did feel staff were competent. One relative said; "I think the staff are brilliant. Most of the girls have been here a long time."

Staff told us they received regular supervision from a manager and said they found supervision useful. We looked at supervision records and found that they took place on a consistent basis. We looked at a sample of these records and saw that topics of discussion included any staff issues, information sharing and any staff training and development requirements.

The service was implementing an induction programme following the care certificate standards. The care certificate provides learning outcomes against a set of identified standards that all health and social care workers should adhere to. We saw some of the areas covered in the initial induction included safeguarding, infection control, fire safety, moving and handling and health and safety. This would help ensure staff were equipped with necessary skills and knowledge to provide people with the care they required.

Good

Is the service caring?

Our findings

Without exception, we received positive feedback from people about the home and staff. Comments included; "I like being here, the carers are all nice;" "They're very good, very kind to you;" and ""They are very nice staff altogether." Relatives we spoke with were also complimentary about the service. They told us they were always welcomed to the home, had good communication from the home and had always found their family member to be well cared for.

One relative told us; "It is well run, it's the resident that's important". Another said; "We know [family member] is getting the care they need and we know when something happens." One relative said they thought the staff had 'the right attitude' and told us how staff had been very patient when providing support to their family member when they had first moved in. Everyone we spoke with told us they were treated with respect and kindness. We received positive feedback from a social care professional who told us they had always found the home to be warm and welcoming. They told us; "I have always found all the staff including management to be very supportive and caring at Ancliffe." Prior to our inspection we had received positive feedback from the relative of a person formerly living at Ancliffe commending the home on the homely environment and the staffs caring approach.

Staff spoke in a caring and respectful manner about the people they provided support to. When observing staff interactions we saw staff were polite and responded positively to any requests from the people they were supporting. Several of the staff, including the registered manager talked about treating people living in the home as family. One member of staff said people's relatives also felt like members of an extended family. Another said; "We're not just carers. People know us well." One relative we spoke with confirmed this and said; "There are better staff here [than a previous home]. It's like a family." They also told us there was a homely environment and that if they got old, they could live there. We asked staff if they would be happy for a friend or relative to live at the home. All confirmed they would, and many said they had either recommended the home to people, or had previously had family members who lived at the home.

We saw relatives were able to visit without restrictions throughout the day, including at meal times. There was a separate lounge with tea and coffee making facilities where people could choose to meet their visitors privately should they so wish. We saw people were able to move around the home freely, and there was a main lounge, as well as two smaller 'quiet lounges', where people could choose to sit. All the people we spoke with told us they were encouraged to be as independent as possible, and appreciated this. We saw examples of staff encouraging independence over the meal times, such as staff enabling people to eat independently. One staff member told us they would support people to be as independent as possible by getting to know them and seeing how much they could do for themselves. One example they gave was in supporting people to be as independent as possible when providing support with personal care.

We saw that people had specific communication care plans in place. This was an area that was also covered during the initial assessment process. These care plans took into account people's speech, hearing, vision and any equipment they required to aid communication. For example, one person was described as needing hearing aids and needed to wear them all times. We observed this person had their hearing aids in

during the inspection. Another person's care plan stated they needed staff to speak to them on their right hand side. However, during the lunchtime meal staff were seen to be sitting on this persons left hand side, and we observed this person was struggling to hear what was being said.

Staff told us they would involve people in developing their care plans by sitting with them if they were able to contribute this way. Staff said they also involved families where appropriate, and one of the family members we spoke with confirmed they had taken part in reviews of their relative's care.

People told us the staff listened to what they said, although they did not always have time to chat. It was apparent from discussions with staff that they knew the people they were supporting well. The registered manager told us agency staff were not used, and that this helped provide consistent support to people. Feedback from the social care professional we contacted was that the registered manager also had an 'in-depth knowledge' of the people living at the home.

Good

Is the service responsive?

Our findings

The home employed an activities co-ordinator and we saw a large number of people participating in activities during the day. The activities we observed included arm chair exercises during the morning and a quiz with people enjoying mince pies and a shandy in the afternoon. We also saw displayed the activities scheduled for December which included; a luncheon club, dominoes, bingo and numerous birthday celebrations. The home was located next to a church and we were told that people frequently attended services. One person had a birthday on the day of the inspection and we saw that staff sang happy birthday to them and presented them with a gift from everybody living at the home during lunch.

People told us they had enough to keep them occupied, and said that although staff were busy, they did spend time when they could to chat with them. During our inspection we saw staff spent time talking with people, including a staff member who was sitting and reading the paper to one person. We saw people living at the home had formed friendships with other people living there, and social interaction was encouraged by staff. For example, we saw one person was encouraged to sit next to a person whom they then chatted with, and who told them jokes. We also saw three people ate lunch together in a separate dining area. These people talked to us about the courtyard garden areas, which they told us they had helped maintain in the summer. There was also a bird-table visible in the courtyard garden that was discussed by these people with interest. The activities co-ordinator told us when possible they would accompany people to the community to places such as the local garden centre. They also told us they would spend time one to one with people who chose to stay in their rooms if this is what they wanted.

Staff had a person centred approach towards providing care and support to people in the home. One staff member said; "'It's a home away from home. That's how it should be. Why should they have to change just because they come into care?" We asked staff if they could give us examples of the ways in which they had worked around the needs and preferences of the people they provided support to. One staff member told us one person liked to eat their mid-day meal at a later time and they were able to do this. Another staff member told us about how they met people's preferences around snacks and drinks before bed. They also told us one person liked having their nails done, and another person liked having a foot spa. The staff member told us the service had worked to enable people to continue to engage in such routines and preferences when they had moved into the home.

We saw people had been able to personalise their bedrooms with their own decoration. The home told us in the provider information return they sent us that they were a member of a charity that aimed to enable people to stay with their pets when they moved out of their homes. At the time of our inspection there was a person who had a small dog who was living at the home.

We saw preferences were recorded in people's care files and were considered during pre-admission assessment. Details were also recorded about people's past experiences, including employment, favourite holidays and school attended. People told us they were able to make choices including what they wore, and what time they got up or went to bed. Staff told us people were free to choose when they went to bed and when they were supported with bathing.

Each care file contained a care plan called 'my life plan', which covered support needs in relation to a range of areas including hearing, communication, vision, mood/behaviour, mobility, continence, toileting, bathing/showers, pain control and nutrition. Staff told us they were given time to read people's care plans and assessments prior to working with them. Staff also told us the registered manager had started holding meetings with the staff to discuss the support needs of any person moving into the home, which they said had been useful in getting to know people and understand their needs.

The care plans we looked at showed evidence of having been reviewed regularly. Generally the care plans contained a good level of detail that would allow staff to provide people with the support they required in accordance with their preferences. We found one file lacked detailed guidance for staff in relation to a particular aspect of their care. However, the staff we spoke with and observed providing this person's support demonstrated a good understanding of their support requirements.

The registered manager told us the home had not received any recent complaints. The relatives and people we spoke with said they did not have any complaints, but would feel comfortable raising one with the registered manager or staff should they feel there was a need. Staff we spoke with told us they would try and put things right if there were any smaller complaints, and would record and pass any more serious complaints to the registered manager.

We saw there was a comments and suggestions box in a communal area of the home. The registered manager told us surveys of residents and relatives had also been completed between August and November 2015. We looked at a selection of the feedback and found it was all positive. The registered manager was in the process of completing a report of the findings of the survey, and sent us the completed version following our inspection visit. This would help the registered manager identify any areas where improvements could be made within the service.

We looked at the minutes from the last residents meeting in September 2015. The meeting appeared to have been well attended by people who lived at the home. This provided an opportunity for people to raise concerns or state how they may like to improve areas within the home. We saw that topics discussed included food menus, laundry services, trips out and upcoming events or entertainment at the home.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager 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.

The registered manager had been in post for several years and spoke about the home being a part of the community. They told us they felt well supported, but were also allowed the flexibility to run the home in a way that could meet the needs of local people. They told us the home put on events such as fairs, which the local community were invited to, as well as making use of local amenities such as social clubs and the church.

All the people and relatives we spoke with during the inspection told us they thought the home was well-led. Relatives and staff told us the registered manager was approachable, and operated an 'open-door' policy.

Staff told us they worked well together as a team, and said they received the support they needed to perform their role effectively. They told us management were fair to staff working there. Staff told us they thought Ancliffe was a 'good home' that was well-led. We received a mixed response when we asked staff if they felt valued for the work they did, although staff said they felt they were listened to. Prior to the inspection we had received positive feedback about the service from the relative of someone who formerly lived there. We had sent this to the registered manager and saw they had printed off and displayed this for staff to read.

Before the inspection we reviewed the notifications the service had sent us. Services registered with CQC are required to send us notifications of significant events including deaths, incidents involving the police, serious injuries and safeguarding concerns. The registered manager had sent us notifications in relation to deaths and serious injuries. However, there were no notifications in relation to safeguarding. When we reviewed safeguarding records at the home, we saw five concerns had been notified to the local authority but not to CQC as is required. This meant we would not have all the information we needed to help enable us to monitor the service appropriately. The registered manager said there had been no further investigation of the incidents by safeguarding, and they had not been clear at what stage notifications were required.

We recommend the provider reviews CQC guidance on the submission of statutory notifications.

There were systems in place to enable the monitoring and improvement of the quality and safety of the service. The areas covered in audits included infection control, medication, kitchen practices and the environment. We spoke with a member of staff on domestic duties who was aware of actions that had been identified in the infection control audit in order to improve standards of cleanliness around the home. There was also a file that provided a high level overview of accidents and falls occurring each month in the home. Care plans were audited on a regular basis, and we saw people's files contained a 'life plan audit'. This helped ensured that information within care plans was reflective of peoples care needs and that any

discrepancies were identified. However, these audits had not identified the lack of a falls risk assessment in one person's care file, or the lack of an update to the falls risk assessment for another person as discussed in the 'safe' section of this report.

There was a regular audit of the home carried out by the area manager and we saw feedback and areas for improvement were fed-back to the registered manager. The registered manager and area manager discussed how these audits had led to improved systems within the home. The registered manager also visited the home at night to carry out checks to ensure standards were still being adhered to.

The area manager showed us an electronic system that was used to enable the monitoring of aspects of service delivery such as complaints, incidents and training. However, we found the training record at the service did not cover all areas of training such as training in MCA and DoLS, which was not reflected on the matrix despite staff telling us they had undertaken this training. We also found the rotas did not always accurately reflect the shifts that had been worked by staff. Although an electronic record was available of hours worked by staff, this did not reflect if a staff member for example, had swapped from a domestic to a care role if this had been required.