Anchor Trust

Thomas Henshaw Court

Inspection report

105 Norwood Road
Southport
Merseyside
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Website: www.anchor.org.uk

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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?	Good

Summary of findings

Overall summary

This unannounced inspection of Thomas Henshaw Court care home took place on 31 March 2016.

Thomas Henshaw Court is a purpose built care home located in its own grounds in a residential area of Southport. It can provide accommodation for up to 44 people in self-contained flats, each of which has an en-suite bathroom and a kitchenette. There is wheelchair access throughout the building. The home is located close to local shops and is near to bus links for access to Southport town centre and surrounding areas.

There were 39 people living at the home when we carried out the inspection.

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

People said they felt safe living at the home and were supported in a safe way by staff.
The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported. Staff confirmed they had received adult safeguarding training. An adult safeguarding policy was in place for the home and the local area safeguarding procedure was also available for staff to access.

Staff told us they were well supported through the induction process, regular supervision and appraisal. The deputy manager advised us that staff supervision was not up-to-date due to changes in staffing but said they were working to rectify this. Staff said they were up-to-date with the training they were required by the organisation to undertake for the job and training records confirmed this.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. People living at the home and staff told us there was sufficient numbers of staff on duty at all times.

A range of risk assessments had been completed depending on people's individual needs. Care plans were well completed and they reflected people's current needs, in particular people's physical health care needs. Risk assessments and care plans were reviewed on a monthly basis or more frequently if needed.

Safeguards were in place to ensure medicines were managed in a safe way. Medicines were administered individually from the medication trolley to people living at the home. Checks and audits were in place to monitor that medicines were managed in accordance with the home's policy and national guidance.

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment and equipment. A refurbishment programme was in place to up-grade the bathrooms in each

of the flats.

People's individual needs and preferences were respected by staff. They were supported to maintain optimum health and could access a range of external health care professionals when they needed to. Staff had a good understanding of people's needs and their preferred routines. We observed positive and warm engagement between people living at the home and staff throughout the inspection. A full and varied programme of recreational activities was available for people to participate in.

People told us they were satisfied with the meals. We observed that people had plenty of encouragement and support at meal times if they needed it. People living at the home and their families were invited to three monthly meetings to review the menus.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the Local Authority.

People described management and staff as caring, respectful and approachable. People said the service was well managed and they said their views were sought about how to develop the service.

The culture within the service was and open and transparent. Staff and people living there said the management was both approachable and supportive. They felt listened to and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it. Opportunities were in place to address lessons learnt from the outcome of incidents, complaints and other investigations.

A procedure was established for managing complaints and people living at the home were aware of what to do should they have a concern or complaint.

A wide-range of comprehensive audits or checks were in place to monitor the quality and safety of care provided. These were used to identify developments for the service.

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.

Relevant risk assessments had been undertaken depending on each person's individual needs.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Safeguards were in place to ensure the safe management of medicines.

Measures were in place to regularly check the safety of the environment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

People told us they liked the food and got plenty to eat and drink. They told us they had the opportunity to influence changes to the menus.

People had access to external health care professionals and staff arranged appointments readily when people needed them.

Staff said they were well supported through induction, supervision, appraisal and on-going training.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received. We observed positive engagement between people living at the home and staff. Staff treated people with privacy and dignity. They had a good understanding of people's needs and preferences.

Effective individual communication plans were in place for people associated with communication.

People told us the registered manager and staff routinely communicated with them about any changes and involved them in reviews of their care.

Is the service responsive?

Good

The service was responsive.

People's care plans reflected their current needs. People said the care was individualised and care requests were responded to in a timely way.

A full and varied programme of recreational activities was available for people living at the home to participate in.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Good

The service was well led.

People living at the home said they were included in discussions about developments to the service.

Staff spoke positively about the open and transparent culture within the home. Staff and people living there said they felt listened to, included and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Processes for routinely monitoring the quality of the service were established at the home.

Thomas Henshaw Court

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 team consisted of two adult social care inspectors

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR 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 also looked at the notifications and other intelligence the Care Quality Commission had received about the home. We contacted the commissioners of the service to see if they had any updates about the home. They expressed no concerns about the service.

During the inspection we spent time with seven people who were living at the home. We also sought feedback about the service from two health care professionals who were visiting people at the time of our inspection. We spoke with a total of seven staff, including the deputy manager, administrator, two team leaders, a cadet, a member of the catering team and the activity coordinator.

We looked at the care records for four people living at the home, four staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms and the lounge areas.

Good

Is the service safe?

Our findings

People we spoke with told us they felt secure living at the home and were supported in a safe way by the staff. A person said, "I do feel safe here but there are some people here who go in the wrong rooms and I don't like that." A visiting professional told us, "[Person] asked to come here because he is so well looked after. [Person] is kept safe here."

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported. Staff confirmed they had received adult safeguarding training and records we looked at confirmed this. An adult safeguarding policy was in place and the procedure for reporting any concerns was displayed for staff to access.

A team leader provided us with an overview of how medicines were managed within the home. We looked at the medication room, which was locked at all times when not in use. The medication trolleys were also locked and secured by a chain to a solid wall. Appropriate written guidance was available and we were told only senior trained staff were allowed to administer medication. Room and fridge temperatures had been recorded daily and we noted that at times. The room temperate was slightly over the recommended 25°C. We raised this with a senior member of staff who assured us she would look into it. Hand wash facilities were observed in the medication room.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We looked at the records for two service user who required controlled drugs and we observed that the medication was in stock. An effective system was in place to ensure the controlled drugs were regularly checked, counted and recorded.

We observed the morning time medicines being given out. People were asked if they were ready for their medication and staff observed while they took it. Drinks were offered with the medication. We checked a selection of medication administration records (MAR) and they were appropriately completed. Each MAR contained the contact details for the person's GP along with any specific advice for administration based on the person's identified need.

We looked at the personnel records for four members of staff recruited in the last year. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff.

We asked people their views about the staffing levels at the home and besides one person suggesting the home would benefit from more staff, all the other people we spoke with said there were plenty of staff on duty at all times. A person said, "There are always staff around and they come quickly when you need something. I don't have to wait long." Another person said, "The staff here are very good but at times I think there isn't enough of them."

The staff we spoke with said there was sufficient staff on duty to meet the needs of the people living there. We observed plenty of staff on duty during the inspection. We noted that staff were regularly checking on people in the various lounge areas and they responded to requests for support in a timely way. We observed people getting support with their lunch in a timely way. There was a calm and unhurried atmosphere and people were not rushed when being supported by staff.

The care records we looked at showed that a range of risk assessments had been completed and were regularly reviewed depending on people's individual needs. These included a falls risk assessment, lifting and handling assessment, nutritional and a skin integrity assessment. Care plans had been developed based on the outcome of risk assessments and they provided good detailed guidance for staff on how to support each person thus minimising the risks.

A process was in place for recording, monitoring and analysing incidents. A structured and detailed monthly analysis of falls was undertaken by the registered manager that took account of the time and location of the fall. We looked at the analysis for January and February 2016 and could see the approach lent itself to the identification of themes and patterns in relation to falls.

We had a look around the home including some bedrooms and observed that the environment was well maintained and clutter free. Equipment was clean and in good working order. A call-bell system was in place in the bedrooms and it was checked regularly. Systems were established for checking the safety of the water, fire systems, emergency lighting and equipment. Service level agreements were established for moving equipment, heating, lighting, electrical and gas checks. The records for the checking and servicing of equipment, including portable electrical appliances were up-to-date. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home so that they could be evacuated safely and efficiently in the event of an emergency. These were located in the foyer.

Good

Is the service effective?

Our findings

We had lunch with people in the dining room. Twenty five people had their meal in the dining room and others opted to have their meal in their flat. Six members of staff were available in the dining room to serve the meals and support people if they needed it. All staff wore protective clothing including aprons and gloves. Staff members interacted well with people and enquired politely if they were satisfied with their meal. Not many people needed support to eat their meal as it appeared people were able to eat their meals independently. However, staff did encourage people to eat if they needed it.

Hot and cold drinks were available and staff offered them to each person in turn. The atmosphere was relaxed with music on in the background. People were given a choice of meals, deserts and drinks. A menu was on the wall as people entered the dining room. We were told if people did not like what was on the menu then an alternative could be prepared for them. However, the majority of people were satisfied with the meals. A person said, "The food is always lovely and you get plenty." Two choices of main meals and deserts were provided. We did not notice much wastage of food, which is often a good indicator that people enjoyed the food.

The people we spoke with all told us they had access to health care services when they needed it. This included visits from or to the GP, chiropodist or district nurse. A person said, "You couldn't get better carers. Whoever you need to see [health professionals], they arrange it all for you. "We could see from the care records that staff were pro-active in referring people to health care services if they needed it. People's weight was monitored on a regular basis and we could see that any significant weight changes were addressed, such as a referral to a dietician. A visiting health care professional said to us, "Staff telephone us with any concerns. They do listen to us and follow any instructions we give them."

Many people were independent and freely left the building when they wished to go shopping or to visit local facilities. Some people needed support from staff and we heard staff encouraging and prompting people with decision making regarding their care needs. Before providing support, we heard staff explaining what they were going to do in a way the person understood.

Although the home was not specifically for people who lacked mental capacity, the deputy manager explained that some people had developed over time needs associated with their memory and decision making. Therefore, we looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

Deprivation of Liberty Safeguards (DoLS) had been submitted to the Local Authority for some of the people

living at the home. One DoLS had been authorised and some were awaiting a DoLS assessment. Through conversation with us, staff demonstrated a good awareness of the principles of the MCA.

Decision-specific mental capacity assessments had been undertaken for the people who had a DoLS authorisation request in progress. Mental capacity assessment had been carried out for people who lacked capacity to consent to their care and we could see that families had been involved in any discussions and agreements regarding care.

Staff told us that people's wishes regarding their end-of-life care were known, including their decisions about resuscitation. We could see that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for some people. These were in accordance with the MCA and had been coordinated by the person's GP.

We spoke with staff who were in the process of a completing their induction. They were pleased with the support and training they were receiving. A member of staff said, "I am doing my induction now and I have been so well mentored. The training has been really great; I've enjoyed it." They told us the induction was thorough and included completing an induction handbook and shadowing a more established member of staff until they felt confident enough to work independently.

All the staff we spoke with all told us they had received regular supervision and had an annual appraisal. A member of staff said, "We get supervisions about every two months. I've just had one as a matter of fact." The deputy manager advised us that staff supervisions were not as up-to-date as they should be due to a recent shortage of staff. They were working on bringing the supervisions up-to-date.

Records confirmed that staff were up-to-date with training the provider required them to complete for their role. Training included food hygiene, moving and handling, first aid and health and safety. Monthly checks were carried out to ensure staff were on target with training.

Good

Is the service caring?

Our findings

People living at the home spoke positively of the staff and the way staff interacted with them. They told us they were treated with dignity, and staff respected their privacy. A person told us, "The carers can't do enough for you. You only need to ask for something and it's done for you." Another person said, "You always see the carers sitting and chatting with people, and they take the time to listen to what you say." People told us their families and friends could visit whenever they wished.

Through conversation it was clear they had a good understanding of people's individual needs and preferences. The staff we spoke with demonstrated a warm and genuine regard for the people living at the home. There was a calm atmosphere throughout the inspection. We observed a positive and on-going engagement between people and staff. We heard staff calling people by their preferred name and supporting people in an unhurried, caring and respectful way. They knocked on people's bedroom doors before entering. Staff conversed with people while supporting them with care activities. We heard staff explaining to people what was happening prior to providing care or support.

Staff told us that people's needs were discussed with them each month. A member of staff said, "All residents have a monthly meeting with their keyworkers and we talk to them about their needs and whether there is anything more we can do for them." A visiting professional told us, "All the staff are very patient and respectful towards all the residents and they are always doing nice things for the residents."

From the care records we looked at we could see that staff routinely communicated with people living at the home or their families in relation to care needs. People or a family representative was involved in the initial assessment of need, the development of care plans and the regular care reviews.

Communication plans were in place for the people that needed them, which meant there was guidance in place for staff to communicate with people who had needs in this area. Because the home accommodated some people who were visually impaired, many notices and documents were displayed in large print. A person had needs associated with both vision and hearing. Staff were using a specific form of communication to support the person to make decisions, such as what to choose from the menu or to explain the activities taking place. All staff were aware of this method of communication.

For people who had no family or friends to represent them, local advocacy service details were held by the manager and available within the home for people to access.

Good

Is the service responsive?

Our findings

The care plans we looked at were comprehensive and focused around each person's specific needs. For example, some people used mobility scooters to get about, maintain their independence and access the local community. Arrangements were in place to support each person with the safe use and storage of their scooter. Good detailed person-centred information was in place for a person on an end-of-life pathway that centred around their specific needs and that of their family. Any health concerns were responded to promptly. For example, if a person was unwell then staff contacted the relevant health professional and informed the family in a timely way.

The care records we looked at contained a document titled 'About Me'. These provided good background information so that staff gained a good understanding about people's backgrounds and likes/dislikes. They took into account people's preferences, including preferred times to arise and retire, and preferred leisure and social activities.

We spoke to people in their bedrooms and could see that the rooms were personalised to each person's taste. People told us they were encouraged to bring in some of their own items, such as wall pictures, ornaments and furniture to create a homely feel.

The home employed an activities coordinator. From our discussions with people living at the home, we heard there were plenty of varied activities held on a regular basis. The planned weekly activities were displayed in the foyer. People we spoke with said there were plenty of varied activities for them to choose from. Others were not keen to participate in activities and said staff respected this. Some people liked to go out on a regular basis so had free access in and out of the home. People living at the home told us they had enjoyed a recent holiday in North Wales.

People living at the home that we spoke with were aware of how to make a complaint. We observed that the complaints process was displayed in the foyer. A person said to us, "If I had to complain, and I never had, I could talk to any of the staff." In relation to making a complaint or raising a concern, a visiting professional told us, "I have been coming here awhile now so I know most of the staff and would feel comfortable talking to any of them."

A process was in place to seek feedback about the service. This was in the form of a questionnaire. A person said to us, "We get asked our opinion all the time. Me and [their relative] have both done surveys recently." Staff were aware that views of people were sought regarding the service. A member of staff said, "Anchor send out surveys to families and professionals every year. I think one has just been sent out."

People also told us they could express their views about the service through regular meetings for the people living there and their families/representatives. A member of staff said, "We hold regular meetings for the residents and if they have any suggestions we do listen."

Good

Is the service well-led?

Our findings

A registered manager was in post. They were not available on the day of the inspection.

People told us the registered manager and staff were very approachable and that they felt their views were listened to. A person living at the home said, "I talk to the manager every day. She is always around so people can talk to her anytime." Another person said, "The manager has been up here a few times to see my new kitchen. She comes up a lot." Equally, professionals expressed satisfaction that they could approach the manager at any time. A professional said, "The manager is easy to talk to and listens. She is keen to see how the service can be improved."

A refurbishment plan was in place to upgrade the bathrooms in all the flats. People told us they were pleased they had been involved in the process and that their views had been sought.

Various approaches were in place to seek feedback about the service from people and their families and to include them in service developments. For example, chef consultation meetings were held every three months to discuss the menus. A complaints/compliment book was located in the dining room for people or their families to provide feedback on the meals. The registered manager or another member of staff also participated in a 'Dining room experience'. This meant the registered manager had lunch with the people living there to test the quality of the food.

General meetings for people living at the home took place on a three-monthly basis. We looked at the minutes from the 3 March 2016 and could see that people living there were reminded of the fire procedure and the safe storage of walking aids. Other topics for discussion included, new staff joining the team, involving people living at the home in the recruitment process and an update on the refurbishment of the bathrooms.

We also asked staff their views of the leadership and how the home was managed. The feedback was positive and staff said they felt supported and involved. They said communication was good and they received feedback, especially regarding the outcome of incidents. A member of staff said, "We have meetings for team leaders and carers. We have got one next week and staff do speak up about anything." Another member of staff told us, I would not have any problems raising a concern or complaint with the manager because her door is always open." Records confirmed that regular meetings were held for team leaders, night staff, care staff along with an annual general staff meeting. In addition, health and safety meetings were held every three months. We looked at the minutes from 23 March 2016 and could see that staff training was considered and lessons learnt from incidents were discussed.

Staff told us an open and transparent culture was promoted within the home. They said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. All the staff we spoke with said they would feel comfortable questioning practice. They were confident the registered manager would be supportive of them if they raised concerns. A member of staff said, "I know about whistle blowing and if I needed to use it I would."

A range of audits or checks were in place to monitor the quality and safety of the service. The audits we looked at included, an infection control audit, healthcare waste audit, audit of pressure area care management, medication audits and care plan audits. All these audits took place in accordance with the requirements of the provider and included action plans if any deficits were identified. We noted that a small number of care reviews had not taken place in accordance with policy. This had not been picked up on audit. The deputy manager showed us a new audit format that had been introduced. This was much clearer in the way care reviews were checked. Despite this, a visiting professional told us, "The records and care plans are really good. You can tell they get reviewed. They are kept up to date which helps."

The provider (district manager) carried out a monthly audit of the service. We looked at the audits from January to March 2016. They covered a wide range of topics, such as staff training, complaints, recruitment and incidents. This showed that there was an additional higher level of monitoring to check the quality and safety of the service.

The registered manager ensured that CQC was notified appropriately about events that occurred at the home. Our records also confirmed this.