Anchor Trust

St Anne's - Saltash

Inspection report

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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?	**Outstanding**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This was an unannounced inspection, carried out over two days on 17 and 18 November 2014

St Anne's provides accommodation for up to 33 older people who require support in their later life or are living with dementia. There were 33 people living at the home when we visited.

The home is a modern purpose built property. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The home has 33 single bedrooms all with kitchenette and en-suite facilities.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We last inspected St Anne's in October 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

People were protected from avoidable harm and abuse that may breach their human rights. Staff understood how the mental capacity act and deprivation of liberty safeguards protected people to ensure their freedom was supported and respected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's medicines were managed well which meant they received them safely. Where able, people were empowered to take responsibility for their own medicines.

People were supported by sufficient numbers of staff who had the knowledge, skills and experience to carry out their role. The registered manager provided support, training and development opportunities for staff. Staff were aware of people's individual nutritional needs and drinks were available at all times. People could access health care services and were empowered to be involved with external health care professionals. The registered manager had systems in place to ensure staff shared information about people's health care. This encouraged effective communication, and meant staff were pro-active in meeting people's needs.

People were supported by staff who promoted and showed positive and inclusive relationships. Staff were kind, caring, compassionate and tactile in their interactions with people. Staff were considerate and respectful which helped to ensure people's privacy and dignity were promoted. People were encouraged to be actively involved in the running of the service. Their views were valued and used to facilitate change. The registered manager and provider welcomed feedback to enable learning and improvement. For example, complaints were considered positively, people were encouraged to attend residents' meetings and participate in interviewing staff.

People received care which was personalised to their needs. Care plans and risk assessments did not always give clear direction to staff about how to meet a person's needs. However, from our observations and conversations with staff it was clear they were knowledgeable about people. Care records demonstrated people were involved in creating their own care plans.

People were encouraged to continue their interests and take part in social activities. Staff recognised and understood people's individuality and social engagements were tailored to suit.

People were able to request the support of an advocate to represent their views and wishes, and the registered manager attended meetings with the local advocacy service to help promote positive relationships.

The registered manager and provider promoted a positive culture that was open, inclusive and empowering to people, staff and visitors. The internal and overarching quality monitoring systems in place helped to ensure continuous improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff could identify the signs of abuse, and knew the correct procedures to follow if they thought someone was being abused.

People's day to day lives were not restricted, as effective systems were in place to manage risks to people.

People's medicines were managed safely and, where possible, people's independence with their own medicines was promoted.

Good

Is the service effective?
The service was effective.

People received care from staff who were trained to meet their individual needs.

People were supported to eat and drink, and any associated risks were effectively managed.

Staff had good systems to help them quickly identify any changes in a person's health or wellbeing.

People could access appropriate health, social and medical support as soon as it was needed.

Good

Is the service caring?
The service was caring.

Staff were motivated and inspired to deliver kind, compassionate and tactile care.

People, visitors and families were treated with dignity and respect. People's feedback and contributions were valued.

An advocacy system was available for people if they wanted independent representation.

People could choose to participate in activities which were designed in line with individual preferences.

Outstanding

Is the service responsive?
The service was responsive.

Care plans were individually reviewed and involved the person.

Staff communicated with each other and external professionals to make sure people's health and social care needs were met.

Staff recognised a person's individuality when providing care and support. People were part of the wider community.

People felt confident to complain and had experienced positive resolutions.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led.

The provider's values and philosophy were used to promote a positive culture.

People's feedback was valued and used to facilitate change. There was a clear management structure in place and staff were valued.

The registered manager monitored incidents and risks to ensure care provided was safe and effective. The registered manager was pro-active in working with external professionals to ensure people received co-ordinated care.

St Anne's - Saltash

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We visited the home on 17 and 18 November 2014. Our first visit was unannounced and the inspection team consisted of an inspector and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service. On the first day of our visit to the home we focused on speaking with people who lived in the home and their visitors, speaking with staff, observing how people were cared for and examined care and management records. We returned to the home the next day to look in more detail at some areas, speak with the registered manager in further detail and to complete the review of staff records and records related to the running of the service.

During our visit, we spoke with nine people living at the home, four relatives, two care managers, one team leader, three care staff, one activities coordinator, two housekeeping staff, and one chef. We also spoke with, the registered manager, the district manager, the dementia care advisor/ regional support manager. We observed care and support in communal areas, spoke with people in private and looked at the care records for five people. We also looked at records that related the home's management. We looked at four care plans, policies and procedures, staffing rotas, the complaints file, three staff files, and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. After the inspection we contacted local commissioners of the service who funded people who lived at St Anne's to obtain their views. We made contact with four GPs, two social workers, one community psychiatric nurse, one Parkinson's nurse, the dental service, and one mental health/best interest assessor.

Is the service safe?

Our findings

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People told us they felt safe and would feel comfortable about speaking with care staff and management if they had any worries. People approached staff without any hesitation, for example people who were sitting in the main lounge engaged in conversation with staff as they walked by.

Staff were able to tell us about what action they would take if they suspected abuse was taking place. Staff told us they would have no hesitation in reporting it to the registered manager or care managers, and were confident their concerns would be acted on. Staff confirmed they had access to the relevant policy as well as contact details for the local authority safeguarding team.

Records were in place for when a person had a behaviour which challenged staff. These helped protect the person, staff and others. However, we found documentation did not always provide staff with clear direction about how to support people, for example when a person became agitated. However, from speaking with staff it was clear they knew how to support people to help ensure their freedom was not restricted, and that they were respected and remained safe.

People were supported as necessary to reduce their risk of falling, for example we saw staff walk with people to support them and saw staff prompted and encouraged the use of mobility aids, such as walking sticks and walking frames.

When there was a risk identified, risk assessments were put into place. This helped to reduce any unnecessary harm and to provide guidance and direction to staff. For example, one person was at risk of pressure sores. Their risk assessments identified the necessary measures and equipment which were required to be put into place to provide protection.

The provider's local and national recording tool monitored accidents, incidents and safeguarding concerns. This helped to identify trends and to make improvements, for example there was a system in place to monitor falls. When a person fell, information relating to the fall was collated and an action plan created. If a person was falling at a particular time, this analysis prompted a review of staffing levels. We found that the recording tool had not identified a safeguarding incident. However, from speaking with the registered manager it was concluded that action had been taken but not recorded effectively.

The provider ensured there were sufficient numbers and an appropriate skill mix of staff to meet people's needs and to keep people safe. A member of staff told us, "we don't have agency staff here. How can they [a person] get proper care and attention if they don't know them?"

The registered manager used a dependency tool which considered people's individual care needs and the staffing which was required. Staff breaks were structured to help ensure staff were always available to assist and support at busier times, such as lunch time. Housekeeping staff were flexible to support the care team, for example collecting breakfast and lunch trays from people's bedrooms. This helped care staff to be focused on the care and support of people instead of domestic tasks.

People told us they thought there were sufficient staff on duty. People mentioned the recent departure of one of the two part-time activity co-ordinators and told us they were concerned about how this would affect trips out and activities. However, the registered manager had already recognised this, and to help ensure this did not happen they had involved a volunteer. On the day of our visit, we saw recruitment to find a replacement had commenced.

People were protected by safe recruitment procedures as the provider had a policy which ensured all employees and volunteers were subject to necessary checks which determined that they were suitable to work with vulnerable people.

People's medicines were managed to help ensure they received them safely. Team leaders made sure people received their medicines at the correct times and records confirmed this. For example, in one care plan it stated if the person did not receive a particular medicine, at a specific time, they could become physically unwell. We saw the person received their medicine at the exact time and in the way which had been described in the person's care plan. This demonstrated staff were aware of the person's individual medical needs.

Is the service safe?

People were encouraged to administer their own medicines and to help ensure the safety of their medicine. People had lockable storage in their bedrooms and documentation had been completed with the person to help manage any associated risks.

People's behaviour was not controlled by excessive use of medicines. We read in the care plans of two people that they had behaviour that may challenge staff. We read staff supported people in a positive way. For example, when a person became agitated, the care plan was descriptive about what action staff should take to minimise the person's agitation, such as a change of staff, and giving the person space on their own. Staff confirmed this was the action they took when required.

The provider had a tool in place which was used to review the prescribing of sedative medicine within the care home. The tool triggered action such as a review of staffing levels and staffing culture, a medicine review, and the involvement of outside health care professionals. We were told, "there is a drive to ensure people are on these drugs for the right reasons". Since the tool had been introduced there had been a positive impact on people as no one was being prescribed sedative medicines to manage behaviour.

The introduction of an electronic medicine system was being introduced to encourage the personalisation of people's medicines, to reduce the risk of medicine errors and improve efficiency of staff time. This demonstrated the provider was continually looking at how procedures could be improved to help ensure people received a high level of care at all times.

Is the service effective?

Our findings

People said "yes" when asked whether they felt staff were well trained. However, one person commented "Some staff are very young and inexperienced but they think that they know it all".

Staff received an induction, ongoing training, support, supervision and appraisals. Staff attended training applicable to their role, for example dementia training. A member of staff told us they had found the training useful, "you have to look at the person, not the problem". Staff who administered medicines explained there were annual competency assessments to help ensure their knowledge was kept up to date. By listening to staff feedback, the registered manager tailored training to staffing needs, for example, staff had requested additional Parkinson's training which the registered manager had arranged. A member of staff told us there was face to face training as well as e-learning. They commented, "there is a lot, but a good balance".

The registered manager told us supervision of staff involved practical observations as well as one to one discussions. When something went wrong the ethos was supportive, to improve performance culture rather than place blame. We were shown an example of how a member of staff had been supported after a medicine error.

The registered manager explained she continually reviewed the skill mix of the staff team, to help enable staff to flourish and to promote ongoing career development. For example, they had identified an enthusiastic member of the team to attend a care planning workshop. We were told "it's about nurturing them…noticing strengths and what they are good at".

Staff demonstrated a good knowledge of and received training about the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's care plans showed care reviews were carried out and care plans were signed, this indicated people were involved in their care and were consenting to the care plan which was in place.

The registered manager was pro-active in working with external professionals to help ensure everyone was working to best practice at all times. For example, a mental health professional/ best interest assessor who had visited told us the registered manager had requested the visit to check they were up-to-date with the latest DoLS legislation and to help ensure they were following the process correctly. This demonstrated the registered manager ensured people's care was provided in line with current legislation and guidance.

People's care plans were used to provide guidance and direction to staff about how to meet individual nutritional and hydration needs. For example, we read in one care plan "eats with fingers". Staff and the chef showed a good understanding of the person and were knowledgeable about their individual needs.

Staff showed us how food and fluid was monitored when there was risk or concern about a person's nutritional or hydration intake. The provider used a malnutrition universal screening tool (MUST) to raise the awareness of a possible risk of malnutrition. The MUST tool triggered action, for example a referral to external health care professionals such as speech and language therapists, more frequent weighing or high calorie diets.

People were encouraged to help themselves to drinks which were available in the lounges, or were supported by staff to maintain their fluid intake. Staff were observed to visit bedrooms to offer or replenish drinks for people who chose to stay in their rooms. This demonstrated staff understood the importance of encouraging and enabling people to drink enough.

The provider offered a "restaurant style" to meals, which meant people were not restricted to set meal times. People told us they were content with the quantity and quality of the meals on offer and acknowledged there was a good choice. People told us if they chose to go out during a meal time, the chef would ensure their chosen meal was held back for them.

People could choose where they preferred to eat their meals, for example, people who preferred privacy ate their meals in their rooms, whilst others chose to eat their meals

Is the service effective?

in the main dining room. Care and attention was given to how lunch was presented, and how tables were laid to enhance the lunch time experience for people. People were able to eat their meal at their own pace. People received assistance in a respectful, tactile and dignified manner when they required additional support.

People answered “yes” when they were asked whether staff reacted quickly and contacted relevant health care professionals when they were unwell. Documentation showed external health care professionals were accessed as required.

Is the service caring?

Our findings

People told us they felt treated with kindness and compassion by staff, and said they felt "listened to". A relative who visited most days told us, "they go the extra mile, staff are wonderful".

External professionals who supported the home were complimentary about the staff. They told us they felt staff were caring and commented about the positive and welcoming atmosphere they received. They told us they thought the staff were very person centred, protective of people in the right way, and the home was a happy place.

People were actively encouraged to give their views. These were listened to and valued. For example, on the day of our visit we saw the registered manager took time to ask a group of people what type of chocolate they preferred before it was bought. New pictures had been purchased for the lounge and people were asked for their opinion about where they should be hung. People were also asked if they wanted to participate in employee interviews. One person had said they wished to attend the handy man interview in the coming week and the registered manager confirmed this was being arranged.

People were able to request the support of an advocate to represent their views and wishes.

The registered manager attended meetings with the local advocacy service to maintain positive relationships for the people who lived at St Anne's.

Care staff gave us examples of how they showed dignity and respect of people. A member of staff described how they were observant of a person's dignity at meal times. They explained if a person was having difficulties, by providing specialist cutlery, crockery and larger napkins you recognised a person's individuality and told us "you are not making them [the person] any different". Our observations of lunch time confirmed this took place. We saw a member of staff had noticed a person's jumper was stained after they had eaten their lunch. The person was discretely and kindly assisted to their bedroom to be given support. This showed the member of staff was observant and recognised the stain was compromising their dignity.

People's dignity had been considered when medicines were administered in communal areas. For example, within people's care plans there were clear directions for staff to follow, for example, we read "eye drops to be done away from the table".

Staff were observant of people's wellbeing, for example, time was taken to support a person to position themselves in their chair more comfortably. The support was given at the person's own pace and the guidance was spoken clearly.

Staff took time to speak with people, showed compassion, and were kind and thoughtful. For example, one person called out "I want to go home". Time was taken to reassure the person of their anxieties, and after the conversation the person became less anxious.

Staff interaction with people was tactile, for example, we saw one person thanked a member of staff by responding by kissing them on the cheek. A member of staff placed their arm around a person to support them to their room to change their jumper, the person seemed to respond well to the touch and comfort which had been shown.

One person took comfort in keeping a possession close to them and staff were knowledgeable of this. For example, when the person was assisted at lunch time, they made sure the possession went with the person. As the person was unable to hold onto it whilst walking, a member of staff placed it in the front of their apron. Staff made sure the person knew where it was at all times. The approach used helped to ensure the person did not become anxious.

Staff communicated with people in a positive and, at times, humorous manner. For example, when asking one person what they would like to drink a member of staff said, "you'd like a St Anne's cocktail" meaning a mixture of two juices. The staff member and person enjoyed laughing together.

Staff understood when to alter their communication style to provide individual support. For example, at lunch time a member of staff took time to show a person three different jugs of juice. The member of staff pointed at the colours which helped the person to make their own choice about what they would like to drink. This demonstrated staff understood the importance of adapting communication styles to support people to make their own decisions

Is the service caring?

People were given time to make their decisions, and their own choices. For example, questions from staff such as, “what would you like?” and “where would you like to sit?” demonstrated staff took time to empower people and promoted their independence.

The provider had five values for staff, and the values were used to encourage and promote positive behaviour. One of these values was for staff to be ‘respectful’, to care and to show kindness. We observed this value being demonstrated by the registered manager towards people, staff and visitors. This meant the registered manager lead by example and was a role model to staff.

Is the service responsive?

Our findings

When a person moved to the home, an assessment of their care was carried out to ensure the staff could support the person. Documentation showed information relating to their health and social care needs was gathered. Two people moved in during our visit. Staff recognised the sensitivity of such a move and spoke respectfully and supportively with the person and their family.

Staff considered innovative ideas to support people to have an enhanced sense of wellbeing. For example, staff were researching equipment to enable people who chose to remain in bed, to have their hair washed whilst lying down.

People had care plans to support the delivery of their care and people and their families were involved in the review of their care plan. When a request for a change to a person's care plan had been made, care had been adjusted. For example, one person had requested an increase in the frequency of their showers and this had been actioned. Information from one care review had not been used to update the person's care plan. This meant there was a risk staff did not have all the information they needed to support the person. However, from speaking with staff they had a good understanding of this person's care needs. We spoke with the registered manager about this who confirmed that the process of care reviews required reviewing to ensure this did not happen.

Care plans considered people's individuality and provided guidance and direction for staff. For example we read in one care plan, "dislikes taking tablets, ask GP for liquid medication if possible" and included a description for staff about how they could tell when the person was in pain. A member of staff confirmed their awareness of the details of the care plan. This demonstrated people's care plans were used to help enable the delivery of individualised care.

People's care plans supported a person if they went into hospital. For example, people had a "hospital care plan". The care plan helped to ensure if a person had to move between different services, the care needs of the person were shared to help enable others to be fully informed of how to support them. This demonstrated the provider understood the importance of sharing information to help ensure people received care which was responsive to their needs.

Staff at the change of each shift discussed people's health care needs to ensure people received the appropriate care and support when there was a staff change over. The discussion which took place about each individual was positive and touched on both health and social care needs. The member of staff leading the discussion took time to establish when other staff members had last worked to help ensure the handover was individually tailored to staff needs. Staff felt comfortable to ask when they required further information.

People and staff were involved in the monitoring of health care needs. GP's who supported the care home told us they felt the home communicated well. A Parkinson's nurse who visited the home told us they found communication to be very good and said staff would ring about people if they were concerned.

People's care plans contained a "my living story" plan of care; this was information about what they enjoyed participating in prior to moving in. A member of the activities team told us of the importance of understanding a person's life history to help ensure social activities were tailored to suit the individual. For example, we saw time had been given to find a social event relating to the RAF. The expression on the person's face as seen in a photo showed they had enjoyed it. This demonstrated staff promoted positive relationships with people and took time to get to know a person as an individual.

Activity and social enjoyment was observed to be a big part for people and for the staff. People were offered an afternoon alcoholic beverage to enjoy whilst socialising and participating in organised events. One person told us, "the activity organisers are marvellous". Staff understood people's individuality when arranging activities and people had a variety to choose from. A member of staff told us, "what suits one person won't suit another; we all have our own hobbies and interests".

People were encouraged to continue with their chosen leisure activities, for example people were supported to go swimming and to go on social outings. A member of the activity team told us, "I never say never, I'll give anything a go!"

Staff recognised the importance of offering daily activities which people may have enjoyed before moving in. For

Is the service responsive?

example, people helped to prepare vegetables for lunch. For one person, cleaning had been an important part of their life prior to moving in, so staff ensured the person had access to dusters so they could dust when they chose to.

The staff had good links with the local community. The activities team spoke passionately about the importance of ensuring people continued to remain part of their own community regardless of whether they lived in a care home. There were connections with local schools, church and community groups. People had the option to attend events at St Anne's or elsewhere. Monthly coffee mornings were held, and a 'community roast', which encouraged people over the age of 55 to come in, enjoy a roast lunch and to socialise with people who lived at St Anne's.

The provider had an effective complaints system in place. When people were asked how and who to make a complaint to, people were confident about speaking with a care manager or the registered manager. Two people told us they had made a complaint and it had been resolved to their satisfaction. We were told the home promotes "complaints as a treasure", meaning they help to make improvements for everyone.

The provider asked people for feedback by the completion of questionnaires. Some people recalled receiving questionnaires but admitted they had not completed and returned them. The feedback which was received was pro-actively used to improve the service. For example negative comments received about the laundry service had been used to improve the systems in place.

Is the service well-led?

Our findings

The provider's values and philosophy of being straightforward, respectful, having personal accountability, being honest and reliable were explained to staff through their induction programme and training. The registered manager told us, "we all work by the values".

There was a positive culture where people felt included and consulted. For example, all staff we spoke with confirmed they could openly speak with the registered manager about any concerns they may have, such as care or personal learning. Staff also told us the registered manager "does a good job" and "will make time to explain things to care staff".

People were involved in the day to day running of their home. Residents' meetings took place, people were encouraged to share how they felt, and their relatives and friends were also welcome to attend. People commented, "residents' meetings are an excellent idea – we usually discuss food", "the cook attends and takes notes". A relative who lived some distance away told us they received minutes of the meetings by e-mail.

During our visit, the registered manager was visible, made herself available, spoke kindly, compassionately and enthusiastically with people, visitors and staff. A member of staff told us the registered manager was always "very polite", always addressed people by their preferred name and added, "the residents know where she is".

When staff were asked if they enjoyed working at St Anne's we were told, "brilliant", and "it's lovely, it's a really lovely home". Staff told us they felt supported and enjoyed their work. The provider sought feedback from the staff through an annual survey and used this feedback to make changes to the service. For example, staff had raised concerns about the lack of time they had to spend with people on a one to one basis and action had been taken to rectify this. The registered manager told us they pro-actively supported the staff in "building strength and confidence". The registered manager was very clear they promoted a "no blame culture" and explained, "we don't want people hiding".

The provider ensured staff were valued by awarding length of service awards. The provider also had a scheme in place which enabled staff to be nominated for their day to day commitment and contributions.

There was a clear management structure in place and staff were aware of the management team. Staff told us the care managers and registered manager were approachable and had a regular presence. All of the managers we met during our visit demonstrated to us they knew the details of the care provided to people, which showed they had regular contact with people and with staff.

As the registered manager had only been in post for six months, they were supported during our visit by the district manager and the dementia care advisor/regional support manager. The registered manager told us they valued the support shown by the organisation. The dementia care advisor/regional support manager told us, "it is so important that we support our managers to deliver. If we don't care for our managers how can we care for others?"

The provider had a system in place to continually monitor the quality of its service. The provider had devised a 'quality excellence tool' which looked at the possible risks to the service, and was used to create actions plans for improvement.

The provider's service improvement plan ensured ongoing quality. The quality monitoring systems were used to "raise awareness" and to keep asking questions such as "is this the right way?" and "this is the evidence, so what are we going to do about it?" The provider's quality and risk systems were being developed with staff to ensure they were useful and effective at capturing where improvement actions were required.

The provider's risk management tool alerted the registered manager and provider when there were certain risks which required action. For example, poor staff retention or increased safeguarding alerts. This helped to ensure the service was being continually monitored and meant action could be taken promptly when concerns were identified.