J.E.M. Care Limited

Ann Challis

Inspection report

128 Stretford Road
Urmston
Manchester
Greater Manchester
M41 9LT

Tel: 01617483597
Website: www.jemcareltd.co.uk

Date of inspection visit:
16 October 2018
17 October 2018

Date of publication:
18 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 October 2018 and was unannounced.

We last inspected Ann Challis on 22 and 23 August 2017 when we rated the service requires improvement overall, and for all key questions other than caring, which was rated good. This will be the third consecutive time that the service has been rated requires improvement overall.

At our last inspection we identified breaches of the regulations in relation to assessing risks to people using the service, accurate completion of care records and systems in place to monitor the quality and safety of the service. Following the inspection, we requested and received an action plan from the provider detailing how they would make the required improvements. This indicated that measures had already been put in place to address the breaches of regulations identified. However, at this inspection, we identified ongoing issues and continued breaches of these regulations. Breaches of the regulations found at this inspection related to; the safe management of medicines, premises and equipment, staff recruitment procedures, acing in accordance with the Mental Capacity Act, and good governance. You can see what action we have told the provider to take at the back of this report. This section will be updated once any actions have been concluded.

Ann Challis is a residential care home for women. The service provides care and support to older people, some of whom are living with dementia. The home has a secure garden area and communal facilities include two lounges and a dining area that are open plan to one another.

Ann Challis is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ann Challis accommodates up to 23 people in one adapted building. At the time of our inspection, there were 23 people living at the home.

The service is also registered to provide personal care as a domiciliary care agency (home care) although they had not provided this service since 2012. We have asked the registered manager to submit applications to cancel the registration for this regulated activity.

The former registered manager had left the service in March 2018, and an existing staff member had been promoted to the registered manager position. Their registration with CQC was completed shortly prior to our inspection. However, at the time of the inspection they were on planned leave, with an expected return date in January 2019. Another staff member had been appointed as the acting manager in the interim.

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 were enthusiastic about making a positive difference to the lives of the people they supported. People told us staff were kind and caring. The interactions we observed between staff and people living at the service showed that staff acted in considerate and caring ways that encouraged people to retain independence.

There were sufficient staff on duty to meet people's needs, although both staff and people living at the home told us there were times when 'another pair of hands' would be useful. We looked at staff rotas and saw levels of care staff on occasions dropped from the expected three, to two staff on duty for an hour or two. The manager told us that domestic staff were fully trained and would provide any additional cover and support needed.

We found ongoing issues in relation to the safe management of medicines. As at our last inspection, the amount of medicines in stock did not always 'tally' with the amount staff had recorded that they had administered. Records in relation to the application of cream medicine were not always completed accurately, and we could not be certain that people had received their medicines as prescribed. We also found that staff on duty at night had not all received medication training. This could delay people receiving medicines such as pain relief if they required these medicines outside normal medicine round times.

The provider had acted to make improvements in relation to concerns raised with them about fire safety and window restrictors. However, we found further shortfalls in the way staff identified and controlled risks in relation to the premises and equipment. The provider had not acted on recommendations made by a third party who had carried out a legionella risk assessment on their behalf. There were no robust systems in place to control risks relating to legionella. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease. Legionnaire's disease can be dangerous, particularly to more vulnerable people such as older adults.

We saw staff had carried out risk assessments and checks in relation to the use of bedrails. However, staff had not fully completed one of these risk assessments. We also found that despite the checks carried out, the bedrails did not conform to expected standards in relation to their safety. Other issues in relation to the safety of the environment included finding that heavy furniture was not secured to prevent it accidentally toppling over, and a radiator in a person's bedroom was not covered.

Staff recorded any accidents or incidents that occurred. We saw that people's care plans and risk assessments had been revised following any significant change in a person's needs. However, it was not always clear what action had been taken to prevent accidents recurring, and the systems in place to track and monitor trends in accidents and incidents needed to be strengthened.

People living at the home and relatives we spoke with were confident that staff had the skills and competence to meet their, or their relative's needs. We received positive feedback from a visiting health professional in relation to staff knowing the people they cared for, and acting on their advice. Staff received a range of training relevant to their job roles. However, completion rates for some of the training, including safeguarding training, were low. Staff told us they were well supported, and we saw they received regular supervision.

The provider was not able to evidence that they had followed robust procedures when recruiting staff to ensure they were of suitable character. The provider had misunderstood advice given to them in relation to data protection laws. This had resulted in them returning documents they needed to hold in relation to the employment of staff such as proof of their identity. We also found satisfactory evidence of conduct in previous employment had not always been obtained, and a full employment history had not been recorded

for one member of staff.

The provider was not always acting in accordance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager had not re-applied for DoLS applications in a timely way, which meant some of these had expired. This meant there was a risk that people could be deprived of their liberty without proper legal authority. We also found shortfalls in relation to procedures followed when deciding to give medicines covertly (without a person's knowledge).

Care plans had improved since our last inspection. We found people's care plans accurately reflected their needs and preferences. They also contained information about people's social history, likes and dislikes, which would help staff get to know them and deliver person-centred care. Staff consulted people and their families about how much they wanted to be involved in reviews of their planned care.

The hours worked by the activity co-ordinator had increased since our last inspection. We saw craft activities and nail painting taking place during the inspection. Staff told us the activity co-ordinator had started supporting people to access the community and visit local shops, lunch clubs and cafés more regularly.

Staff, relatives and people using the service told us the manager and provider (directors of the company) were approachable. There was evidence that the provider was in regular contact with staff and the manager. They had asked for feedback from people living at the home and their relatives in relation to how they could improve the service.

There were a range of checks and audits completed by staff to help monitor the quality and safety of the service. However, these had not always been effective at identifying and addressing risks, such as those in relation to the safety of the premises and equipment and medicines. Sufficient improvements had not been made to improve the overall rating of the service, and we found ongoing breaches of regulations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We found shortfalls in procedures to assess and act on risks in relation to the safety of premises and equipment. The provider had not acted upon recommendations made in their legionella risk assessment.

Robust procedures had not always been followed when recruiting staff. Evidence of some checks that had been carried out had not been retained by the service.

We identified ongoing issues in relation to the safe management of medicines. Records were not always accurate and people had not always received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The manager had not applied for deprivation of liberty safeguards (DoLS) applications in a timely way and some had expired.

Staff undertook a range of training relevant to their job roles. However, completion rates for some courses, including safeguarding were low.

Staff received regular supervision and told us they felt supported.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well. People told us staff were kind and caring.

Staff understood the importance of supporting people to retain independence. People's care plans identified what they could do independently as well as what support they needed.

Relatives were involved in people's care when this was

appropriate. They told us they were kept informed about any changes affecting their family member.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to care plans, which accurately reflected the needs and preferences of the person they related to. People were asked what level of involvement they wanted in reviewing their planned care.

People told us they had not raised any complaints, but would be confident doing so if they felt this was necessary.

The number of hours the activity co-ordinator worked had increased since our last inspection. During the inspection we saw people taking part in craft activities and getting their nails painted.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits and checks were completed by staff to help them monitor the quality and safety of the service. However, these were not always effective. The provider had not always identified or acted on known risks.

The provider was in regular contact with the manager and staff. Staff told us the provider (directors of the company) were approachable and investing in the home.

Staff were happy in their roles and motivated to make a positive impact on people's lives.

Ann Challis

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 October and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports, the action plan sent to us by the registered manager following our last inspection, statutory notifications received from the service and any feedback received from people using the service or their representatives. Statutory notifications are notifications that registered persons must send us by law in relation to significant events such as safeguarding, serious injuries, deaths and police incidents.

We contacted Healthwatch Trafford, the local authority quality/contracts team and local authority area infection control team for feedback about the service. We received feedback from all those we contacted, which we considered when planning the inspection and making judgements about the service. Healthwatch Trafford shared a draft report from an 'enter and view' visit they carried out in September 2018. Healthwatch gather and represent the view of people who use services. The findings of their enter and view visits can be viewed on the local Healthwatch web-sites once the reports have been finalised.

We used information contained in the provider information return (PIR) submitted by the service to help plan the inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection site visit we spoke with five people who were living at the home, and two people's relatives who were visiting at the time of our inspection. 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 spoke with five members of staff. This included the manager, the area manager, and three members of care staff. We reviewed records about the care people were receiving. This included five people's care files, nine medication administration records (MARs) and daily records of care. We looked at records relating to the management and running of the service including, five staff personnel files, records of audits and checks and records of servicing and maintenance.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2017 we found accurate records relating to the administration of medicines were not always kept. We found this to be a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified ongoing issues in relation to the safe management of medicines, including the completion of records.

Although records of the application of creams had improved since our last inspection, there were ongoing issues. For example, when we checked records in the afternoon of the first day of our inspection, they showed that only one person had had their prescribed creams applied by staff that morning. Another person had two creams that should have been applied three times per day, but staff consistently recorded that they had only applied these twice per day. This meant we could not determine that people had received these medicines as prescribed to them.

Whilst in most instances staff recorded the administration of medicines on medication administration records (MARs), we also saw there had been several omissions where staff had not signed for the medicines they had administered. As at our last inspection, we found stocks of medicines did not always reconcile with what the MARs indicated should be left in the medicines trolley. We found one person had two medicines where there was one less tablet in stock than there should have been if the medicine had been administered correctly. The provider carried out an audit but was not able to identify the reason for this discrepancy. Another person had run out of one of their regular medicines and so had not been administered it for two days. The manager told us this was due to the ordering being 'out of sync' with the cycle for ordering the rest of their medicines.

At our last inspection we noted that the provider had acted on advice from the local authority to put in place protocols for 'when required' (PRN) medicines. PRN protocols give staff information about when they should administer these medicines and what their intended effect is. At this inspection we did not see any protocols in place for people prescribed PRN medicines. These medicines were predominately pain relief medicines, and staff told us the people they were prescribed to could tell them whether they were in any pain. However, they were not certain whether these medicines were prescribed for a specific condition or recurrent pain that would help them monitor whether they were effective. The information in PRN protocols is also important to help ensure all staff, including new staff or agency staff who may be required to administer medicines are aware of how they should be used.

One person living at the home was administered medicines covertly (without their knowledge). Whilst we saw there was documentation in relation to this in their care file, there was nothing in the medicines file to inform staff which medicines should be given covertly, or how this should be done. This information is important to ensure such medicines are administered safely and that their efficacy is not affected by the way they are given.

These issues demonstrate that medicines were not consistently managed in a safe way. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not always taking reasonable steps to ensure the premises and equipment were safe.

At our last inspection we were concerned that the fire risk assessment was not suitable and sufficient, and the previous registered manager showed us evidence that a third party had been commissioned to undertake a more detailed risk assessment. Following this, Greater Manchester Fire and Rescue Service visited the home and made us aware that the risk assessment had identified significant findings that needed to be addressed to ensure the safety of the premises. The fire service agreed interim measures, such as increased staffing and checks during the night to reduce risk to people living at the home. An action plan was also agreed, and at this inspection we saw all actions had been signed off as complete.

We made a recommendation at our last inspection that the provider reviewed guidance in relation to window restrictors, as the type installed at the home were not tamper-proof. The provider had acted on this recommendation and all window restrictors had been replaced with a new type that could not be easily overridden.

Despite these positive examples, we found the provider had not always undertaken suitable and sufficient risk assessment, nor acted on the findings of risk assessments to help ensure the safety of premises and equipment. For example, we saw a third party had undertaken a legionella risk assessment for the provider. This made a number of recommendations, including that thermostatic mixer valves (TMV's) were fitted to taps. This would allow hot water to be hot enough to control risks relating to legionella, whilst ensuring water was not dispensed at a temperature that would present a scalding risk. The provider had not acted on this, or other recommendations made and we found staff had a poor understanding and no training in relation to how to manage risks relating to legionella. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease that can be dangerous, particularly to more vulnerable people such as older adults. Tests of water temperatures were carried out and these showed hot water was not hot enough to manage risks relating to legionella, whilst also being slightly above the recommended level to manage potential risks of scalding.

Checks of equipment such as hoists had been carried out as required by a competent person. We also found that people who used bed-rails now had a bed-rail risk assessment in their care plans, which was a gap identified at our last inspection. These risk assessments should help staff decide whether they were safe to use for that individual. However, we saw one bed-rail risk assessment had not been fully completed to indicate whether bumpers would help reduce risks such as the risk of entrapment. When we looked at this person's bed-rails we saw there were bumpers just on one side. We also found that despite both daily and monthly recorded checks of the suitability and condition of bed-rails that this person's bed-rails did not comply with standards in relation to the maximum gaps between the rails and mattress/headboard. This meant there would be an increased risk of entrapment and injury. We raised this issue with the manager who told us the bed-rails had been altered to ensure they complied with the relevant standards and guidance.

When looking around the home we found heavy furniture such as wardrobes had not been secured to the wall, which could present a risk of injury if they toppled over. The manager told us this shortfall had already been identified and that fixings had already been ordered. Following our inspection, they confirmed the fixings had arrived and were ready to be fitted. At our last inspection, we identified that two people's personal emergency evacuation plans (PEEPs) were not accurate or did not reflect their current mobility support needs. At this inspection, we again found an example of a person's PEEP that had not been updated to reflect the correct level of support they required following a significant decline in their mobility. PEEPs help ensure staff and potentially emergency services, are aware of the level of support people would need to evacuate in the case of an emergency.

The provider was not taking reasonable steps to ensure premises and equipment were safe for use. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accommodation at the home was located across three floors, with a passenger lift between the ground and first floor. The manager told us that only people with good mobility would be allocated rooms on the second floor due to the need to use the stairs. We noted that there was no restriction to people accessing and using the stairs on any level of the home, although the manager told us a stair-gate was used during the night at the top of the first flight of stairs. We saw that each person had a risk assessment in place that identified whether they were able to use the stairs, or were at risk of accessing the stairs when they were not able to use them safely. Control measures generally consisted of reminding people not to use the stairs without support and staff maintaining awareness of their whereabouts. Some people living at the home were at risk of falls and had advanced dementia. The manager told us no-one had attempted to use the stairs when it was not safe for them to do so, and they were confident that staff were able to provide adequate supervision to prevent any incidents.

At our last inspection we identified shortfalls in relation to the way staff were assessing risks to people's health and welfare. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made some improvements and the requirements of the regulation were being met in relation to this issue. However, there was scope for the provider to strengthen their approach to risk assessment and management.

As already noted, we identified ongoing issues in relation to bed-rail risk assessments and PEEPs. However, we found other risk assessments were generally accurate, although additional detail would have been beneficial in some cases. We saw staff had assessed risk in relation to malnutrition, falls, skin integrity and use of a call bell. Dependent on the findings of risk assessment, we saw different measures to reduce risks had been put in place. For example, if a person was assessed as not being able to use a call bell, staff were directed to undertake more frequent checks during the night. We saw one person had been assessed by a speech and language therapist (SALT) in relation to the support they required when eating and drinking. We found that staff were aware of the guidance and were following it in relation to the required consistency of the person's food and fluid for example. However, they were not following the directions in relation to the support given to this person to eat their meal. Staff explained this was because this person was sometimes able to eat independently with a lower level of supervision. Whilst we were satisfied with this explanation, this detail was not recorded in the care plan or risk assessment.

We saw staff completed accident reports for any accidents and injuries sustained by people using the service. These detailed any immediate actions taken such as contacting emergency services, providing first aid and carrying out post-incident observations to help monitor for any delayed signs of injury. A manager reviewed and commented on accident reports. However, it was not always clear from accident reports and other documentation that staff had considered the cause of accidents, or whether any further measures were required to reduce the likelihood of a repeat incident. However, we did see evidence that people's care plans and risk assessments were reviewed and updated following significant changes in need, such as following a discharge from hospital.

There were sufficient staff to meet people's needs. People using the service and relatives we spoke with felt there were sufficient staff on duty to meet their or their relative's needs. One person and one staff member commented that there were times when an additional member of staff would be useful. One person told us, "I think inevitably there will always be situations where more staff would be a great help such as when there are problems." However, people felt they received support in a timely way and staff told us there were sufficient staff on duty to allow them to complete their duties and provide adequate supervision and

support to people using the service. During our inspection we observed that there were sufficient numbers of staff to provide people with the support they needed, including during meal times and to provide support to people when mobilising around the home.

The provider told us they had used a dependency tool to help them determine how many staff were required to meet people's needs. However, they were not able to locate this during the inspection, and accepted that it had not been reviewed recently. Looking at the rotas, we could see that staffing levels during the day sometimes dropped to two, rather than the usual three members of care staff on duty. The manager assured us that in such situations, domestic staff were fully trained and would be called upon to provide cover.

The provider was not able to evidence that they had followed robust procedures when recruiting staff. The provider had misinterpreted advice given to them by the local authority in relation to requirements relating to the general data protection regulation (GDPR). This had resulted in them returning documents they were required to hold such as proof of staff member's identity. However, we were satisfied that these documents had previously been held as we had seen them during our last inspection, and the local authority also confirmed they had seen such documents when carrying out their quality check.

However, we found further gaps in the recruitment procedures. Two recently employed staff members had worked in care settings prior to starting work at Ann Challis. One staff member did not have a reference, or other satisfactory evidence of their conduct during this previous employment as required. The second staff member had listed two previous social care employers as potential referees. We saw two verbal references had been recorded in their file, but we could not tell from the notes made who had supplied these references.

One staff member had not provided a full employment history, two did not have a recent photo on file, and there was no record of another staff members disclosure and barring service (DBS) number. Other staff members DBS numbers had been recorded. However, there was no record as to whether the checks had reported any criminal record. The provider told us if this had been the case that a note would have been made and a risk assessment undertaken. DBS checks provide information such as whether the applicant is barred from working with vulnerable persons, and whether they have a criminal record. This helps employers make safer recruitment decisions. The manager told us potential staff were interviewed prior to being offered a position. However, no records of interviews were kept demonstrating the provider had considered applicants suitability for the role they had applied for.

These gaps in recruitment processes were a breach of Regulation 19(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had been audited by Trafford's community infection control team in May 2018. The outcome of this audit was that the home received on overall amber RAG (red, amber, green) rating. We saw the provider had responded to the action plan and had taken a number of steps to make required improvements. During our inspection we observed that the environment was clean and did not identify any areas of uncleanliness. We saw personal protective equipment (PPE) such as gloves and aprons were readily available to staff, and there were signs displayed to remind staff of good technique in relation to hand washing. Whilst looking round the home we saw that the flooring in one person's room was in poor condition and torn/lifting in one area. This would have made it hard to clean effectively. The manager completed their own infection control audit, and was aware of this issue. They told us there was an ongoing programme of refurbishment, and that this person's bedroom was the next to be done. The home received a food hygiene rating of five (very good) in July 2018.

People told us they felt safe living at Ann Challis. One person told us, "You can't not feel safe. It's not frightening." The home had not notified the CQC or local authority of any safeguarding concerns arising at the home since our last inspection. Staff we spoke with understood how to identify signs of potential abuse or neglect, and they told us they would report any concerns to their manager. We saw safeguarding continued to be a standing agenda item in team meetings, which would help ensure staff maintained an awareness of how to identify and report any potential concerns. We saw steps were taken to help protect people's property. For example, staff photographed people's valuables and recorded the belongings they brought into the home.

Requires Improvement

Is the service effective?

Our findings

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

At our last inspection in August 2017 we found that the registered manager had not submitted DoLS application for a person who was subject to potentially restrictive practices. A best interests decision had also not been undertaken in relation to this practice. We recommended the provider review guidance in relation to the implementation of the MCA and DoLS. We found the provider had taken action to ensure best-interests decisions were recorded in relation to the use of equipment such as bed-rails that might restrict people's movement. However, we identified ongoing shortfalls in relation to the implementation of the MCA.

We saw people's care files contained consent forms that covered consent to care planning, administration of medicines and use of the person's photo for example. Where people were able to sign these forms themselves they had done. We also saw that if it was suspected that a person lacked capacity to consent to these areas, that staff had completed decision specific capacity assessments, and documented a best-interests decision. This involved consultation with a person's relatives where appropriate. Staff understood the key principles of the MCA, such as that any decisions taken on behalf of a person lacking capacity should be the least restrictive option and in their best interests. One staff member told us, "You always start by assuming capacity… We try not to restrict people. DoLS is there to protect and safeguard people and ensure you can work in their best interests."

Two people's care files we looked at contained DoLS authorisations that had expired, and the manager had not submitted a re-application. There was no indicated change in these people's presentation or circumstances that meant they would no longer require a DoLS. The manager showed us a 'DoLS matrix' that showed that two further DoLS had expired without a re-application having been made. The manager told us they thought this lapse had occurred due to the changeover in management at the home, and they submitted the required applications during our visit.

Staff administered medicines to one person living at the home covertly (without their knowledge). There was a letter in this person's care file from their GP stating they believed it to be in this person's best-interests to administer their medicines covertly. However, there was no formally recorded capacity assessment, best-

interests decision or details about how and when the decision to administer medicines covertly should be reviewed. The Court of Protection provided guidance in relation to the administration of covert medicines in 2016, which included that there should be a best-interests meeting held, there should be a management plan with indicated timeframes for review and that this information should be easily accessible and held on the person's medical/care home records. Whilst the GP had made the decision for medicines to be administered covertly, the provider did not have evidence or reassurance that the correct procedures had been followed in this decision being made.

The provider was not acting in accordance with the Mental Capacity Act 2005 and proper lawful authority for deprivations of liberty was not always in place. This was a breach of Regulation 13(1)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection there had been a continued programme of refurbishment. This had included replacement of much of the furniture in communal areas. The carpet in the communal lounges had been replaced with a plain carpet that would be more 'dementia friendly' than the previous carpet that was heavily patterned. There were several adaptations to help make the environment more dementia friendly. This included pictorial and directional signage, people's photos on the doors of their rooms and a 'reminiscence area' that contained old memorabilia and books.

People we spoke with were positive about the environment, with comments including, "My bedroom is nice", "The home is very clean, and everything you need is here" and "There have been a lot of improvements since the change in management such as the re-decoration and new furniture." We saw some bedrooms had been recently re-decorated. However, some of those that had not yet been redecorated were in poor condition. For example, one bedroom we saw had two light fittings, one of which did not have a bulb or lampshade on it. A second bedroom as previously described in the safe section of this report, had previously been an office and still had office blinds, a false ceiling with broken ceiling tiles, florescent lighting and torn wallpaper. The manager told us this was the next bedroom due to be re-decorated.

At our last inspection we found there were not always clearly recorded assessments carried out prior to a person moving to the home and made a recommendation that the provider reviewed their procedures. We discussed the assessment procedure with the manager and saw that a needs/requirements assessment was populated by staff as part of this process. This then formed the basis for the first draft of that person's care plan. We saw assessments covered a broad range of people's needs in relation to their physical, psychological and social support needs, along with a plan as to how staff would meet people's identified needs. For example, we saw there were care plans and assessments in relation to sleep, oral care, nutrition, mobility, continence, mental state/cognition, communication and social needs.

Records showed that the home regularly engaged the support of other health and social care professionals to meet people's needs. For example, we saw district nurses were involved in some people's care, and this was documented in their care plans. In one case we saw that staff had asked district nurses to review a person due to erythema (redness) of their skin. Other professionals such as speech and language therapists (SALTs), GP's and mental health/dementia services had also been consulted. We spoke with a GP from a local practice who told us staff were contacting them for the right concerns, and they told us staff were good at following any advice they gave. Relatives we spoke with were confident that staff would notice and act on any changes to their family member's health. One relative told us, "Staff called an ambulance when [relative] had a chest infection. They were spot on recognising deterioration, and they kept us informed at home."

People told us they received sufficient amounts to eat and drink and said they usually enjoyed the food

provided. Comments included, "The food is not bad at all. You can't always expect luxury. There is usually a choice of porridge or toast, and the food is always regular and decent", "Sometimes the food is particularly nice and sometimes it doesn't suit me and I don't find it very tasty" and a relative told us, "[Relative] does enjoy the food as much as they can… they [staff] try and cater for her preferences." We saw people's dietary needs and preferences were assessed and a record was kept in the kitchen. The cook told us they usually provided two choices for the main meals, one being a vegetarian option.

People told us they felt confident that staff had the skills and competence to meet their, or their family member's needs. One person told us, "They [staff] are marvellous with people living here." Staff confirmed that they felt they received adequate training to enable them to meet the needs of people living at the home. We saw staff had completed training in a range of topics relevant to their job roles including safeguarding, food hygiene, moving and handling, fire safety, fluids/nutrition and dementia awareness. However, completion rates for some training courses such as safeguarding (66%), fluid and nutrition (50%) and dementia awareness (63%) was relatively low. These were all courses where it would be important for staff to maintain awareness of current good practice to provide safe and effective care.

We saw that staff received regular supervision every other month and sometimes more frequently. Standing agenda items at supervisions included training and development, safeguarding, dignity and infection control. The manager told us one of the directors also provided occasional supervision. This allowed them to provide support to front-line staff, as well as giving staff an opportunity to raise any issues they might have directly with senior management. Staff told us they found supervision useful and supportive.

Good

Is the service caring?

Our findings

People living at the home and their relatives told us staff were kind and caring in their approach. Comments included, "I've no complaints, the staff are really good", "I like it here, it's my home. I like the staff", "They [staff] are all very obliging. They're not nasty. Staff are very good, you can't grumble about them, they are kind" and "The home is good. [Relative] is well cared for. It has a homely feel, the staff stand out as very caring". One relative spoke about how staff had called them when their family member had returned for hospital and had told them that they had given them a 'nice bowl of homemade soup' before supporting them to bed, which they felt demonstrated how considerate and caring staff were. We saw written feedback from another relative that described the service as 'exemplary' and commended staff for their 'consistent, friendly, kind and supportive manner'.

Our observations during the inspection supported these reports and we found staff had developed positive, caring relationships with people. For example, we observed staff talking and laughing with one person, and they were smiling and laughing back. Staff supported people at a pace that they were comfortable with, such as when helping people mobilise or to eat their meals. Staff were polite and respectful when communicating with people, and used appropriate touch to show warmth and offer people reassurance when needed.

The provider told us there were no restrictions on people's friends and relatives visiting, which was confirmed by people we spoke with. We saw that visiting relatives knew the staff members on duty by name and were comfortable approaching them and chatting socially. People's care plans contained details about the agreed frequency and type of contact that staff would have with people's relatives. The relatives we spoke with told us they felt involved in their family member's care, and that they were kept informed of any changes by staff at the home. At the time of our inspection, staff told us no-one using the service needed the support of a lay advocacy service. However, we saw information was available within the home should staff or an individual identify that such support would be beneficial.

Staff produced a monthly newsletter that helped keep people updated about what was going on in the home, including any changes in management and planned events. Information that might be helpful to people living at the home and their relatives was displayed on a notice board by the entrance to the home. This included information on end of life care, dementia and skin care for example.

Staff supported people to retain as much independence as possible. One relative told us, "I think they try and get [family member] to do as much as they can, but understand their limitations." We saw people's care plans identified what they were able to do independently as well as areas they needed support from staff. During the inspection we observed staff encouraging and supporting people to do things for themselves. For example, staff encouraged and prompted people when eating their meals, and we saw one staff member offer a person jam with their toast and asked if they were happy to spread it themselves. When asked what they did to support people's independence, on staff member told us, "We try and keep people active as long as we can, and try to maintain people's normal routines."

People told us staff respected their privacy and dignity. Staff told us they would knock on people's doors before entering and would ensure people's privacy as far as possible when providing intimate personal care. Staff told us people could use the medication room if they wanted to speak with others such as visiting healthcare professionals in private. We looked at minutes of a staff meeting and saw that staff had been reminded of their responsibilities in relation to maintaining the confidentiality of people's personal information. The provider had also considered the steps needed to ensure they were compliant with data protection laws.

The manager told us there was no-one living at the home who had any specific support needs arising due a protected characteristic such as age, race, religion or sexual orientation. People's care plans contained a section that staff used to identify any social or cultural support needs that people had and how they would be met. Some of the care plans we looked at identified whether people associated with a particular religion, and the extent to which they wished to be involved in religious activities. Staff told us some people living at the home were religious and that relevant religious leaders visited the home. The home provided support only to older women, and the provider also ran a sperate men's home. The manager told us that people liked the fact the home provided support only to women for reasons including dignity.

Good

Is the service responsive?

Our findings

At our last inspection in August 2017 we found people's care plans did not always reflect the support they were currently receiving. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and the service was meeting the requirements in relation to this issue.

Since our last inspection, the provider had introduced a new format of care plan. We saw that care plans contained relevant, up-to-date information that would help staff to provide care that met people's needs in accordance with their preferences. Care plans were reviewed every month or following any significant changes. Staff were asked to re-read care plans following any significant revisions and sign to confirm they had done this. Staff told us they found the care plans useful and confirmed that they were asked to read people's care plans before providing them with any support. This would help ensure people received consistent care.

People were asked about the level of involvement they wanted to have in reviews of their planned care, and this was recorded in their care files. Staff told us they would sit down with people, and where appropriate, their families to talk through their care plans and get their views about what support they wanted and how staff would provide it. Care plans contained details about people's social history, interests, likes, dislikes, and preferences about how they received their care. This would help staff get to know people and provide care that was person-centred.

The manager told us there was no-one living at the home who required any specific communication support needs. The area manager was aware of the accessible information standard (AIS) and told us they had carried out a review to ensure they were meeting the expected standards. The AIS was introduced in August 2016 and applies to providers of NHS and publicly funded care. It sets out requirements in relation to identifying, recording, flagging, sharing and meeting people's communication support needs. We saw people's care plans identified any support needs they had in relation to communication, and how staff would meet their needs. The manager told us in the past this had included using 'flash cards' to facilitate communication. Care plans also detailed how people's needs in relation to their hearing and vision would be met, including through the use of glasses and hearing aids, and receiving check-ups from relevant professionals such as an optometrist.

There were systems in place to help ensure complaints were managed effectively. Relatives and people living at Ann Challis told us they had not had to raise any complaints, but would feel comfortable doing so should they have any concerns. One relative told us, "I could talk to any of the staff about anything" and a second relative said, "They have residents and relative's meetings. They are useful, but if I had a concern I would just say, I wouldn't wait." There was one recorded formal complaint on file. We saw this had been investigated by the directors who had responded to the person raising the complaint, detailing their findings. We saw the complaints policy was displayed at the entrance to the home, which would help ensure people could seek guidance about how to raise a formal complaint and how the home should handle it if needed.

People told us there was enough going on at the home to keep them occupied. The manager told us that the hours worked by the activity co-ordinator had increased since our last inspection, and they now worked five days per week. During the inspection we observed people being supported to make Halloween decorations for an upcoming fair that staff told us was open to members of the local community. We also saw the activity co-ordinator painting people's nails on both days. We saw people took pride in showing other people their painted nails and this also created a topic of discussion between people living at the home.

People's social support needs were outlined in their care plans, along with details of significant people in individual's lives such as family and friends. Staff told us they encouraged people's friends/relatives to visit, and this included supporting one person to regularly sit down and have a meal at the home with one of their visitors. Staff told us the activity co-ordinator had recently started taking people out to local groups in the community such as a lunch club, as well as to cafés for coffee and cakes or shopping at a local shopping centre.

There was no one receiving end of life care at the time of our inspection. We saw people's care files contained a 'preferred priorities for care' document that could be used to help identify and set out people's wishes in relation to end of life care. These were completed to varying degrees of detail, and two people's preferred priorities for care documents were blank. The manager told us they were trying to find times when they could sit down and discuss these documents with people's families, which was why some had not been completed. We saw people's care files clearly identified if they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) in place. Discreet symbols were also used in people's bedrooms to act as a reminder to staff if that person had a DNACPR in place.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2018 we found the provider did not have effective systems in place to monitor and improve the safety and quality of the service. We found this to be a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified ongoing issues and an ongoing breach of this regulation.

The registered manager in post at our last inspection left the service in March 2018. Following this, a new manager was appointed whose registration with the CQC was completed on 11 October 2018 shortly before our site visit. The registered manager was taking extended leave and had not worked at the service since July 2018, with their return being expected in January 2019. During their absence, the provider had appointed an acting manager.

At our last inspection we expressed concern that the registered manager did not have any dedicated time in which they were able to undertake management tasks. The current manager told us they had two days per week management time and told us they also worked long hours out of choice. They told us they found this gave them sufficient time to undertake their required duties, but also told us the registered manager would be permanently 'off-rota' when they returned to work.

We saw a range of checks were completed to help monitor and improve the quality and safety of the service. For example, there were audits of care plans, medicines, equipment, accidents and the environment. However, these audits were not always an effective tool to drive improvements in the service. The most recent medicines audit in October 2018 identified issues where some medicines did not reconcile with the amounts that records showed staff had administered. We found this to be an ongoing issue, along with long-standing issues in relation to the completion of records relating to the application of cream medicines.

There were checks of equipment such as bed-rails, however we found that despite these checks, bed-rails did not always meet standards required to ensure they were safe to use. There was a tracker for DoLS applications, but the manager was not initially aware of this, and DoLS applications had been allowed to lapse. Staff completed an audit of accidents, which involved counting how many accidents there had been in the month, and how many falls each person had sustained in the month. However, there was no running total to track how many falls people had sustained in a longer period, such as the past year, either in people's care files or the accident file. This would increase the risk that trends or repeat incidents would not be identified and actions taken to prevent a re-occurrence.

Whilst the provider had acted on concerns raised with them explicitly, such as in relation to fire safety, there were ongoing issues identified in relation to the safety of the premises and equipment. This included the provider not taking action based on the findings of a legionella risk assessment.

These shortfalls in processes to monitor and drive improvements to safety within the service were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed the provider (directors) had monthly meetings with the manager. The manager and care staff told us the provider was often at the home and they told us they were supportive and approachable. One staff member told us, "The whole home has changed. The directors have spent a lot of money doing it up" and a second staff member said, "The directors are very supportive and approachable. They are totally aware and accountable for each of the residents."

We saw the provider completed audits of the service, which were used to create action plans for the manager. These audits consisted of check-lists and more in-depth audits that focussed on the key questions CQC asks of services, whether they are safe, effective, caring, responsive and well-led. We saw that these audits involved seeking feedback from staff, relatives, people living at the home and reviewing records.

Staff and people living at the home were involved developing the service. We saw the views of people living at the home and their relatives were sought through questionnaires and at relative's and resident's meetings. We saw a briefing from the provider where they had indicated that they would be attending a resident's/relative's meeting and inviting people to share their ideas for how to improve the service. The manager told us questionnaires were not sent out in batches, but were given out and returned on an ongoing basis. Whilst there was no overview of responses received, the manager told us they reviewed every returned questionnaire and acted on the feedback if needed.

Staff attended team meetings, the most recent of which had been held in April and August 2018. We saw discussions included operational issues, the support provided to people living at the home, data protection requirements, dignity and safeguarding. We saw the provider had attended the staff meeting in April 2018 to provide feedback to staff.

We saw the next planned team meeting included an agenda item to discuss requirements under the duty of candour regulation. This would help ensure all staff were aware of what incidents were notifiable, and what needed to be done in response to any notifiable incidents. The duty of candour regulation sets out requirements for acting in open and transparent ways, as well as what must be done if something goes wrong and a person is harmed. Staff told us they felt confident to approach the manager and raise any concerns they might have. They told us they would feel confident and supported to act in an open and honest way if they made any mistakes in the course of their work.

The manager told us some staff had been unsettled by the previous registered manager leaving, but told us they felt staff were 'back on board' now. The manager told us they had received positive feedback from relatives and professionals that the service had developed a more 'relaxed' atmosphere where the team worked more effectively together. This was supported by feedback we received from the local authority. People we spoke with including relatives, people living at the home and professionals were all positive about their experiences of Ann Challis and told us they felt comfortable approaching the manager or other staff. One health professional we spoke with told us, "I really like it here, the staff seem to be really on it and know people… I've said that I'd like to be here as an old lady." A relative we spoke with said, "It's smashing, no complaints" and another commented, "The management are very visible. The office is there [located off a communal area] and I can wander in any time." A person living at the home told us, "Everyone does the best they can. I've been quite surprised as it's better than I expected."

The staff we spoke with were happy in their roles and conveyed enthusiasm for helping make a positive contribution to people's lives. Comments from staff included, "Staff are working hard to keep the home nice for the ladies" and "I'm a proud carer on the floor. I'm proud of the ladies, how they look and how we look after them. I like coming to work and doing my job." The manager told us, "I'm very lucky getting up every day and coming to a job I love."

We saw the home's CQC performance rating from their last inspection was displayed clearly on both their website and within the home as required. The home had submitted statutory notifications to the CQC in relation to events such as serious injuries and deaths as is a legal requirement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not acting in accordance with the Mental Capacity Act 2005 and proper lawful authority for deprivations of liberty was not always in place. Regulation 13(1)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not operating robust recruitment procedures to ensure staff were of suitable character. Information required under schedule 3 relating to the persons employed was not available. Regulation 19(1)(2)(3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were shortfalls in relation to the safe management of medicines. The provider was not ensuring that the premises and equipment were safe for the people using them. Regulation 12(1)(2)(d)(e)(g)

The enforcement action we took:

We served a warning notice. The provider is required to be compliant with this regulation by 04 January 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective processes to monitor and improve the safety of the service. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We served a warning notice. The provider is required to be compliant with this regulation by 04 January 2018.