Ourris Residential Homes Limited

Anastasia Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this inspection on 27 and 28 April 2017. The inspection was unannounced. At the last comprehensive inspection which took place on 15 October 2015 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for issues that we found around the safe management of medicines. At this inspection we found that the provider had addressed the issues and were meeting the requirements of Regulation 12 of the Health and Social Care Act 2008.

On 5 April 2016, we undertook a focused inspection of the service, following some concerns that we had received about staffing levels, especially during the evenings, and the management of complaints and concerns. We found that although the provider was not in breach of any of the regulations, we made recommendations around the setting of staffing levels according to people's needs as well as ensuring that complaints and concerns raised were dealt with in a professional manner. At this inspection we found that the provider had responded to our recommendations in order to make improvements in those areas.

Anastasia Lodge Care Home provides residential accommodation for up to 29 people primarily from Greek origins. On the day of our inspection 27 people were using the service. The home covered three floors. There were two lounges and one dining room situated on the ground floor and 27 bedrooms over all three floors. Lift access was available to the first and second floor.

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

People and relatives told us that they felt safe at Anastasia Lodge and were happy with the care and support that they received. Staff were able to demonstrate a good understanding of safeguarding vulnerable adults and whistleblowing and the actions they would take if abuse was suspected.

Issues that we had identified at the last inspection on October 2015, around safe management of medicines with the focus on record keeping, had been addressed. The provider had made appropriate improvements in order to ensure that people's medicines were managed and administered safely.

People, relatives and staff confirmed that overall staffing levels were appropriate to meet the needs of the people living at Anastasia Lodge. Where concerns had been noted at the last focused inspection on April 2016, the provider had consistently monitored staffing levels to ensure that where people's needs were seen to change reasonable adjustments of staffing levels had been made to respond to those changing needs.

Relatives feedback during the last focused inspection on April 2016, was found to be consistently negative around the way in which a relatives meeting held in March 2016 had been conducted by the provider.

Comments were made about the way in which relatives were spoken to when clarification around the care and support people received was raised and that this was noted as unprofessional. At this inspection we found that the provider had undertaken appropriate training on how to manage difficult situations and relatives told us that they had since not had any further concerns in approaching senior managers and the provider with any concerns.

During this inspection we were informed by the registered manager that people's bedrooms were locked once people had retired to bed. This was so that, people who had a tendency to walk around the home and into other people's room, were stopped from doing so, so that other people who had experienced this occurrence in the past felt safe in their own rooms and did not get disturbed. Consideration had not been given to the principles of the Mental Capacity Act 2005 (MCA) and to the implications of imposing this form of control which could be interpreted as a form of restraint. As a result of our feedback the provider and registered manager assured us that they would stop locking people's bedroom and implement other appropriate systems to manage this situation safely.

On speaking with the operations manager, registered manager and care staff, they were able to describe and explain the key principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this impacted on the care and support people received. Where people had been assessed to lack capacity this had been documented appropriately and best interest decisions had been made to reflect the reasons why the decisions needed to be made. However, where the service was locking people in their rooms during the night, this had not been given the appropriate consideration under the directive of the MCA 2005.

An activity timetable was on display and people were able to access a variety of activities if they wanted to. However, relatives feedback was that people were not sufficiently stimulated and that more could be done to enhance the provision of activities.

The service implemented a number of systems and processes to ensure that people were kept safe and free from harm. Detailed risk assessments had been completed which identified generic risks as well as individual risks associated with people's health and care needs. Detailed guidance was provided to staff on how to manage or reduce identified risks in order to keep people safe.

The provider ensured that care staff received regular training to ensure that they held the appropriate skills and knowledge in order to support people effectively. Care staff told us and records confirmed that they received mandatory training which was refreshed on an annual basis and additional non-mandatory training as and when required.

Care staff told us and records confirmed that they received regular supervision and an annual appraisal and felt appropriately supported in their role. Robust systems were in place to ensure that all staff recruited were assessed as safe to work with vulnerable adults.

We observed caring and positive interactions between people and care staff. Care staff were observed to communicate with people in Greek even though this was not their first language. This meant that people whose first language was Greek were able to communicate effectively their needs and requirements and care staff were able to understand and respond accordingly.

Care plans were person centred and detailed and focused on people's needs and requirements as per their choices and wishes. Care plans were reviewed on a monthly basis and involved people and their relatives.

The registered manager and operations manager implemented a number of checks and audits in order to monitor the quality of care provision. This included health and safety checks, medicine audits, environmental checks and care plan checks. Records confirmed that action plans were then developed as a result of the quality check to ensure that improvements were made and where further learning was identified this was provided.

People and relatives told us that meals provided at the home were of a good standard. People were observed to enjoy their meals and always had access to drinks and snacks throughout the day. However, we noted that some care staff did not always engage and interact appropriately with people when supporting them with their meal. This included lack of conversation and on occasions the use of inappropriate methods when supporting people with their meal.

We saw records detailing complaints that had been received and how this had been dealt with. A complaints policy was clearly on display in the entrance of the home and had also been translated in Greek for those who were unable to read English. People and relatives told us that they knew who to complain to if they had any concerns or issues and were confident that their concerns would be addressed appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and relatives felt safe living at Anastasia Lodge and with the care and support that they received.

The service carried out risk assessments that identified generic as well as individualised risks associated with people's care and support needs. Care staff were provided with detailed information on how to mitigate or reduce identified risks in order to keep people safe.

Safe and robust medicines processes and systems were observed to ensure people received their medicines.

All staff understood the term safeguarding and whistleblowing, what they meant and the actions they would take to ensure people were protected from harm.

Safe recruitment processes were adhered to ensure that staff employed by the service were safe to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective. Although staff demonstrated a good understanding of the key principles of the MCA 2005 and DoLS and the home had applied for Deprivation of Liberty Safeguards (DoLS) where appropriate to ensure that this was done in the least restrictive way, consideration had not always been given to people who had been assessed as lacking capacity, where the decision had been made to lock their bedroom doors during the night once people retired to bed.

Care plans demonstrated that people and relatives were always asked to consent to their care and treatment, however where locks were used on the bedroom doors during the night, this had not been documented appropriately to record and ensure that decisions were being made in the people's best interests.

Care staff received the relevant and appropriate training in order to effectively carry out their role. Care staff were supported through regular supervisions and annual appraisals.

People and relatives were complimentary of the food provided at the home and people were observed to have access to snacks and drinks throughout the day.

Is the service caring?

Good

The service was caring. We observed positive and caring interactions between people and care staff. People had established close relationships with all staff and were clearly able to communicate their needs.

People and relatives were involved in the care planning process.

Care plans were person centred and gave detailed information about people's likes and dislikes and how they wished to be supported.

Care staff knew people's likes and dislikes and were able to respond to their needs according to their choices and wishes.

Is the service responsive?

Good

The service was responsive. Care plans contained detailed information about people and their care and support needs. Care plans were reviewed and updated monthly with the involvement of people and their relatives.

People and relatives were aware of the complaints procedure and knew who to speak with if they had any concerns or issues to raise. They also told us that they were confident that the service would appropriately address their concerns.

An activity timetable was on display and people were able to access a variety of activities should they have chosen to. However, relative's feedback was that people were not sufficiently stimulated and that more could be done to enhance the provision of activities.

Is the service well-led?

Good

The service was well-led. People and relatives knew the provider and the registered manager and were confident in approaching them when required.

The quality of the service was monitored on a regular basis and where issues or concerns were noted an action plan had been devised to encourage learning and drive improvements.

People and relatives confirmed that they had completed an

annual satisfaction survey where they were able to provide feedback, ideas and suggestions on the quality of service that they had received.

Care staff told us that they were supported appropriately through various methods including supervisions and team meetings. Care staff told us that they were always encouraged to approach the provider and senior managers to highlight concerns or to make suggestions.

Anastasia Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 27 and 28 April 2017 and was unannounced.

The inspection team comprised of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had about the provider including notifications and incidents affecting the safety and well-being of people using the service. We also received a provider information return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with three people who used the service, 13 relatives, one friend, five staff members, the registered manager and the operations manager. During the inspection we observed how staff interacted and supported people who used the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

We looked at the care records of six people who used the service and checked files and records of eight staff members. Other documents we viewed were related to people's care including risk assessments, medicine records, relatives, resident's and staff meeting minutes as well as
health and safety documents.

Good

Is the service safe?

Our findings

People and relatives that we spoke with told us that they felt safe living at Anastasia Lodge and with the care and support that they received from care staff. Comments from people included, "I do feel safe here if you are not well the nurses see it and put it right" and "Oh yeah quite happy here, all the residents pull together." Relatives comments included, "I feel [relative] is safe here and taken really good care of by the carers. They treat her like one of their own relatives" and "Absolutely, he is safe or we wouldn't keep him here."

At the last comprehensive inspection on 15 October 2015 we found a number of failings in relation to safe management of medicines and records that were kept to ensure people received their medicines safely and as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Issues we found included that relevant documentation had not been completed and signed by relevant healthcare professionals in order to authorise the safe administration of medicines to people who required their medicines to be administered covertly, people had been prescribed pain relief patches to be applied to the body, a record was not kept of the site of application so that care staff would be aware of previous site applications to avoid patches being consistently applied to the same area in order to prevent unnecessary side effects and the service did not have PRN 'when required' protocols as part of people's care plans. At this inspection we found that the provider had made significant improvements to address the concerns we had found and were now no longer in breach of the Regulation.

During this inspection we looked comprehensively at how medicines were managed and administered to ensure people received their medicines safely and on time. We checked medicines storage, medicines administration record (MAR) charts and medicines supplies for 10 people. All prescribed medicines were available at the home. All medicines were stored securely in a locked medicines trolley within a locked room. Staff secured the medicines trolley to the wall of the medicines room when not in use. The room where medicines were stored was clean. Staff recorded the medicine and fridge temperatures daily to ensure that medicines were kept at the appropriate required temperature.

Care staff kept records of stock levels for all medicines on the MAR charts and this was updated daily. The 'date of opening' was recorded on all oral liquid medicines and eye drops. Controlled drugs were securely kept as per guidance under the Misuse of Drugs legislation. Controlled drugs are classified by law based on their benefit when used in medical treatment and their harm if misused. Clear records were kept in relation to the administration of controlled drugs which included two signatures confirming administration and stock levels. All unwanted medicines were returned to the pharmacy for disposal at the end of each month and records of these were maintained.

We saw documentation that the pharmacist had provided detailed guidance for each individual about the medicines they were to be administered covertly. Information was available on whether the medicine was suitable to be given covertly or crushed in its current form as crushing certain medicines could alter the effectiveness of the medicine. Where the pharmacist had recommended alternative forms of medicine suitable for covert administration this had been actioned by the service in partnership with the person's GP.

Only the deputy manager and senior carers were responsible for administering medicines to people. On the first day of the inspection we observed medicines being given to people by the deputy manager. The deputy manager took time and care to speak with people in a person centred way ensuring that people were given choice and autonomy when taking their medicines. Records confirmed that the deputy manager and senior carers had undertaken appropriate medicine training which included observed competency assessment every six months to confirm that staff were competent to administer medicines.

The registered manager and deputy manager conducted daily, weekly and monthly medicines audits to ensure that medicines were administered and recorded safely. An external pharmacist had conducted a medicines audit in November 2016. The audits looked at supply, levels of support, storage, basic hygiene and housekeeping, administration, recording of medicines, disposal of medicines, CDs, non-prescribed medicines, advice and training, monitoring, policy and procedures and communication. Completion of these audits highlighted areas for improvement and the actions taken to make improvements had been recorded.

Records confirmed and staff told us that they received annual training on safeguarding. Care staff were able to clearly explain the meaning of safeguarding and whistleblowing, the different types of abuse that a person could be subjected to and the actions they would take if they knew that a person was being abused. One care staff said, "I would inform the manager and if the manager didn't listen I can call CQC [Care Quality Commission]." Another staff member when asked about whistleblowing told us, "If we have any concerns even if it's about staff and the management didn't do anything about it I would call you [CQC]."

We saw records confirming that the registered manager had investigated and provided detailed responses to each safeguarding concern that had been raised. This included actions taken and improvement measures put in place as a result of the concern that had been raised.

Care plans contained detailed information and guidance to staff on each person's individualised risks associated with their care and support needs. Risk assessments detailed the identified risk, how this affected the person and guidance and measures put in place to mitigate or reduce the identified risk. Identified risks included falls, nutrition and hydration, pressure ulcers, use of bed rails, behaviours that challenged and moving and handling.

Appropriate assessments such as Waterlow and Malnutrition Universal Screening Tool (MUST) had been completed. Waterlow assessments assessed the level of risk of a person developing a pressure ulcer. A MUST is used to establish nutritional risk. Where people were assessed to be at high risk appropriate equipment and measures had been put in place to ensure that people were supported safely to mitigate and reduce the risk. Risk assessments were reviewed and updated on a monthly basis or sooner where a change had been noted.

The service had detailed records of each accident or incident that occurred within the home. This included the date and time of the accident, the type of accident, details of how it occurred, the injury sustained and the actions taken to support the person and keep them safe. Following the accident, the registered manager conducted an investigation into the incident so as to determine the possibly causes of the accident and preventative measures that could be put in place to prevent any future re-occurrences. Actions that had been taken included referrals to external healthcare professionals such as the district nurses, falls clinic and the local care home assessment team (CHAT) so that the appropriate help and support could be provided to the person.

At the last focused inspection in May 2016 we saw that although the service completed level of needs

assessment for each person living at the home the provider did not complete an evaluation or combined review of people's level of need assessments to determine staffing levels within the home. At that time we made a recommendation to the service to seek reputable advice and guidance in order to complete an evaluation and combined review of people's level of needs in order to determine appropriate staffing levels. During this inspection we found that although the provider had not sought any external advice about reviewing people's level of needs which would determine staffing levels, the provider continued to assess people's levels of need and the combined results of these assessments were used by the provider to review and set staffing levels based on their judgement and observation of what they felt was required to appropriately support people. The provider told us that they were confident with their processes and trusted the judgement that they had reached.

Feedback from people and relatives was generally positive, however, some relatives continued to make comment that additional staff were required possibly at the evenings and weekends. For the most part of the inspection we observed there to be sufficient staff available to meet people's needs. However, at the end of the first day of the inspection we observed that there were no staff available in the 'English' lounge. The registered manager was approached by a relative stating that there was no staff to support and one person had soiled their clothes and required immediate attention. The operational manager was also present when this situation presented itself. We spoke with the operations manager about this observation and that they needed to consider deployment of staff to ensure that staff were visible and available at all times around the home.

We looked at eight staff files and saw that the service had safe and effective systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that staff were eligible to work in the UK.

We looked at maintenance records for the home which included annual, monthly and weekly fire checks, call bell checks, monthly water temperature checks and equipment checks. These had been completed with noted action points were issues had been identified.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw records confirming that where people lacked capacity this had been appropriately assessed and where decisions were required to be made in the person's best interest, this had been documented to reflect the care and support the person required in specific decision making processes. This included decisions around a person requiring bed rails, receiving medicines covertly and where a person or family had requested for a 'do not attempt cardiopulmonary resuscitation' order to be in place. Where appropriate, requests for DoLS authorisations had been made and granted and documents confirming these were contained within the care plan including details of any conditions that had been set where appropriate. An overview was available confirming when the DoLS had been granted and when it was due to expire so that a re-authorisation could be submitted.

However, during the inspection we were informed by the registered manager that people's bedrooms were locked once people had retired to bed. The registered manager explained that doors could be opened with a key from outside and from inside people would be able to turn the lock and open the door, where people were capable and had the understanding to do so. This was because people who had a tendency to walk around the home and into other people's bedrooms, were stopped from doing so. The registered manager also stated that where other people who had experienced this occurrence in the past, by the locking of bedroom doors felt safe in their own rooms and did not get disturbed. The provider and registered manager told us that they had not given full consideration as per the Mental Capacity Act 2005 (MCA) to the impact of this on people especially those who lacked capacity. The decision to lock people's bedroom doors had not always been appropriately documented for people who had capacity and where people lacked capacity, best interest decisions had not been considered or documented. The operations manager did show us forms that could be used to obtain consent from people who had capacity but had only been signed by one person living at the home. As a result of our feedback the provider and registered manager assured us that they would stop locking people's bedrooms and would implement other appropriate systems to manage this situation safely.

Despite the lack of awareness around the MCA in relation to the locking of bedrooms, the operations manager, registered manager and care staff, were able to describe and explain the key principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this impacted on the care and support people received. One care staff told us, "If a client can't make a decision for themselves

other people can get involved including the GP, social services, managers and the family." Another staff member said, "The MCA is where we make decisions for people and apply for a DoLS so that we can decide in the best interest of the person."

Care plans contained signed confirmation that people had consented to their own care and support that they received. We saw, that where people were unable to sign their own care plan, relatives had signed the care plan confirming that they agreed to the care and support their relative received. Throughout the inspection we observed care staff asking for people's consent whenever they were about to support the person. This included asking if people wanted to wear a meal protector or if they were ready to have their medicines. Care staff told us, "We always ask for consent. We have to explain what we are doing, they have a right" and "It doesn't matter if they don't understand. We still have to ask them [people] and explain what we are doing."

People and relatives told us that they believed staff were appropriately trained and skilled to do the job. One person, when asked if they thought care staff had the training to do the job replied, "Oh yeah." Relatives comments included, "As far as I can see, yes", "In general yes. One or two don't speak good English, even when they talk to other staff, let alone other residents and staff" and "As far as I can see, yes."

Care staff told us and records confirmed that staff received regular training in mandatory topics such as moving and handling, medicines administration, first aid, safeguarding and MCA and DoLS. Additional training in other topics such as dementia, challenging behaviour, activities and end of life care had also been provided. All new staff employed by the service were required to attend a period of induction which covered topics as per the Care Certificate. The Care Certificate is training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

Care staff told us and records confirmed that they were regularly supported by senior managers which enabled them to carry out their roles effectively. Comments from care staff included, "[Registered Manager] is very supportive. I have supervision every month. I can talk to her even about my personal problems", "We have monthly supervision. We talk about things we have to do and how to look after people" and "We have supervision every month. We talk about progress and how to improve." We saw records confirming that all staff in addition to supervision took part in an annual appraisal which discussed performance and training needs.

People and relatives feedback about the meals that they received at Anastasia Lodge was positive. One person when asked about whether they liked the food told us, "Oh I love it." Another person said, "Yes I have no complaints about anything." Relatives comments included, "Yes it looks good. They also feed me at lunchtime too and it is alright" and "She is putting on some weight. Glad she is eating well. Lovely food, I have it as well."

During mealtime, we observed that people were offered a choice of meal and drinks and were seen to enjoy the meal that they had been given. Where people required assistance with their meal, care staff were seen to be available to support them. However, we did observe some negative interactions which did not promote person centred care. Care staff were seen to be standing over people when supporting them with little or no interaction with the person and on two occasions were observed to be putting food in the person's mouth with little regard to whether the person had swallowed the previous mouthful or no consideration given to when a person was expressing not wanting any more by keeping their mouth shut. These noted observations were fed back to the registered and operations manager to address.

Four weekly menus as well as weekly pictorial menus were on display around the home and people were

given the opportunity to choose what they wanted to eat every morning. Four week menus were discussed and planned by the head chef and discussed with people living at the service. The chef was aware of people's specific requirements especially where some people required a pureed diet or had cultural and religious requirements. Snacks including fruit and biscuits and drinks were visible around the home and people had access to these at any time. People's weights were monitored on a monthly basis and these were recorded as part of their care plan review. Food and fluid charts were completed for those people where concerns had been identified in relation to poor food and fluid intake and follow up actions were recorded where other healthcare professionals had been involved to ensure that people's nutritional and hydration needs were appropriately met.

Care plans contained detailed records of people's health and wellbeing and included information on how people were supported to access a variety of services as well as details of how their health and wellbeing was monitored. We saw records confirming visits from the GP, district nurses, speech and language therapists, chiropodists, physiotherapists and dieticians. Where people required professional input in relation to dietetic services or the speech and language therapists, we saw records of referrals that had been made. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

Good

Is the service caring?

Our findings

Care plans were seen to be person centred, individualised and responsive in order to meet people's needs. As well as people's likes, dislikes, choices and preferences, a life history document had been completed for each person which gave detailed information about the person, their childhood, their hobbies and interests and a list of their favourite things. Care staff told us that care plans were useful documents and gave them significant information about how the person wished to be cared for whilst living at Anastasia Lodge. One care staff told us, "The care plan tells you everything you need to know about the person. The first thing you have to do before you start caring is read the care plan." Another care staff said, "We know each person and we learn about their needs and requirements."

A pre-admission assessment had been completed for each person living at the home which gathered detailed information about the person and their care needs to ensure and confirm that the service could appropriately meet the person's needs.

Every month the service scheduled a monthly care plan evaluation meeting in conjunction with the person, their relative and their allocated key worker. The meeting involved reviewing the person's care needs, risk assessments and care plan. A document was then produced which contained details of the meeting and any noted changes that had been made. Relatives confirmed that every time they visited the home they were asked to read through the care plan and sign to confirm that they agreed with what was written and any noted changes. One relative told us, "Every time I go there, they ask me to read the care plan and sign it to confirm I agree."

Each care staff member was an allocated key worker for two or three people living at Anastasia Lodge. The key worker role involved paying specific attention to a person's personal care needs, ensuring they had sufficient personal clothing and toiletries, communicating with the family on day to day matters, arranging monthly reviews and updating their care plan.

Care staff at Anastasia Lodge had, over time, learnt how to communicate with people in their preferred language of Greek. Some care staff, who were not of Greek origin, had taken steps to ensure they had learnt basic and common words from the language so that people could express their needs and requirements and that care staff would understand what their needs were. This allowed them to be responsive in their approach to people. We also observed positive interactions between people and care staff especially with people who were living with dementia and required a specific approach. We saw care staff to be caring, patient, comforting and always explaining what they were doing.

However, during the inspection we observed an interaction of negative person centred, dementia care which did not support the person to be in positive well-being. The registered manager was approached by a person who wanted to go home to visit their parents and needed one or two shillings to allow them to do this. The registered manager responded by telling the person that their parents were no longer alive, that this was their home and that their home had been sold. This resulted in the person becoming further agitated and were left with a poor understanding of why they could not visit their parents. An inspector

intervened and used a dementia friendly approach that re-assured the person and left them in positive well-being. We spoke with the registered manager and operations manager about this and asked them to reflect on the approach that was used. We also asked them to review their own training and understanding of dementia care to ensure that the registered manager and all care staff were appropriately trained on how to support people living with dementia in a positive way.

A weekly activity planner was on display around the home and listed a variety of activities that included bingo, chess, orientation, music and signing. We observed activities that had been scheduled on the day of the inspection to have taken place. A daily record of what activities people had participated in or what they had done throughout the day had been recorded on an activity log. In the 'Greek' lounge, the service had provisions for people to watch Greek channels and had options to watch the news, drama's and music channels. People could choose to participate in group activities or an individual activity that they chose. However, we observed there to be certain times of the day where no specific activities were taking place and that people were left unattended with little or no interaction from staff. One person told us, "We have a lady that comes and we do exercise. One comes every day." We received mixed feedback from relatives about the level of stimulation that people received. Positive comments from relatives included, "He likes when they take him out. They have been to a pub twice" and "I am happy". Negative comments included, "There doesn't seem to be a lot of activities", "Our only concern is that there is not enough stimulation" and "There could be more stimulation for [relative]. [Relative] doesn't always interact with puzzles and games. The activities person does one to one activities like foot raising etc. They could do with a little more input."

The provider had a complaints policy and procedure which was clearly displayed around the home and gave clear directions on how and who to complain to if they had any concerns. The policy had also been translated in Greek so that people and relatives who were unable to read English, could read and understand the processes to follow in their preferred language of choice. Since the last inspection, the home had received one complaint. We saw records confirming that the provider was corresponding appropriately to manage and resolve the complaint.

People and relatives confirmed that they did not have any concerns or issues to raise but knew who to speak with to address concerns when they arose. One relative told us, One time I wasn't happy. [Relative] was sent to hospital on her own (number of years ago). I raised this and it hasn't happened again." Another relative said, "Every time we have asked about anything we have always got a professional reply."

Good

Is the service responsive?

Our findings

Care plans were seen to be person centred, individualised and responsive in order to meet people's needs. As well as people's likes, dislikes, choices and preferences, a life history document had been completed for each person which gave detailed information about the person, their childhood, their hobbies and interests and a list of their favourite things. Care staff told us that care plans were useful documents and gave them significant information about how the person wished to be cared for whilst living at Anastasia Lodge. One care staff told us, "The care plan tells you everything you need to know about the person. The first thing you have to do before you start caring is read the care plan." Another care staff said, "We know each person and we learn about their needs and requirements."

A pre-admission assessment had been completed for each person living at the home which gathered detailed information about the person and their care needs to ensure and confirm that the service could appropriately meet the person's needs.

Every month the service scheduled a monthly care plan evaluation meeting in conjunction with the person, their relative and their allocated key worker. The meeting involved reviewing the person's care needs, risk assessments and care plan. A document was then produced which contained details of the meeting and any noted changes that had been made. Relatives confirmed that every time they visited the home they were asked to read through the care plan and sign to confirm that they agreed with what was written and any noted changes. One relative told us, "Every time I go there, they ask me to read the care plan and sign it to confirm I agree."

Each care staff member was an allocated key worker for two or three people living at Anastasia Lodge. The key worker role involved paying specific attention to a person's personal care needs, ensuring they had sufficient personal clothing and toiletries, communicating with the family on day to day matters, arranging monthly reviews and updating their care plan.

Care staff at Anastasia Lodge had, over time, learnt how to communicate with people in their preferred language of Greek. Some care staff, who were not of Greek origin, had taken steps to ensure they had learnt basic and common words from the language so that people could express their needs and requirements and that care staff would understand what their needs were. This allowed them to be responsive in their approach to people.

However, during the inspection we observed an interaction of negative person centred, dementia care which did not support the person to be in positive well-being. The registered manager was approached by a person who wanted to go home to visit their parents and needed one or two shillings to allow them to do this. The registered manager responded by telling the person that their parents were no longer alive, that this was their home and that their home had been sold. This resulted in the person becoming further agitated and were left with a poor understanding of why they could not visit their parents. An inspector intervened and used a dementia friendly approach that re-assured the person and left them in positive well-being. We spoke with the registered manager and operations manager about this and asked them to reflect

on the approach that was used. We also asked them to review their own training and understanding of dementia care to ensure that the registered manager and all care staff were appropriately trained on how to support people living with dementia in a positive way.

A weekly activity planner was on display around the home and listed a variety of activities that included bingo, chess, orientation, music and signing. We observed activities that had been scheduled on the day of the inspection to have taken place. A daily record of what activities people had participated in or what they had done throughout the day had been recorded on an activity log. In the 'Greek' lounge, the service had provisions for people to watch Greek channels and had options to watch the news, drama's and music channels. People could choose to participate in group activities or an individual activity that they chose. However, we observed there to be certain times of the day where no specific activities were taking place and that people were left unattended with little or no interaction from staff. One person told us, "We have a lady that comes and we do exercise. One comes every day." We received mixed feedback from relatives about the level of stimulation that people received. Positive comments from relatives included, "He likes when they take him out. They have been to a pub twice" and "I am happy". Negative comments included, "There doesn't seem to be a lot of activities", "Our only concern is that there is not enough stimulation" and "There could be more stimulation for [relative]. [Relative] doesn't always interact with puzzles and games. The activities person does one to one activities like foot raising etc. They could do with a little more input."

The provider had a complaints policy and procedure which was clearly displayed around the home and gave clear directions on how and who to complain to if they had any concerns. The policy had also been translated in Greek so that people and relative's who were unable to read English, could read and understand the processes to follow in their preferred language of choice. Since the last inspection, the home had received one complaint. We saw records confirming that the provider was corresponding appropriately to manage and resolve the complaint.

People and relatives confirmed that they did not have any concerns or issues to raise but knew who to speak with to address concerns when they arose. One relative told us, One time I wasn't happy. [Relative] was sent to hospital on her own (number of years ago). I raised this and it hasn't happened again." Another relative said, "Every time we have asked about anything we have always got a professional reply."

Good

Is the service well-led?

Our findings

People and relatives knew the registered manager, deputy manager and the operations manager and felt confident in approaching them to discuss their or their relatives care and support needs. One relative told us, "She [registered manager] is approachable. No issues with speaking to her." Another relative said, "I know the manager to look at but not by name." Throughout the inspection we observed that people and relatives knew the management team by name and were able to approach them with their concerns and problems.

At the last inspection in May 2016 we found that a relatives meeting held in March 2016, had not been handled by the management team in a professional manner. As a result we recommended that the provider sought support and training, from a reputable source, for the directors and management team on how to deal with complaints and difficult situations. The provider confirmed that training had been delivered to the entire management team on how to deal with difficult situations.

The provider had changed the way they ran meetings to avoid a repetition of the issues that arose at the meeting in March 2016. This included set timings for comments, questions and answers after each topic discussed. In addition, an allocated time is set at the end of the meeting for people and relatives to approach the director and senior managers privately to discuss personal concerns and issues. We found that the most recent relatives and residents meeting held in October 2016 had followed the newly implemented format and feedback received from relatives on how the meeting had been conducted was positive. Agenda items discussed at the meeting included housekeeping, mealtimes, care needs of residents and staffing.

During the inspection we saw a number of posters displayed around the home which stated, 'Photos and Videos not permitted as per the meeting in October 2016, and for the reasons given there placements will be at risk if this is not adhered to.' This was due to previous complaints and safeguarding concerns that had been raised which had resulted in photos of people being used to evidence concerns without their or their relatives consent. Although relatives feedback about the posters was that they did not have any objections to them and found them to be clear on the message that needed to be communicated, we found that this poster did not promote a culture of openness and transparency which would encourage or support people and relatives to come forward with concerns. As a result of our feedback the posters were removed and the provider acknowledged that this directive could also be communicated by other means which could include providing relatives with a copy of their 'Photography and Videography Policy'.

During the inspection we were told that the home had implemented 'visiting times' for relatives and friends during the hours between 10am and 8pm. The operations manager confirmed that these timings were flexible and for guidance only and that people would not normally be asked to leave the home especially where people were not well and relatives expressed the wish to be with their relative. We asked the provider to look at recently published guidance that had been issued by the Care Quality Commission (CQC). The operations manager and registered manager was not aware of the guidance and confirmed that they would look at this immediately to ensure that they were meeting the regulations as per the guidance

recommendations.

Care staff were complimentary of the registered manager, the operations manager and the provider. Care staff told us that they could approach any member of the management team with their concerns or issues and were listened to. Comments from care staff included, "It's a nice place to work. [Registered manager] is very supportive", "Its good here. Very pleased to be working. [Registered manager] is supportive, whatever we need we can ask her" and "I am happy working here. I love my home."

Care staff told us and records confirmed that regular staff meetings were held, where a variety of topics were discussed and care staff were able to give feedback, make suggestions and give their own ideas on how to make improvements. Minutes of meetings were then circulated to all staff members so that staff that had been unable to attend were provided with information and details of the discussions that had taken place. Topics discussed included moving and handling, safeguarding, accidents and incidents, key working, activities and training needs. One care staff told us, "Staff meetings are helpful. We can give ideas and suggestions and they [provider] do listen." Another care staff said, "When we have something to say, we can. We give ideas and suggestions and they listen to us."

The registered manager and operations manager carried out a number of checks and audits to monitor the quality of care that the service delivered. This included care plan audits, medicine audits, health and safety checks, daily checks of people and their rooms, weekly monitoring chart checks including checks of food and fluid charts, monthly accident and incident analysis and a provider monthly care audit. Where issues or concerns were identified an action plan was in place to drive forward learning and to ensure improvements were implemented.

The provider had sent people and relatives an annual satisfaction survey to be completed between April and September 2016. The provider received 14 completed surveys from people and relatives and five from healthcare professionals involved with the home. Relatives confirmed that they had received questionnaires which they had completed. Results of the questionnaire were overall positive with some minor issues identified. The provider had compiled an analysis of the results which was presented at the relatives meeting in October 2016, with details of any learning that had taken place and improvements implemented as a result.