Authentic Care Services Limited

Anchor House - Doncaster

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Anchor House is a care home providing accommodation for up to 23 people. It is situated on the outskirts of Doncaster in the area of Town Moor. Accommodation is provided on both the ground and first floors and a secure accessible garden at the rear. At the time of our inspection there were 15 people using the service.

People's experience of using this service:
At the time of our inspection the service had a registered manager. 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.

Audits were in place to monitor the service. However, these were not always effective and did not always identify issues we found as part of this inspection. Some issues which had been identified had not been actioned.

There was not always enough staff available to meet people's needs and to complete essential jobs around the home such as cleaning. Some days the home did not have a domestic staff on duty which impacted on the care staff who were then responsible for the essential cleaning of the home.

We completed a tour of the service with the deputy manager and found there were some areas of the home which required attention as they were tired and worn.

People were supported to have maximum choice and control of their lives and staff supported people in the least restrictive way possible; the policies and systems in the service were designed to offer people maximum choice.

During our inspection we observed staff interacting with people and found they were kind and caring and treated people with dignity and respect.

Health care professionals were requested when people needed their support and guidance. Staff we spoke with confirmed they received training and support to carry out their roles and responsibilities. People received a balanced diet which met their needs and dietary requirements. Drinks and snacks were provided throughout the day.

We looked at care records and found they were clear and concise and contained relevant information. We observed staff supporting people in line with their individual care plans. On the day of our inspection there were no social stimulation provided for people who used the service.

More information is in the full report

Rating at last inspection:
Good (report published 28 September 2016).

Why we inspected:
This was a planned comprehensive inspection based on the rating at the last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Anchor House - Doncaster

Detailed findings

Background to this inspection

The 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.

Inspection team:
The inspection team consisted of one inspector.

Service and service type:
Anchor House is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We did not ask the provider to complete a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with other professionals supporting people at the service, to gain further information about the service.

We spoke with people who used the service and their relatives. We spent time observing staff interacting with people. We also 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 four staff including care workers, the deputy manager and the registered manager. We looked at documentation relating to three people who used the service, three staff files and information relating to

the management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

Requires improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
•Risks associated with people's care were identified and risk assessments were in place to minimise the risks.
•Risk assessments we looked at addressed hazards around things such as moving and handling, pressure area care, nutrition and risks associated with the environment. For example, one person had a risk assessment in place due to the risk of falls. Instructions were for staff to ensure the person walked with their walking frame and that all walkways were free from obstruction. We saw staff ensured this plan was followed.
•People had a Personal Emergency Evacuation Plan in place known as a PEEP. These were available in the reception area of the home. However, these were very brief – requires direction, and number of carers required.

Staffing levels
•There was not always enough staff available to meet people's needs and to complete essential jobs around the home such as cleaning. Some days the home did not have a domestic staff member on duty which impacted on the care staff who were then responsible for the essential cleaning of the home.
•We looked at the off-duty rota and found three shifts where only two care workers were scheduled to work over a 24-hour period. We spoke with the registered manager who stated this number of staff was sufficient for the dependency of the 15 people currently residing at the home. However, the care staff were also expected to complete other duties such as cleaning and food preparation on a regular basis.
•The registered manager explained that they provider was currently in the process of recruiting more staff. The registered manager also explained that the use of agency staff was kept to a minimum to ensure people who used the service knew the staff on duty. The deputy manager and registered manager also covered shifts on the care rota to prevent the need for agency cover.

Using medicines safely
•The provider ensured people received their medicines as prescribed.
•The deputy manager had the lead responsibility for ordering and returning medicine which were not required.
•Medicines were administered by staff trained to do so. The deputy manager told us that checks and observations of practice were carried out regularly to ensure staff were competent to administer medicines.
•Each person who required medicines had a medication administration chart (MAR). This was signed each time medicines were administered so that a clear record was maintained.
•Some people who required medicines on an 'as and when' required basis known as PRN. We saw PRN protocols were in place to ensure these medicines were administered appropriately.

•We saw medicines were stored in a locked room and medicines requiring cool storage were kept in a fridge in the same room. However, the temperature of the room and fridge was frequently too high. The registered manager told us they had tried a range of ways to bring the temperature down but nothing had worked. There was no plan to address this further.
•Some people were prescribed controlled drugs. These were stored and recorded safely. We checked the record against the stock and found them to be correct.

Preventing and controlling infection
•The provider did not always ensure that people were protected by effective prevention and control of infections.
•We completed a tour of the home and found some areas were tired and worn and potentially difficult to clean effectively. For example, one bed had a worn patch at the foot of the bed. One bathroom had a bath chair which was rusty and dirty underneath. The bath chair had also worn away some enamel off the bath side and this did not allow for it to be cleaned effectively. The mops we saw were grey as they had been over used and needed cleaning. The mop heads were also worn and required replacing.
•The registered manager did not have an infection control audit and therefore these issues had not been identified.
•The service had one domestic staff who worked Monday to Friday and one who worked Saturday and Sunday. These covered the hours of 9am to 1pm daily. However, the domestic staff usually working during the week was required to cover the rota as a care assistant. Therefore, essential cleaning only was being completed, when care staff had the opportunity.

Learning lessons when things go wrong
•Accidents and incidents were recorded on an accident form.
•The registered manager told us that all accident and incident reports were reviewed to determine if there were any lessons to be learned and shared with staff to prevent re-occurrences. However, there was no documented evidence of this.

Safeguarding; systems and processes
•The provider had systems in place to ensure people were protected from abuse.
•Staff received safeguarding training and staff we spoke with knew what actions to take if they suspected abuse.
•Staff we spoke with were confident the registered manager would take appropriate actions to ensure concerns were reported.
•People we spoke with told us they felt safe living at the home. One person said. "I'm very safe here."
•The registered provider had a recruitment policy which assisted them in the safe recruitment of staff. This included obtaining pre-employment checks prior to people commencing employment. These included references from previous employers, and a satisfactory Disclosure and Barring Check (DBS). The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. We looked at three staff recruitment files belonging to staff who had been employed since our last inspection and found they contained all the relevant checks.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Prior to people moving in to the home, an assessment of their needs was completed. This was to ensure the service could meet people's needs.
•People's needs were continually reviewed to ensure the care they received met their choices and preferences. Care was managed and delivered within lawful guidance and standards.

Staff skills, knowledge and experience
•People were supported by staff who received appropriate training and support to carry out their roles and responsibilities.
•Staff we spoke with confirmed they received training and support. One care worker said, "We all work as a big team and support each other. We get training and have supervision sessions."

Supporting people to eat and drink enough with choice in a balanced diet
•People received support to eat and drink enough to maintain a balanced diet.
•People received drinks and snacks in-between meals.
•We spoke with people who used the service and they told us the food was good. One person said, "We have a choice. This morning I asked for porridge and that's what I got."
•Meals were delivered to the dining room from the kitchen by a dumb waiter and served straight away, as there were no facilities to keep food hot.
•This limited the option for a second helping if people should request more lunch.
•At our last inspection we discussed the issue with the registered manager, and were told that the provider was looking at buying suitable equipment to keep food hot in the dining area, whilst maintain people's safety. This had not been addressed on this inspection.

Staff providing consistent, effective, timely care within and across organisations; Supporting people to live healthier lives, access healthcare services and support
•People were supported to live healthy lives and have access to healthcare services.
•We looked at care records and saw that where healthcare professionals had advised staff this had been documented within the care plans.

Adapting service, design, decoration to meet people's needs
•The service was tired and worn in places and in need of re-decorating.
•This had been identified on the providers action plan following a visit in May 2018, but also stated that they were waiting for occupancy levels to pick up.
•There was no decoration plan in place to address this issue.

Ensuring consent to care and treatment in line with law and guidance

•The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 people lack mental capacity to take 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

•We looked at care records and found they reflected the support people required to make decisions. Where people lacked capacity to make decisions, they had been made in the person's best interest.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported
•We spoke with people who used the service and they told us the staff were "lovely." Relatives also felt staff were caring. One relative said, "I would recommend it [the home] to anyone, it's welcoming and friendly and the staff always ask me if I want a drink. Staff are respectful and understand people's needs and are on the ball."
•We observed staff interacting with people who used the service and found they were kind and caring.
•Staff knew people well and were knowledgeable about people's needs their choices and preferences.

Supporting people to express their views and be involved in making decisions about their care
•Care records included a life history of people. This included their family, places they have lived and their hobbies and interests.
•We observed staff interacting with people and saw they offered choices, one person wanted a drink of coffee and they said just a bit of coffee. The care worker asked if they wanted a cup or a mug and the person said a mug but only half. Another person was looking for a comb and a carer said come on we will find one. The person said not before a hug They exchanged a hug and carried on looking for a comb the person had a smile on their face.
•The service had a key worker system in place where staff were responsible for ensuring people's needs are met and they had all their personal items they required.

Respecting and promoting people's privacy, dignity and independence
•Staff were respectful of people and the home. They respected privacy and dignity and ensured people's choices were respected.
•We saw staff closing doors and talking quietly to people to maintain confidentiality.
•Staff we spoke with told us how they ensured they maintained people's privacy. One care worker said, "We make sure people are happy and explain everything we are doing."

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

Good: People's needs were met through good organisation and delivery.

Personalised care
•People received care and support which met their needs and took in to account their preferences and choices. For example, one person required staff to speak slowly so they could understand the conversation. We observed staff communicating with this person in a caring and supportive way.
•Staff knew people well and were able to support them in line with their care plan.
•People were not supported to follow their interests and take part in activities daily. People who used the service, their relatives and staff, told us the home invited entertainers in to the home on occasions. We saw photos which reflected some of the activities which had taken place.
•The home employed an activities co-ordinator who was currently covering the night care rota due to staff shortages.
•During the day of inspection, we saw no activities taking place. People were watching television and sat together in the lounge areas. We saw that social stimulation had been recorded on other days. This included cards and board games and the choice was limited.

Improving care quality in response to complaints or concerns
•The service had a complaints procedure which was displayed in the main entrance of the home.
•People we spoke with and their relatives told us they were comfortable to raise any concerns with any of the staff. They felt their concerns would be appropriately addressed.

End of life care and support
•People were supported to make decisions about their preferences for end of life care.
•Care plans were in place to indicate people's funeral wishes and how they preferred to be cared for at this stage of their life.
•The registered manager and deputy were both end of life care champions. They had attended training and cascaded the information down to the staff team. This included staff watching a DVD called death, dying and bereavement which they were then asked questions about. This was to check their knowledge and understanding.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

•At our last inspection this domain was rated as requires improvement. This was because audits lacked detail and required embedding in to practice.

•At this inspection we found a range of audits were completed monthly and included areas such as personal allowance checks, wheelchairs and walking frames cleaning schedule, nurse call system test, medication audit, cleaning of commode chairs in bedrooms, and mattress audit.

•We found these audits had not identified the areas of concern we identified on our inspection, such as the worn bed and rusty bath seat.

•We also found that where audits had identified areas of concern, no plan was in place to address them. For example, the temperature of the medicine room and fridge was frequently too warm. This was identified on the audit as a concern. However, we spoke with the registered manager and were told that they had tried several options to bring the temperature down but nothing had worked. This had been left unresolved.

•The registered manager informed us that the provider visited the home every fortnight. Every three months the provider completed an audit. This looked at care plans, accidents, complaints, social activities, operation of the home. However, in May 2018 this audit identified that redecoration was required but were awaiting occupancy levels to pick up. The registered manager told us this was a funding issue and there was no decorating plan in place to address this.

•There was no infection control audit in place to ensure people were protected by the prevention and control of infection. The registered manager told us that the other audits encompassed infection control issues. However, the audits had not identified that mop heads required replacing.

•This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audit systems were not effective in identifying improvements and resolving concerns.

Engaging and involving people using the service, the public and staff

•The registered manager told us that questionnaires were sent to relatives and professionals twice a year. People living at the home were also asked to complete a questionnaire twice a year. This was to gain people's views and opinions about the service.

•Comments from questionnaires were positive. For example, one professional said, "Staff always polite and happy to help I have no complaints." Another professional said, "Car parking could be improved on, but it is always a pleasure to visit the home." Relatives questionnaires stated that they felt welcome, happy with care provided to their relative, totally happy with the service.

Working in partnership with others
•The management team had established and maintained good links with the local community and with other healthcare professionals which people benefited from.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility
•Since the last inspection the deputy manager had been assigned two management assistant days where they were supernumerary. This was to the rota to assist with management issues. There were plans to increase this support to four days a week.

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 17 HSCA RA Regulations 2014 Good governance Audit systems were not effective in identifying improvements and resolving concerns.