Anchor Lodge Retirement Home

Anchor Lodge Retirement Home

Inspection report

Cliff Parade
Walton On The Naze
Essex
CO14 8HB
Tel: 01255 850710

Date of inspection visit: 25 September 2015
Date of publication: 29/12/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

Anchor Lodge provides accommodation and care for up to 14 older people, some of whom may be living with dementia. At the time of this inspection seven people were living in the home.

This inspection took place on 25 September 2015 and was unannounced.

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

Staff understood their obligations in ensuring people were protected from the risk of abuse and knew what action to take if they had any concerns. People's care was assessed to identify areas of risk to their wellbeing and plans were made to mitigate these risks as far as possible.

Summary of findings

There were enough staff to support people effectively and staff recruitment processes were thorough with the necessary checks being made to ensure people who worked at the service were of suitable character. An induction and ongoing training programme was in place to support staff to develop and maintain the skills and knowledge needed to meet the assessed needs of people who used the service.

People could be assured the arrangements in place to manage their medicines were robust.

People's consent was sought for day to day care and support tasks and staff acted in people's best interests when they could not obtain this consent. People or their representatives were supported to make decisions about how they led their lives and wanted to be supported. Where they lacked capacity, appropriate actions had been taken to ensure decisions were made in the person's best interests. The service was up to date with changes regarding the Deprivation of Liberty Safeguards (DoLS).

The service had a long standing working relationship with the local GP who visited the service regularly. People were supported to access a wide range of health care professionals when required.

People had enough to eat and drink and those who required more or specialised support with their nutrition received it.

Activities were available and some people told us they enjoyed them. However some people were of the view that the management team could do more to promote individual engagement with people who used the service and encourage staff to do more with people who used the service. The manager agreed to meet with those who raised this issue and ensure their concerns were addressed.

Staff were observant and caring, ensuring people's emotional needs as well as physical needs were considered, and providing people with individual support based on their specific needs and preferences.

The home was well led and managed by the manager who was effectively supported by the providers. People living in the home, their relatives and staff were complimentary about the way the home was run and had confidence in the management team. Robust systems were in place to ensure that the standard of care people received was constantly under review and improvements were made when identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe in the home and were supported by staff who knew what actions to take to reduce the risks to people's welfare.

Staff knew how to recognise and report concerns of abuse.

There were enough knowledgeable and experienced staff on duty to meet the needs of people who lived in the home.

People were supported to take their medicines as prescribed.

Good

Is the service effective?
The service was effective.

The registered manager ensured staff were up to date with their training requirements and had the knowledge and skills to meet people's needs.

The service complied with the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People received enough to eat and drink and people's individual nutritional requirements were effectively met.

People had good access to a range of health care professionals and could be confident that guidance received from them would be acted upon and implemented by staff.

Good

Is the service caring?
The service was caring.

Staff knew people's needs and preferences well and treated people with dignity and respect.

Positive caring relationships had been formed between people using the service and staff.

Good

Is the service responsive?
The service was not consistently responsive.

Whilst the service provided the facilities for staff to engage people in social and recreational activities, and some organised activities did take place, not all people felt the service provided enough stimulation for people who used the service.

People's needs had been assessed and care and support was planned in accordance with people's wishes.

Requires improvement

Summary of findings

People and their relatives were confident that if they needed to raise any issues of concern that appropriate action would be taken by the service to resolve the matter to their satisfaction.

Is the service well-led?

Good

The service was well-led.

The manager was well regarded by people using the service, their relatives and staff.

The provider had robust systems in place to ensure the service delivered a good standard or care and support to people.

Anchor Lodge Retirement 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 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 25 September 2015 and was unannounced. This inspection was carried out by one inspector.

Before we visited the service we reviewed the information we hold about it. This included statutory notifications.

Statutory notifications include details about specific events which include incidents affecting people's welfare or accidents occurring which the provider is required to notify us of by law.

We spoke with four people who used the service. We also spoke with the relatives of two people and obtained the views of a community healthcare professional who regularly visited the home. We spoke with the registered manager and two care staff.

We reviewed the care records of four people including their medicines records. We looked at records relating to the management of the service including safety of equipment, staff recruitment records and training. We also looked at the systems in place for assessing and monitoring the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. A visitor told us, “There’s no need to worry about [relative]’s safety here.” Another person told us they felt safe when staff assisted them to move from a chair to a wheelchair.

Staff were vigilant of people’s physical safety. We observed one person falling asleep whilst holding a cup and saucer. A member of staff ensured the cup and saucer were placed safely on a table and the person was comfortable in their chair. Some people’s care records showed that staff needed to be present when they were walking around the home and we saw that people received the level of support they had been assessed as requiring which promoted their independence whilst keeping them safe.

Staff were knowledgeable about the vulnerability of adults living in residential care and told us they had received training about safeguarding. They demonstrated that they understood about different types of abuse and gave examples of circumstances where they might be concerned. Staff expressed confidence that the manager would deal with any concerns in the correct way and involve external professionals as necessary. They told us what action they would take and understood that they could, if necessary, report concerns outside of the provider’s organisation.

Staff followed effective risk management strategies to keep people safe. People’s care records contained a set of risk assessments, which were up to date and detailed. These assessments identified the hazards that people may face and the support they needed to receive from staff to prevent or appropriately manage these risks. For example, where a person was identified as at risk of developing pressure ulcers due to poor mobility, an assessment identified the need for a pressure –relieving mattress, which was obtained for the person concerned and was seen to have benefitted them.

People told us there were sufficient numbers of staff around to meet their needs. One person told us, “I know that if I need something there’s likely to be someone around any minute. If not I use the call bell and they always come then.” We saw that people spent their time together in the lounge during our visit, and there were always staff present ensuring that people were not left alone. We saw some people go for a walk to the sea front and a member of staff stayed with them making sure they were safe. A staff member told us that there was always enough staff on duty and that there were opportunities to just sit and talk to people. This was confirmed by our observations, where people were seen chatting for periods of time with staff. When staff did have to leave, to attend to another person or one of their tasks, they reassured the person that they would return when able and continue their conversation. We saw that the manager often helped out and staff told us this was routine due to the relatively small staff team and number of residents.

Staff recruitment processes were robust. References from previous employers were obtained and criminal record checks made before staff were able to commence working at the home. This helped ensure that the risks of recruiting unsuitable staff were minimised.

We looked at the systems in place for the management of people’s medicines and found them to be safe. Medicines were stored securely and at temperatures within the required ranges to ensure that the medicines were effective. We saw records were made when people received their medicines and observed a staff member administering medicines to people in accordance with best practice. The service had recently undergone an inspection by the supplying pharmacy and had responded positively and promptly to the few recommendations made.

Good

Is the service effective?

Our findings

Effective training and supervisory arrangements were in place to support staff. One person told us that they found staff at the home to be competent and knowledgeable about their needs. They said, "The staff know what I need and what I can do for myself. When they help, they do it with confidence and I feel assured." One staff member told us that the training they had received was good and they received regular updates to refresh their knowledge. Staff, including the manager, confirmed they received regular supervisions as well as an annual appraisal. They told us this process helped them to identify areas they needed more support and/or training. This meant people received care from people who were themselves trained and support to do their jobs.

The manager and staff team had completed training in the application of the Mental Capacity Act 2005 (MCA) and had demonstrated their understanding of the issues involved by completing clear and recorded assessments of capacity in respect of people who used the service. Where the staff had identified a person as lacking in capacity, a series of 'best interest' decisions were recorded in order to identify the ways the service would meet the needs of the person who lacked capacity. These decisions were reached after consultation with representatives of the person concerned along with involved health professionals and ensured that the least restrictive options were considered for areas the person could not consent to, for example, the administration of medicines required to promote the wellbeing of the person concerned.

When providing people with care, we observed that staff asked for people's consent. For example, people were asked their permission before clothes protectors were put on them prior to lunch and were asked whether they wanted to sit nearer to the table before their chair was moved in.

People told us they enjoyed the food. One person said, "The pudding was very nice today." Another person commented, "I didn't much like the vegetables served today, but normally the food is first rate." People could freely choose whether to take their meals in the dining room or their own accommodation. One person, who was eating in the dining room told us, "I sometimes eat in my room, which is fine, but normally I eat in here." We saw people's drinks were topped up with their choice of drink and they were offered second helpings of food or alternatives if they didn't want to eat what they had previously chosen. Lunchtimes were relaxed and people enjoyed their meals.

People were provided with flexible mealtime arrangements. One person told us, "I can have meals wherever I want." We heard staff asking people where they would like to have lunch and, if they chose the dining room, which table they wanted to sit at. We observed some people having their meals saved for them and they confirmed that this was their choice. One person said, "I had a late start today, but it's no problem here."

We saw in care plans that notes recorded people's eating and drinking preferences, for instance if a person found specific types of cutlery easier to manipulate. Recognised nutritional assessment scores were recorded and food and fluid charts were in place where needed. If any person's food and/or drink intake was causing concern a referral would be made to their GP, with a food intake chart used to provide evidence for the GP. The manager also informed us that nutritionists and dieticians had been commissioned to come to the service and provided guidance for staff on how to fortify meals. This demonstrated that care was taken to ensure that people had the food and drink that they needed to help them keep healthy.

Referrals were promptly made to other social and healthcare professionals when needed. We saw from people's care plans that health specialists involved in providing care included district nurses, community nurses and physiotherapists. A chiropodist visited regularly and opticians were called in when required. People's care records clearly showed what interventions had occurred and we were able to trace specific health matters raised through to plans of care to provide the required support, daily actions to show that the necessary care had been received by the person and medicines people received.

Good

Is the service caring?

Our findings

People were positive about the staff that supported them. One person said, "They're very good, and very kind." Another person told us, "Obviously I would rather still be at home, but it couldn't be any better here."

We observed that staff had good relationships with people who used the service and knew their needs well. One member of staff described in detail the measures the service took to respect people's preferences, such as how they liked to keep their bedroom, or their preferred hobbies and interests. One person commented, "I've been here over three years now and most of the staff are the same as when I moved in. I get on with every single one of them."

We saw that staff were observant of people's comfort. For example, they noted when people might have been getting cold and offered to fetch jumpers and offered to draw curtains when the sunlight through a window was making it difficult for people to see the television.

When care related tasks had been completed in the lounge we saw that staff often stayed with people for a few minutes more, chatting generally to them about things of importance to them or about things happening in the home at the time.

Staff took their time to explain options to people in order to give them the opportunity to make an informed choice and listened patiently when people had something to say or observed their physical response to suggestions to interpret the person's opinion. They understood the concerns, behaviours and preferences of the people they were supporting which helped staff to deliver people's care in a way that would be well received. Relatives told us that their views were sought by the staff when planning people's care and were regularly asked if they had any comments to make about the way care was organised and delivered at the service.

People told us that staff were caring and respected their privacy and dignity. Our observation during the inspection confirmed this. People who liked their privacy and wished to spend time in their bedrooms were supported to do so. Staff were clear about the actions they needed to take to ensure people's privacy when delivering personal care. We observed staff knocking on people's doors and waiting before entering. Staff spoke with people discretely about their personal care needs. We observed that staff were respectful when talking with people, calling them by their preferred names.

Relatives told us that they were always welcomed at the home and that staff were friendly and approachable. One told us that there was always a good atmosphere in the home and that they felt that staff, "Really go out of their way to make you feel at ease with everyone."

Requires improvement

Is the service responsive?

Our findings

The manager informed us that due to the small number of people , care staff generally arranged activities as and when people requested them. They also told us that one member of staff provided beauty treatments for people, along with aromatherapy, and was employed as an activities coordinator for one day a week. However, the feedback we received from people was mixed about the levels of stimulation provided. Some people told us they felt that staff did not take all the opportunities available to engage with people on a one to one basis, particularly in activities that provided emotional and mental stimulation, such as reminiscence and/or word games. We spoke with the manager about this perception and they agreed to meet with the relative concerned and discuss the issues concerned to ensure that the service provided the required opportunities and encouragement for people to engage in stimulating activities based their preferences.

People told us that the service was responsive to their needs. People's care records contained assessments of their needs and details of their preferences. care plans were reflective of people's needs and supported staff to manage specific health conditions. For example, one person required support to attend their place of worship and the manager had ensured suitable arrangements were put in place to enable them to continue to observe their faith in the way they preferred. Where people were at risk of deteriorating health such as developing pressure ulcers, risk assessments had led to individualised care plans which staff demonstrated they knew about and could explain what action they took**.** There were ongoing reviews of people's needs. Where changes had been identified, care plans had been updated and the information disseminated to staff. Staff told us that they felt well informed about people's needs and that there were a number of ways in which information was shared, including a verbal handover session at the beginning of each shift. We observed a staff handover and found that detailed information about each person's needs was shared and discussed by all those concerned.

Staff knew about the people they cared for and had a good understanding of what circumstances could cause people to become anxious or distressed. They were able to tell us how they worked to avoid these situations as far as was possible, but when this was not possible, how they helped the person to become less upset. These included changing the staff working with particular individuals, if they presented as more anxious and/or distressed when different members of staff were around.

People told us they had no concerns about the care they received. One person said, "I've got no complaints, but if I did I have a good relationship with the manager and they would sort it out, no problem." Two relatives told us if they had any concerns they would feel comfortable in raising them and felt sure that their concerns would be taken seriously and acted upon. Information on how to make a complaint was available for people and visitors to the home. We examined the records the home kept in relation to complaints. Only one complaint had been received in the last 12 months. The records indicated that the manager had responded appropriately to the concerns raised and taken the appropriate actions. However, the records did not include any written confirmation that the person making the complaint was satisfied with the outcome. The manager told us that they were certain the complaint had been resolved to the satisfaction of the complainant but identified the gap in the records and agreed to rectify the shortfall in the future.

Good

Is the service well-led?

Our findings

People and their relatives were positive about the way the home was managed. They told us they saw the manager often throughout the day and knew her by name and that she knew people living in the home and their visitors. Relatives told us the manager was approachable and that they had confidence in her leadership of the home.

The manager had worked for the provider for several years in a number of different roles. They told us they felt very well supported by the providers who were, "Always ready to come down and support me, or talk on the phone and give advice if needed. But they trust me to get on with my job."

Staff were supportive of the manager and the providers and told us that they felt the ethos of the management was clear, and it was, "To provide the best possible care for people and make them feel like this is their home." Staff told us they felt able to put forward suggestions for improvement with the manager and that these were always considered by the manager.

There was a good atmosphere and an open culture in the home. We observed staff taking time to communicate with and involve everyone, not just those who were more able or more inclined to respond. Staff were cheerful and people were relaxed in their presence. People were asked their views about day to day matters, for example, what was on the television and encouraged to have their say.

We saw that the provider sought feedback about the service. A quality assurance, 'Customer satisfaction' survey had been completed and people had responded consistently positively to questions about the service. The manager informed us that they always responded individually to anyone who raised any suggestions or concerns, ensuring that improvements were implemented wherever possible. They gave us an example, where people had suggested celebrating harvest festival and the staff team arranged for an outing to a local church to celebrate.

Systems were in place to check the quality of service provided, including regular checks on the quality of recording of staff, medicines and care plans. The manager confirmed that when these checks were completed, she made a list of any actions required to improve the service and ensured these were undertaken, with the support of the provider if needed. The records we saw confirmed this.

We were satisfied that the provider had systems in place to gather information on the quality of the service provided to people and that areas requiring action were identified and standards of care provided were maintained and improved as necessary.