

Anchor Trust

Annesley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We inspected the service on 19 April 2018. The inspection was unannounced. Annesley Lodge is a care home providing accommodation, and personal care for people who live at the service. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Annesley lodge accommodates up to 51 people. On the day of our inspection 31 people were using the service.

A registered manager was not in post during the inspection. There had been no registered manager working at the service over the previous five months. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was being managed by an interim manager. The provider had based a regional support manager at the service on a full time basis since February 2018. The provider was aware that once a permanent manager had been appointed this person would be required to register with the Care Quality Commission. We will continue monitor the progress of the appointment and registration of a new manager for this service.

This inspection was planned to follow up on concerns we found at our last inspection. When we previously visited the service we found them to be in breach of three regulations of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. These related to safeguarding concerns and management of medicines. At this inspection, we found evidence to show they were no longer in breach of these regulations. However, we found a further breach in the regulations relating to the need for consent, and there were still further improvements to be made at the service. Our overall rating for the service is Requires Improvement this is the second consecutive time the service has been rated as Requires Improvement.

People living at the service were protected from the risk of abuse as the provider had responded to and reported safeguarding concerns relating to the people in their care. Staff had a good knowledge of their responsibilities in relation to safeguarding and they had received recent training to support their knowledge base. The regional support manager dealt with safeguarding issues openly, so lessons could be learnt to prevent future incidents.

The risks to people were assessed, and staff showed a good knowledge of the individual risks to people's safety. However, the risk assessments sometimes lacked detail. The regional support manager was aware of the need to improve this information and had plans in place to address this.

The management of medicines showed improvements and people were receiving their medicines safely from suitably trained staff. People were protected against the risk of cross infection as the provider had protocols and processes in place, and staff had the knowledge and equipment to manage any infection control issues, and maintain the cleanliness of the service.

Staffing levels met the needs of the people in the service and they were supported by staff who received an induction, were well trained and received regular assessments of their work. People felt staff understood how to support them effectively. Staff used nationally recognised tools to assess the needs of people who lived at the service.

People lived in an environment which met their needs, however the service was in need of refurbishment in places, and there was a lack of permanent storage for some pieces of equipment. People's health and nutritional needs were well managed and staff acted on advice given to them by health professionals to manage people's health and nutritional needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People were cared for by staff who showed kindness and consideration of their needs and had knowledge of their preferences and views on their care. They were supported with respect by staff who maintained their privacy and dignity whilst encouraging their independence.

People received individualised care from staff, however there were some aspects of care not clearly documented to give staff the knowledge they needed to provide people with the care they required. People's wishes in relation to their end of life care were not always documented and as a result staff did not always know about people's preferences.

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 were protected from the risk of abuse, as safeguarding concerns were highlighted, investigated and measures put in place to prevent further occurrence.

The risks to people's safety were reduced as staff had good knowledge of the risks people faced. However, some risk assessments in place required more detailed information to support this knowledge. The regional support manager was addressing this issue.

The staff levels met the needs of people at the service.

Medicines were managed safely and people were protected from the risks of infections, as staff had the knowledge and equipment in place to support good practice.

There were processes in place for staff to learn from incidents and accidents.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People's needs were assessed using nationally recognised assessment tools and staff received appropriate training for their roles.

People's nutritional and health needs were well managed and although the environment required some updating, it was suitable for the needs of the people who were there.

The principles of the Mental Capacity Acts were not always followed and people were not always supported to make decisions for themselves.

Is the service caring?

Good ●

The service was caring.

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

People's views in relation to their care were supported by the staff who cared for them.

People were treated with respect and dignity, and their privacy and independence was maintained.

Is the service responsive?

The service was not always responsive.

Some aspects of care were not clearly documented to give staff the support they needed to provide people with the care they needed. People's end of life care wishes were not always discussed and plans of care for this were not in place.

People were supported with a wide range of social activities and encouraged to pursue their hobbies.

People felt comfortable in raising any complaints or concerns and systems were in place to ensure complaints would be addressed when raised.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

There was not a registered manager in post.

There were processes in place to monitor the quality of the service, but these were not fully effective.

Staff and people had the opportunity to give their views on the service and staff felt supported.

Requires Improvement ●

Annesley 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 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.

We inspected the service on 19 April 2018 and the inspection was unannounced. The inspection team consisted 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.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved with the service, and commissioners who fund the care for some people who use the service.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

During the visit we spoke with seven people who used the service, two relatives, one team leader, three care workers, the cook, the regional support manager and the regional manager. 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 looked at all or part of the care records of four people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including maintenance records and quality audits carried out by staff at the service. We asked the regional support manager to email the service's training matrix to us following the inspection and this was provided to us.

Is the service safe?

Our findings

When we previously visited the service we found they were not responding to, or reporting safeguarding concerns relating to the people in their care. There had been a lack of investigation into safeguarding incidents. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had also failed to inform us of these events. It is a legal requirement of the registered manager to submit this information to the CQC and because of these omissions there had been a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

Prior to and during this inspection we found the provider was managing safeguarding issues appropriately and were no longer in breach of these regulations. Where they had identified issues of concern the management team had ensured they had informed the local authority safeguarding team and the CQC in a timely way. We viewed records that showed what investigations had taken place when there had been issues of concern. This meant the provider had made the necessary improvements to support the people in their care.

People we spoke with had no concerns about their safety at Annasley Lodge. One person said, "I feel safe here." Another person said, "I feel secure, you go to bed at night and know you're secure." Other people told us they could talk to the care staff if they did not feel safe.

Staff told us they had received training in how to recognise and deal with any concerns they may have relating to potential abuse of people in their care. They told us there were clear guidelines in place to assist them with reporting any concerns. Two members of staff discussed the whistle blowing policy when we spoke with them and both were aware that the details were in their staff room. Another member of staff told us they could also report concerns to either the local safeguarding team or CQC. Staff had confidence that the regional support manager would deal with any concerns they had.

At our last inspection we found the management of medicines was not always safe and because of this there was a breach of Regulation 12 of the health and Social Care Act 2008 (regulated Activities) Regulations 2014. Following our inspection we were informed of a small number of medicines errors at the service. However, during our inspection we found the regional support manager had investigated and addressed the issues around these errors. Since being in post the regional support manager had closely audited the ordering, storage and administration of medicines and had documented the safety checks they regularly performed. This meant there was better oversight of the management and safety of administration of medicines for people living at the service.

People we spoke with told us they were happy with the way they received their medicines. One person said, "I get my medication on time when it is needed." We observed a member of staff administering medicines and they did so in a safe way and clearly knew the needs of the people who they supported.

Our observations of the way medicines were managed showed there had been improvements to the safety

of medicines management at the service. The storage of medicines was safe, although we saw there were a small number of gaps showing staff had not monitored the daily temperatures of the medicines room and medicines fridge. The regional support manager had already highlighted this on their last audit and had fed back to the relevant members of staff.

Where people received medicines on an 'as required' basis, there were individualised written instructions to assist staff to ensure people received these medicines when they needed them. Staff we spoke with told us they received training before they were able to administer medicines and had their competency checked on a regular basis. As a result of what we found at this inspection the provider was no longer in breach of this regulation.

People we spoke with told us they had the equipment they needed to help them move around the service safely and as independently as they could. During our visit we saw people using different aids to help them with their mobility. For example, we saw some people had electric wheelchairs and other people used walking frames or sticks to support them.

Staff spoken with were able to explain how the different risks to people's safety were managed. For example, one person's health was variable and as a result they sometimes spent long periods in bed. Staff were aware and the person's care record showed how staff needed to support the person in maintaining their skin integrity and reduce to risk of pressure damage to their skin. The information in some risk assessments we viewed was limited and generic. They lacked clarity on how the scoring system, used to grade the risks to people, was to be used and in some cases the scoring had not been completed. We discussed this with the regional support manager who told us they were aware the information in people's files needed to be improved. They told us they were planning to address this issue as part of work to improve the information in people's care plans over the next few weeks.

We did see there was good information in some risk assessments for staff on the different equipment used to support people. For example, people who required a hoist to assist them to move from one place to another had the type of hoist, sling type and size in their care plan. There were basic safety instructions for staff on what checks they should carry out before using this equipment. During our visit we saw staff using moving and handling equipment confidently and safely. As we toured the service we saw people who required pressure-relieving equipment had this in place such as pressure relieving mattresses.

The majority of people felt there were enough staff on duty and the staffing levels had improved, but one relative felt at times that there was not enough staff to check on people particularly after the lunchtime period. We discussed this with the regional support manager and regional manager who told us they were already looking at the way staffing was managed after the lunchtime period. They were changing the way the afternoon handover meeting was managed so there were more staff around during this period. However, one person we spoke with also told us, "The staff are quite prompt to answer the buzzer, you don't have to wait very long." During our inspection we saw there was enough staff on duty to meet the needs of people.

Staff we spoke with felt staffing levels had improved since the last inspection and they felt people's needs were being met with the current staffing levels. One member of staff told us earlier in the year the staff levels were "not great." However, since the regional support manager had been managing the service staff had felt more supported. The regional support manager had employed new staff and had managed staff sickness more robustly, and as a result things had improved. Staff felt they were better organised now and we saw at a staff meeting how the management team had listened to staff when they discussed how staff numbers on shifts should be organised.

The provider undertook safe recruiting practices when employing staff. The staff records we viewed contained references from previous employers. The provider had used the Disclosure and Barring Service (DBS) to carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. The checks are used to assist employers in making safer recruitment decisions.

People were protected against the spread of infection at the service as the provider had processes in place to manage any outbreaks. People told us they felt Annasley Lodge was clean and they were happy with the way their rooms were maintained. One person told us their room was cleaned on a daily basis. They also said, "The rooms are very clean and tidy and everywhere is so clean."

Staff we spoke with showed a good knowledge of how to protect people from the risk of infection. We discussed a recent outbreak of infection with staff and the practices they had undertaken to reduce the spread of the infection. Staff showed good knowledge of how personal protective equipment and handwashing was used to be effective in reducing the spread of infection. We viewed an infection prevention and control audit the regional support manager had undertaken in March 2018. We saw they had highlighted areas for action with dates for completion and the person responsible for the action. We noted these actions had been completed.

The regional support manager worked with staff to ensure lessons were learnt following any issues of concern. They did this through staff meetings, supervisions and staff handovers. We viewed staff meeting minutes that showed how safeguarding concerns had been discussed and what measures were in place to reduce the risk of reoccurrence of particular issues. This showed the regional support manager continued to work to protect people through learning from previous safeguarding concerns.

Is the service effective?

Our findings

Where people lacked the capacity to make a decision, the provider had not always followed the principles of the Mental Capacity Act (2005). The 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.

We viewed mental capacity assessments for one person. We found documentation was incomplete and did not give a clear picture of the person's mental health needs. Our discussions with staff showed the person was living with dementia but that their capacity fluctuated. The person's care plan did not give clear guidance on how staff should manage this aspect of the person's care. There was no information on what advice or support had been obtained from health professionals or the person's family on decisions made to ensure the least restrictive options were in place to manage this person's care.

Another person's care record show the principles of the MCA had not been followed when people had Deprivation of Liberty Safeguards (DoLS) authorisations in place. People can only be deprived of their liberty to receive treatment and care 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).

The DoLS authorisation for this person had stated conditions, which the provider was legally obliged to follow. The condition stated the person was known to enjoy going out and that the service should review off site activity options for them. We found the condition had not been met and there was no record in the person's care that the options had been explored. One member of staff we spoke with told us the person had not left the service during the time they had worked there, which was prior to the authorisation of the DoLS.

The above issue is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not always supported to make decisions about their needs and could be discriminated against as a result. For example, we saw one person who was living with dementia, had some visual and hearing impairment. Staff we spoke with told us how they needed to sit close to the person so they could see them and speak slowly and clearly. However, they were not aware of any aids used to assist the person with communication such as sign language, large print cards or picture cards. We spoke to the regional support manager who told us there were visual aids that could be used. However, they were unaware of whether the person had been assessed to find out if these aids would be useful in communicating with the person. They told us they would address the issue. Following our inspection regional manager sent us information on the measures they had undertaken to address this issue.

People's needs were assessed using nationally recognised assessment tools. These tools assist staff to assess different aspects of people's needs to ensure they receive the most appropriate individualised care. For example, the water low assessment scoring tool, to identify if a person is at risk of skin damage that could lead to pressure ulcers, was used. In addition, the malnutrition universal scoring tool (MUST) was also used to monitor people's weights and identify when staff need to offer extra support with their nutritional needs.

People told us they thought the staff were well trained. Our observations of staff practice were positive. When assisting people staff took their time and were caring and confident in their actions.

Staff felt the training they received was appropriate for their roles. The training was a mixture of e-learning, face-to-face training and group supervision. One member of staff told us the regional support manager had arranged for a number of face-to-face training refreshers for staff. This included moving and handling training. We saw a session in progress on the day of our inspection. The member of staff said the extra training was "brilliant." Another member of staff said, "Yes (we get) the right sort of training, and I enjoy the training as we have group sessions. I feel I can say if I don't understand and they (trainer) will help." Staff also told us the regional support manager had put up a display board with information on how to prevent pressure ulcers. A health professional we spoke with told us they had also been asked to provide training sessions for staff on particular health conditions. Throughout our inspection we saw staff working confidently in their roles.

Staff also told us they had been supported with regular supervision and this had been helpful for them. One member of staff told us the supervisions made them feel supported. They told us the regional support manager made sure they were listened to and gave clear feedback on what was expected of them in their roles.

People were very complementary about the food they received at Annasley Lodge. There were comments such as, "The food is very nice." "It's gorgeous actually, really good." "The food is very good." People told us there was a choice of at least two meals, and if they did not like anything on the menu, an alternative would be found for them. We saw a snack trolley was brought out during the morning and people were offered drinks and snacks such as little bowls of grapes, biscuits or a small bowl with some sponge cake in it. Jugs of juice, water and glasses were available at all times in the sitting area. This meant people nutritional needs were met by staff.

Staff at the service were able to discuss the different diets people required and what support people needed with their nutritional needs. When required, staff had referred people to specialist health professionals for support with their diets. For example, one person had recently had a problem with coughing when eating and staff felt they were at risk of choking. They had gained advice from the Speech and Language Therapy (SALT) team on what modifications they could make to the person's diet to reduce this risk. We saw they had put a food monitoring chart in place and had been recording the types of food the person ate and any effects this had on the person in relation to triggering any coughing incidents. They told us as the person had some short-term memory loss this helped them to remember what foods they should avoid to reduce the risk to their safety/health.

Our discussions with the chef showed they were very knowledgeable about people's specialist diets and their preferences. They told us they made sure they spoke with people to ask if they enjoyed the food and get feedback on the meals provided. The chef told us the menus were on a four week rotation basis, but twice a year, Autumn and Spring, the whole menu was changed. They also explained that every six months they had menu taster sessions for people who lived at the service and their relatives, and for them to give

feedback on the new menus. This meant people's choices and views on the food they received were concerned by the service.

People told us they were supported when they had any health concerns. They told us sometimes the GP came to the service see them, but when they were able they were supported to attend the GP surgery. One person told us the optician and chiropodist regularly visited the service.

Staff we spoke with told us the team leaders responded promptly to any concerns they had about people's health and either spoke with the GP or district nurse who regularly visited the service. On the day of our inspection, we saw a health professional had come to see one person to undertake some tests following some health concerns. We discussed the service's responses to the health care needs of people at the service. The health professional felt over recent months staff had been more responsive to instructions given by health professionals. They felt communication had improved and the management team had been working to improve relationships with the health professionals who visited the service.

The environment people lived in was on the whole suitable for their needs. However, the environment in some places was in need of redecoration. The service also lacked sufficient storage space for some equipment that was being inappropriately stored. For example, the hairdressing suite that was used once a week had several wheelchairs, a hoist and other equipment stored there. This needed moving out each time the room was used for its primary purpose. We discussed this with the regional support manager who told us they were aware of the issue and had plans in place to address the issue of adequate storage.

Is the service caring?

Our findings

People were supported by staff who were caring and knew their needs and preferences. We received positive feedback in relation to staff's behaviours towards people. One person said, "I can have a laugh with the staff, they are like friends." Another person said, "I'm happy here. The people are nice. I seem to get on with everybody." A further person said, "The staff are lovely. I have no complaints about the staff. They make me feel wanted." Relatives told us they were not restricted as to when they visited their loved ones, one relative said, "I come anytime to suit me."

Staff told us there was a caring attitude towards people by their colleagues. A team leader told us there was a good attitude among staff and they made sure staff acted in a professional way. The regional support manager also monitored the practice of staff to ensure their actions supported good care.

Our observations throughout our visit supported what people had told us. We saw some positive interactions between staff, people and relatives. A number of times we saw staff giving reassurance to confused or distressed people, taking them by the hand or putting an arm around a shoulder, sitting with them, smiling and engaging in conversation. This behaviour was not restricted to care staff. The kitchen staff were well known to people as they chatted to them as they went around the building. This led to a relaxed and pleasant atmosphere at the service for the people who lived there.

The staff we spoke with knew the people they were supporting well, they knew about people's likes, dislikes and preferences. One member of staff told us they had got to know people's routines well. They discussed how some people liked to get up at a certain time each day and what their personal care routines were. They told us they knew how important it was for these people that staff followed their chosen routines so they felt in control of their day. People told us they felt comfortable talking with staff and asking for support and that staff responded to their requests for support.

People's care plans lacked evidence to show if they had been involved in the decisions about their care. However, people told us they made their own choices about how their care was managed. For example, we saw one person was undergoing some therapy sessions and they were independent enough to get themselves to these appointments. The regional support manager told us they were aware that a number of people's care plans needed reviewing and they were planning to arrange these meetings as they updated the care plans.

Where people required the service of an advocate they were provided with information about advocacy services available to them. Advocates support people who are unable to speak up for themselves. One person at Annasley Lodge was using the services of an Independent Mental Capacity Advocate (IMCA). IMCA is a type of statutory advocacy introduced by the Mental Capacity Act 2005. The Act gives some people who have impairment, injury or a disability, which results in them being unable to make a specific decision for themselves, the right to receive support from an IMCA.

People told us staff were careful to maintain their privacy and treated them with respect and dignity. One

person told us they liked to be as independent as possible, but sometimes needed help with washing and dressing themselves. The person told us the staff treated them with dignity, and respected their choice to be as independent as they could be. Staff we spoke with understood their responsibilities in maintaining the privacy and dignity of the people they cared for. We observed staff knocking on bedroom doors and respecting people's privacy. People told us they went to bed and got up when they wished to. One person said, "We do as we like, nobody dictates," Another person told us, "You can to go to bed whenever you want to. You get up when you're ready." People also said that they could, "go out when we want to." All they had to do was tell a member of staff.

Is the service responsive?

Our findings

People told us they felt staff treated them as individuals and provided person centred care. However, the care plans we viewed did not always contain detailed information for staff about people's care. One person's care plan noted in a mental capacity assessment that the person was sometimes resistant to personal care at a certain time of day. However, there was no further information about this issue in the person's personal care record, which gave staff information on the strategies they should use to assist the person should this behaviour occur. A risk assessment tool in the person's care plan also highlighted a risk of the person attempting to leave the building. While the risk assessment highlighted the security measures in place to prevent this, there was no information for staff on how they should manage the person's behaviours should they try to leave the building. This placed the person at risk.

However, one of the care records we viewed had some good information on the care the person required. For example, the person was becoming increasingly confused and their care plan gave staff information on how to orientate them by telling them the time of year, what day it was and the time of day. There was also good information on how staff should manage the person's tissue viability needs.

People's wishes around their end of life care had not always been discussed or recorded and plans were not always in place to support them when the time arose. Of the care plans we viewed only one had information around people's end of life wishes. We also found some documentation relating to people's end of life care was not correctly completed. For example, we found two 'Do Not Attempt Resuscitation' (DNAR) orders in one person's care plan. One of which was incomplete and the second had been completed in 2016 when the person was acutely ill. It was not clear from the documentation that a full discussion had taken place with the person and their relatives about this decision. We discussed this with the regional manager who told us they would address the issue to ensure the correct information was in the person's care record that reflected their wishes.

Staff we spoke with told us they did not always find the care plans useful, as they were not always able to find the information on people's care easily. The care plans we reviewed lacked organisation. We discussed this with the regional support manager who told us these issues would be addressed as they worked through the care plans to improve the information in them and made them more person centred.

Staff told us the communication around people's care needs had improved since our last inspection. They felt the daily handovers were more robust and the handover sheets were available for them to read so if they had been off for a few days they could use them to catch up on any changes in people's needs.

We checked to see if the Accessible Information Standard was being met. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. We found this standard had not always been met and people with impairments were not always supported with their communication. There was a lack of communication aids to support people who had visual and hearing impairments. Some signage at the service required some improvement. Whilst there was signage on toilets and bathrooms, some people did not have their names on their bedroom doors.

to assist them find their rooms. This meant some people living with dementia had difficulties finding their rooms.

People told us there were social activities available to them and the service had an activities co-ordinator in place. However, some relatives we spoke with felt the activities at the service could be improved. On the day of our inspection the activities co-ordinator facilitated a quiz for people in the main lounge area. We also saw there was an activities schedule in place on the wall in the main corridor of the service. We saw a planned walk to the local park took place during the afternoon of our visit. One person who spent a lot of time in their room told us, "Staff sometimes come down and talk to me." They also told us they were informed of the different activities on offer and could join in if they wanted to.

There was information available for people and their relatives on how they could raise complaints and concerns should they have any. The people and relatives we spoke with told us they knew how to raise a complaint and would feel able to do so should they need to. The relatives we spoke with told us when they had concerns and complaints they felt comfortable talking with the staff and any issues had been resolved for them. We saw the management team had managed concerns and complaints to people's satisfaction. On the day of the inspection, one relative told us they had just been into the office to discuss a concern and had been very happy with the way the regional manager and regional support manager had dealt with their concerns. Following our inspection, we received a complaint about the service. However when we contacted the person they told us they had been able to discuss their complaint with the regional manager that day and now felt much more settled and happy with the outcome of their complaint.

Staff we spoke with were aware of their responsibilities when dealing with complaints and concerns. They told us they would deal with any issues they could and raise any issues they could not resolve to the management team. They told us the team leaders and regional support manager would act on any issues.

Is the service well-led?

Our findings

The service did not have a registered manager in post at the time of our inspection. The registered manager had left the service in March 2018 but had not been working at the service for approximately five months prior to this inspection. During that time, three of the provider's senior managers had shared the management of the service. Each spending a number of days at the service each week. The regional manager we spoke with told us they had recognised that this approach had not been beneficial for the service, and since February 2018 a regional support manager had been based at the service full time. They also told us they had been successful in recruiting a deputy manager to the service who would start work within the next three weeks. The regional manager also told us they had now advertised for a permanent home manager who, once appointed would be registered with the CQC.

The senior managers at the service were aware of their responsibilities to ensure we were informed of any reportable incidents. These include reporting serious injuries, allegations of abuse and events that could stop the service running appropriately. The ratings for the last inspection were displayed on the provider's website and at the service.

The majority of the people and their relatives we spoke with did not know who was managing the service at present. One relative told us they thought someone from head office had been appointed to manage the service, but they were not able to tell us the person's name. A relative told us Annasley Lodge, "used to be the bees knees," but over the previous year the management of the service had "gone downhill." They went on to say that there had been some improvements recently with the 'interim manager' (regional support manager), but the service "still had a long way to go to get it back to where it was."

Staff we spoke with echoed these views. They told us since the regional support manager had been based at the service full time things had improved. They told us the regional support manager was visible and approachable. One member of staff told us up to and over the Christmas period they had felt very unsupported. They went on to say, "Now with (regional support manager) in place we know where we are. (Name) is approachable, firm, we know what we are meant to be doing." Another member of staff told us they felt things had improved since the regional support manager had been in post full time. They said, "It's simple things like having someone to talk to. There was a time if you wanted to know something you felt there was no one to ask, now there is more direction."

The quality monitoring of the service had not been robust over the previous months. There had been a lack of regular audits of essential areas of practice such as medicines, falls, management of people's weights, infection prevention and control (IPC) and care plans. However, since being in post the regional support manager had begun to address these issues. We saw they had undertaken auditing of medicines, falls, weights and IPC and had the template in place to audit care plans. The audits they had undertaken were robust and showed actions had been taken to improve practice following the audits. Measures had been introduced to reduce medicines errors and the regional support manager had undertaken spot checks on the way medicines were stored, administered and recorded. We saw evidence of these checks on medicine administration records (MAR). We viewed the falls monthly analysis and found prior to the regional manager

taking responsibility for this analysis (in January 2018) information had not been accurate. However, this had also shown improvement and the previous two months' analysis reflected the numbers of falls at the service and what measures there were in place to reduce risks to people.

People, relatives and staff we spoke with told us they had been given the opportunity to give their views on the service through surveys, questionnaires and meetings. However, people were unsure if changes had been made as a result. We saw the management team had put up a notice board with the title "You said, we did." heading, however the notice board was blank. We discussed this with the regional support manager. They told us they had removed information from the board as it was old and not relevant to what was happening in the service at present. The regional support manager told us, "Going forward this is where I will discuss with residents and their relatives on a monthly basis what they want to see, changes and improvements etc. My next meeting is planned for the 30 April." The regional support manager was planning to put relevant information on the notice board following this meeting.

Staff however told us they felt the regular meetings they had attended had resulted in them having a better idea of what was going on at the service. One member of staff told us, "At one time we were the last to know anything and now we are the first." They went on to say, "Now our ideas are listened to."

We discussed how the service learnt from past events with both the regional support manager and the regional manager. The regional manager felt they had learnt from not having a stable manager in place at the service and had changed this practice as a result. They recognised this had improved staff morale and they felt staff commitment had improved. Staff we spoke with supported this view. The regional support manager and staff felt the daily handover had a positive effect on learning from events as issues were discussed at handovers. The staff meetings had also played a part in helping staff learn from events and improve practice. We saw the minutes of the meetings. There was an agenda with headings such as Care practice and Safeguarding concerns. We saw at one meeting the issue of a person developing pressure sores had been discussed. The minutes showed what the regional manager had done to support staff with pertinent information and support from health professionals.

People could be assured the service worked in partnership with other agencies to support them. We saw the management team had worked with the local authority safeguarding team to learn from safeguarding concerns. They had recently worked with health professionals to support one person with health needs to ensure the person's needs were met in the most appropriate setting for that person.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.</p>