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Anbridge Care Home

Inspection report

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Anbridge Care Home on 26 and 28 September 2017. Our visit on 26 September was unannounced.

The service was last inspected in April 2016, and rated Requires Improvement. There were two breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to safeguarding people from abuse and carrying out financial assessments. Following the inspection the provider sent us an action plan which stated the breaches would be addressed. At this inspection we found significant improvements in all areas.

Anbridge Care Home provides accommodation and personal care for up to twenty people in a large converted and extended residential building approximately one mile from the centre of Oldham. At the time of our inspection the service had no vacancies.

When we looked around the home, we found it looked clean and homely with no unpleasant odours, and had been decorated in a dementia friendly fashion.

We spoke with staff who demonstrated a good understanding of safeguarding and showed they understood how abuse can occur. We saw that the service had safeguarding procedures in line with legislation and local authority policies so when incidents of potential abuse occurred these were reported and appropriate action taken to protect people from harm.

We saw that when recruiting new staff, appropriate processes were in place to ensure that they had the right quality and character to work with vulnerable people, and once in post all staff were provided with training opportunities to develop their skills. There were sufficient staff on duty, and we saw that they had time to spend talking and interacting positively with the people who used the service.

The home had good systems in place to provide safe administration of medicines, but we noticed that it would be possible for people to gain access to the room where medicines were stored when not being used. We pointed this out to the registered manager who took immediate action to ensure that the room was kept secure and accessible only to the responsible person on duty.

When we looked at care plans we saw that risks had been identified, assessed and steps had been taken to minimise the risk. When accidents and incidents occurred these were logged and audited so that any patterns could be identified and remedied.

Where people lacked the capacity to consent to their care and treatment, and were subject to a deprivation of liberty the service obtained the appropriate authorisation to provide care and support. We saw evidence in the care files of discussion and negotiation to show that people were consulted on how they liked their care to be delivered, but best interest decisions were not always documented.

Care staff at Anbridge House monitored people's general health, and where specific healthcare needs were identified the service was proactive in seeking the right level of support; liaising with health care professionals, such as general practitioners (GPs), District Nurses and mental health workers to provide an appropriate level of support. We spoke to a health care specialist who was visiting the home, who told us that staff listened to, accepted and acted on their advice.

Systems were in place to ensure good recording of information, and communication amongst staff ensured that information was passed on in a timely manner. Staff demonstrated a good understanding of the needs of people who used the service and how they would like their needs to be met. This information was recorded in care plans.

We found the service had developed a homely and caring atmosphere. Staff demonstrated a knowledge and understanding of the people who used the service and provided care in a person centred way. Case notes and daily logs reflected interventions.

There were a variety of activities and we saw that people were not left to their own devices. Staff spent time with people to provide stimulation and activity.

The registered manager had developed a good system of governance with regular reviews of care files and risk assessments. Elements of service delivery were audited on a regular basis, and people were consulted in how they wanted their care to be delivered. We saw that when complaints were made directly to the service these were investigated with a response sent to the complainant. However, we were aware of an outstanding complaint being handled by the local authority.

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.

Staff understood how to keep people safe from harm, and when allegations of abuse were made these were thoroughly investigated.

People were supported by a well established team who had been recruited safely.

Medicines were administered in line with current medical guidelines.

Is the service effective?

Good

The service was effective.

Staff were well trained and people felt confident in their abilities to care for them.

Where people were deprived of their liberty the correct authorisation had been applied for.

There was good liaison with health care professionals.

Is the service caring?

Good

The service was caring.

People were happy with the care they received.

People were consulted and assisted in drawing up their care plans.

The service respected people's privacy.

People received good end of life care.

Is the service responsive?

Good

The service was responsive.

People contributed to their care reviews and were consulted on service provision.

Care plans reflected people's needs and how they would like their care to be delivered.

There were a variety of activities available.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place who understood his legal obligations.

The service promoted a person centred culture.

The service regularly conducted audits and completed satisfaction surveys.

Anbridge 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.

This inspection took place on 26 and 28 September 2017. The first day was unannounced. The inspection team consisted of one adult social care inspector, 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, specifically working with older people and people living with dementia.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Anbridge Care Home, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

During our visit we spoke with the registered manager who is also the owner of Anbridge Care Home. In addition we spoke with two team leaders, four care workers, the home administrator, a cook, a housekeeper, and a volunteer. We observed how staff interacted with people and spoke with seven people who used the service and seven visiting relatives. We also spoke with one visiting health care professional.

We looked around the building, including all of the communal areas, toilets, bathrooms, the kitchen, and the garden. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We observed how staff cared for and supported people, and looked at food provision.

We reviewed the care records for six people, four medicine administration records and five staff personnel files, and other documents related to the management of the home, such as maintenance records and service invoices.

Prior to our inspection we reviewed the information we held about the service, and contacted the local authority safeguarding and commissioning teams to obtain their views about the service.

Good

Is the service safe?

Our findings

When we spoke with people who used the service, they told us that they felt safe. One person said, "I like it here, because I feel safe", and another told us, "Yes it's very nice here and they look after you really well". A visiting relative told us, "I couldn't have found anywhere better for [my relative], there's nowhere like it. I know [my relative] is safe here and I've got my life back too! I didn't sleep for three years worrying about her so its win-win for everyone". Another remarked, "People are safe here, there is always someone to keep an eye on them, and I haven't seen anyone who isn't caring or would cause them harm."

All staff had access to the agency's Safeguarding Adults policy, which provided guidance on their responsibilities to protect vulnerable adults from abuse. The staff told us that they were aware of these procedures and demonstrated a good understanding of different types of potential abuse, and an understanding of the signs and symptoms that may indicate abuse. We saw that when incidents of suspected abuse had been raised with staff these were reported to the local authority safeguarding team and we saw evidence of investigation and follow up action, with protective measures put in place.

Similarly, the staff were aware of the provider's whistleblowing policy. We asked if staff had ever had to raise any issues with the management, and they replied, "Never. I have always been happy with how staff treat people here, but if I saw something not right I wouldn't think twice about reporting it believe you me! And if I got no joy from the manager I'd be right on to the CQC!"

People were supported by an established staff team, many of whom had worked at Anbridge Care Home for eight years or more. We saw from the provider information return sent to us by the registered manager prior to our inspection that the ratio of staff to people who used the service had increased in response to the increasing level of need. People who used the service told us that they believed there were sufficient staff on duty. One commented, "Help comes straight away when I need it", and another told us, "There's always someone around and they have time to listen to us".

Staff turnover was low. We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people living at Anbridge. We looked at five staff personnel files. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, interview notes, a job description, two references and a medical questionnaire. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work, and these checks were updated every three years. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Anbridge Care Home. During our inspection there were sufficient staff on duty, and when we reviewed the rotas for the previous three weeks we saw that this was consistent. The registered manage/owner told us they did not use agency staff but had developed a small bank of staff to cover shifts as required. This meant that people were not supported by unfamiliar staff.

The home had a bright and airy feel with no malodour in any areas visited. Two of the people who used the service kept pets: one a budgie and another a hamster. This helped create a homely atmosphere. When we toured the building we saw that all areas were clean, but noticed some of the doors, walls and skirting boards were heavily scuffed, and carpets worn. We raised this with the registered manager/owner, who showed us the business plan which proposed some repair and replacements to fixtures and fittings. The home did not employ a maintenance officer, but the owner would carry out any day-to day and routine repairs within his competence, and contract any further work to the appropriate contractors. A rubber bath mat covered with mould/mildew was in the communal bathroom. We were told this belonged to person who had recently had a bath, and when pointed out the condition of this mat staff agreed to talk to the person to arrange for a replacement.

When we toured the building we saw that any equipment or substances which could cause damage to health if used incorrectly, such as bleach, disinfectants or other cleaning materials, was secured in locked cupboards. Baths had thermostatically controlled taps to maintain a comfortable water temperature, and to minimise the risk of scalding.

We saw alarm calls were close to beds so that people could summon assistance during the night if necessary, and where people had been assessed as being at risk of falling out of bed or getting up during the night there was appropriate equipment in place to alert staff.

We saw that the home was secure. The entrance was kept locked; to gain entrance we were required to ring the doorbell and staff checked our identity and asked us to sign the visitors' book before allowing us access. This ensured that unauthorised people would have difficulty entering the home. However, room call alarms were linked to the same system and there was no differentiation between sounds. Although we noticed calls were answered promptly the sound of call bells provided a consistent background noise, especially as there were lots of people entering and exiting the home. People who worked in, or used the service told us that they had become accustomed to this.

Staff had undertaken infection prevention and control training, and those we spoke with understood the importance of infection control measures. Anti-bacterial hand gel dispensers were situated in the foyer and throughout the home. Posters detailing correct hand washing procedure were on display in toilets and bathrooms and in the kitchen and laundry.

We inspected the kitchen and saw that it was clean and that the daily cleaning schedules were completed correctly. Food was stored safely and the fridge and freezer temperatures were monitored and recorded daily. These procedures helped to minimize the risk of food contamination. A 'Food Standards Agency' inspection had been carried and the home had been awarded the highest rating.

Colour coded mops and buckets were in use to help prevent cross infection, for example, from toilets areas into bedrooms, and followed the National Colour Coding Scheme. We observed staff using tabards, disposable gloves and other protective measures when completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care Soiled items were transferred from people's bedrooms or toilets to the laundry in special bags that could be put straight into the washing machine to help reduce the spread of infection.

We looked at records which showed appropriate and timely recording of incidents and accidents. However, the forms did not provide much information to show how people were monitored after an incident occurred. We spoke to the registered manager about this and he agreed to consider revising the accident logs to record how staff monitored people in the hours and days after they had been involved in an accident

or incident.

We saw that environmental risks had been assessed and where issues identified appropriate measures were in place to mitigate the risk. Team Leaders would conduct a daily 'walkabout' where they would walk throughout the building and if any issues of concern were identified these would be reported. In addition, the registered manager/owner would completed and record a monthly maintenance check which identified issues such as structural damages, or leaks and would arrange for repair. Electrical installation and gas equipment were checked by external contractors and records kept to show that these were safe. We also saw documentation for the lift, wheelchair, hoist and sling checks, the control of Legionella and portable appliance tests (PAT). This meant equipment was safe for staff and people who used the service.

The service had a business continuity plan to inform staff of how the home could function with a loss of facilities such as gas, electricity or bad weather. Each person who used the service had a personal emergency evacuation plan (PEEP) which informed any emergency services what support each person needed to leave the building safely. The fire alarm and call bell system were also checked monthly to ensure they were working correctly, and records showed all fire equipment was tested externally on a yearly basis. There was a record of fire drills with staff being taught evacuation of the premises. During the most recent drill, notes show that the evacuation process included simulation of a horizontal evacuation.

We asked staff how they managed risk to individuals who use the service. One person told us, "We manage them at their own pace, and support them to be independent, intervening only when it is necessary". All the staff we spoke with were able to give a good account of people's needs and how their behaviours placed them at risk. The information they gave us was reflected in individuals care plans. We looked at the care records for five people. In addition to assessments for generic risks such as the risk of falls, or developing pressure sores, we saw risks specific to individuals had been assessed. For example, pain relief, use of alcohol, entering kitchen using lighters, or getting in and out of bath. Each identified risk detailed the hazard, benefits to the individual, and the desired outcome. A subsequent care plan provided guidance to staff to meet and minimise the risk. Risk assessments were regularly reviewed and we saw that interventions had helped to reduce the risk over time.

We looked at the system for managing medication at Anbridge Care Home. Medicines were ordered by the Team Leader on a 28-day cycle the week before the cycle was due to begin, and checked in and signed for by two staff.

All medicine was stored in a locked cabinet in a treatment room when not in use. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines are stored correctly. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct. The team leader we spoke to told us that the team leaders starting and finishing each shift completed a full count of controlled drug stocks. This minimised the risk of error, or loss of controlled medicines.

The treatment room was kept locked, but we noticed that the key was kept on a hook above the door. This was not secure, as it meant that anyone who could reach the key would be able to enter the treatment room unattended, and gain access to the medicine stock. We raised this with the registered manager/owner, who agreed that this was a risk and took steps immediately to ensure that the team leader would hold the keys on their person throughout the shift.

Relatives of people who use the service told us that the care staff were attentive to people using the service when they gave them their medicines. Team Leaders were trained to administer medication. We spoke with a Team Leader who informed us that they had completed regular medication training and confirmed that they were happy with the training received. We observed one medication round during our inspection. The senior care worker checked the dosage and that they were for the right person before placing the tablets into a small pot. They approached the person, addressed them by name and explained what they were offering. They then checked the person had a drink to help wash the tablet down. Once satisfied that the person had taken their medication the Team Leader recorded this accurately on the Medication Administration Record (MAR Sheet). MAR sheets included a photograph of the individual and noted any allergies. The records we checked were accurate, up to date and matched the medicines in stock. There were no gaps in signatures. There was also a signed log of all returned unused medicines.

Good

Is the service effective?

Our findings

When we spoke with people who used the service and their visitors, they told us that in general they felt the staff were competent and knowledgeable. One visitor, for instance, told us, "The staff know all the residents as individuals, their quirks, likes and dislikes. There is flexibility with their needs, no restrictions, but there is a good structure in place. They've got it just right." Not everyone was so happy, and when we asked one person who used the service about the competence of the staff they told us, "Staff don't always help me, it depends who it is". This person appeared uncomfortable due to back pain, but informed us that they refused to take pain killers. This was confirmed by care staff, and when we reviewed this person's care plan we saw that alternative ways of reducing pain were being sought, including assessment for a more suitable chair to relieve pressure, and regular positional changes were recorded.

When we looked at personnel files we saw that as a part of their recruitment and induction process staff undertook a one day 'trial' at Anbridge. This helped to assess their capability and attitude, and allowed people who used the service to feed back to managers their views on the suitability of people. It also allowed potential recruits an opportunity to experience work in a care home.

The home administrator told us about the induction process for new starters. All new recruits would spend time working in each section of the service: office, housekeeping, kitchen and care, and spent time reading and understanding the policies and procedures, with particular emphasis on safeguarding and whistleblowing procedures. During their induction process, they would undergo mandatory training in health and safety, infection control, fire safety, moving and handling, food hygiene and first aid. They would also begin the Care Certificate. The care certificate is a nationally recognised qualification which provides staff with the knowledge to ensure they provide compassionate, safe and high quality care and support. During their three month induction period they worked alongside a more senior and experienced member of staff irrespective of their own experience to understand the routines and get to know the people who use the service. They would also undertake further training in safeguarding vulnerable adults and end of life care. At the end of three months, if suitable they would be offered a permanent contract.

We saw that the service valued opportunities for staff development, and all staff had enrolled on, or completed the National Vocational Qualification (NVQ) in Care at least at level two, with some reaching level four or five. Training opportunities were sourced from a variety of providers, including the local authority, Clinical Commissioning Group (CCG) and independent training consortia. From the training matrix, which maps out what training each person has received, and the date of renewal, we saw that all staff had completed training in moving and handling, infection control, health and safety, safeguarding adults and children, first aid, food handling and dementia training.

Most staff had competed other training such as end of life care, and 'react to red' (a workshop for care staff to respond appropriately to signs of poor pressure care), and we saw that other staff had been recommended for future courses. We saw that training was not provided exclusively for care staff. One person who was not directly involved in care provision told us, "I did dementia training; we are working around and with people living with dementia, so we really need to know about this".

The staff we spoke with told us that they received regular supervision and found this to be useful. One person said, "I get supervision from [my Team Leader]. It's good. They work alongside me, so will point out ideas for improvement. I find them easy to talk to; supportive too with personal needs". Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at five staff supervision records which showed that meetings were productive and staff used the opportunity to discuss issues of concern. The records also showed and documented consultation with people who used the service, offering them an opportunity to comment on individual staff performance.

Each member of staff would have a yearly appraisal where their performance over the previous year was analysed, and targets set for the following year. This also included an opportunity to review any training and how attendance on courses had helped improve their performance.

We saw the service operated effective systems of communication. We noticed that the afternoon shift would begin at 2:30 pm, but staff would begin to arrive from around 2:00pm. One person told us that this was because it allowed them to read up on any changes which might have occurred since they were last on shift, and allow for a good hand over of information.

During each shift staff would complete a handover file, providing a short summary for each resident and longer section for any intervention out of the ordinary. All staff would attend a morning and evening handover, and team leaders would meet in the morning with the home administrator to review the Team Leader Diary, which documented any issues of concern or scheduled appointments, and deal with any specific events planned for the day, allowing greater oversight of any specific issues during the coming shift.

Where untoward concerns were identified staff would call a 'safety huddle'. This allowed all staff the opportunity to get together to informally discuss a specific matter and agree or pass on ideas. This helped inform any risk assessments and lead to positive outcomes for the individual.

The Mental Capacity Act (2005) (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether Anbridge Care Home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw information to show that applications to deprive people of their liberty had been authorised by the supervisory body (local authority), or were awaiting authorisation. Where authorisations had been granted the service had informed the Care Quality Commission. Where a DoLS had been requested or authorised the information was stored within the person's care records, and a central file showed when the request had been made, authorised or due to expire. Records showed that the service had conducted best interest meetings for eleven people who used the service, and had applied for a DoLS for all of these people. At the time of our inspection applications had been lodged with the relevant authorising body (local authority, with two requests authorised). When we spoke to the relative of one of these people they were able to tell us, ''He's on a DoLS. They talked to me about this so I knew what was happening and why he had to be on one".

When we looked at care files we saw that people who were able had given signed consent to receive care and treatment at Anbridge Care home. However, we noticed that some people had fluctuating capacity, and decisions taken in their best interests, were carried through even when the person had capacity to make their own poor choices. We spoke to the registered manager/owner about the decisions made, and were given a clear rationale as to why this was in the person's best interest. When we spoke to one of the people involved, they agreed that the service "Does not always take me at my word, but I'd be dead right now if they did!" This person implied that they recognised that they were liable to make unwise decisions and that decisions taken on their behalf were in her best interests.

We saw that attention was paid to what people ate and drank and people received a nutritionally balanced diet. The kitchen displayed information about specific dietary needs and staff understood the specific requirements of people living at Anbridge Care Home. People told us that they enjoyed the food on offer. One person who used the service said, "The food is always good, we get the food we like, and portions are ample". The visitors we spoke with were also complimentary. One person told us, "The meals are good here; I have lunch here with my [relative] every Sunday". They told us how staff will assist with their relative's meals. One visitor said, "My [relative] has difficulty swallowing and he has no teeth. They are very good with him though; they give him soft food and always watch over him at meal times".

People had a choice of a cooked breakfast or cereals, porridge and toast. The main meal was served at lunchtime, and a lighter meal such as fish fingers, chicken dippers, or quiche for tea. During the day and evening snacks, such as biscuits fruit or cake were available, and drinks were offered throughout the day. Menus were planned four times yearly and rotated on a three weekly basis for the season. We saw that people who used the service were consulted when drawing up the menus. We saw people were given a choice of main meal. On one day of our inspection the main meal was either chicken curry or cottage pie. People were asked before the meal was served which they would prefer. One relative we spoke to told us that if their relative was unhappy with the choice, they could arrange an alternative: "The meals are good here but if there is something the others are having, such as beans on toast for tea which [my relative] doesn't like, then they will make her homemade vegetable soup. She doesn't like fish with batter so they will make her cod in butter sauce. All the staff here are just great".

We saw the dining experience was a pleasant occasion. Light classical music was played in the background. Tables were set with plain linen tablecloths, and cruets, and people who required assistance with eating were supported patiently by staff who maintained contact and supported people to eat at their leisure.

People's weight and diet were monitored. Weight charts were kept up to date and Malnutrition Universal Screening Tool (MUST) scores were reviewed on a monthly basis. MUST is a commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity.

Where poor food intake had been identified as a risk we saw that appropriate steps to minimise the risk had been taken. If necessary referrals were made to the appropriate health service professionals, such as Speech and Language Therapists, and dieticians. Food and fluid intake was recorded. Information about diet was shared with kitchen staff who showed a good understanding, not only of people's preferences, but also how they would need their meal to be prepared. For example, care plans showed if the person needed food to be of a certain consistency to aid swallowing, if meals needed to be fortified to build weight or if they required a specific diet for either cultural or medical reasons. We spoke to a visiting health professional about diet and monitoring food and fluids, and they told us that the staff reported issues of concern appropriately and responded to advice they offered, following instruction and helping to ensure safe and balanced nutritional intake.

People had good access to healthcare and staff monitored their physical and mental health needs. The service had established good working relationships with health professionals such as the older people's Mental Health Team. For example, we saw from one care record that when staff noticed unusual and challenging behaviour for one person who used the service, a referral was made to the 'Home Intervention Team'. Working closely with this team staff at Anbridge monitored the person's behaviour and fed back information to assist the team to work out the best strategy and medicine regime to help the person settle. We also saw evidence that people were referred appropriately to district nurses, for support to minimise skin integrity issues, and physiotherapists for advice around mobility and equipment. Evidence in the case notes we reviewed showed regular health checks and GP visits, and when we spoke to visitors they confirmed this. One told us, "They suspected [my relative] had an infection and contacted the Doctor to prescribe [my relative] some antibiotics for a urine infection. They are so caring and responsive to what [my relative] needs. They know her so well". We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

When we toured the building we saw that toilets had been adapted, for example, with toilet frames and wider doors to help people with walking aids. The building had been redesigned to be dementia friendly, for example, there was appropriate natural and artificial lighting, toilet doors were painted yellow to help orientation and there was good signage. One corridor had been designated a 'dementia walk', and papered to resemble an Edwardian Street.

Close to the entrance there was a 'café' area where visitors and more able people could make their own drinks. There were two lounges, which meant that people had a choice of where to sit during the day. We were told the 'Butterfly' Lounge was preferred by people who had a greater level of dependency, and this area was used during the day for group activities. There was also a conservatory where people could spend quiet time in reflection, or entertain visitors in a more private area. There was an outside courtyard with an enclosed garden. A gate leading to the street at the rear of the building was kept padlocked for security.

Good

Is the service caring?

Our findings

When we spoke with people who used the service and their visitors they all told us the staff were kind and caring. Comments included: "The girls here are fantastic; living here has extended [my relative's] life and quality of life. They treat [my relative] like she is one of their relatives and the minute there is not something quite right with [my relative] they know". Another told us, "I would recommend here to anyone, [one relative] was in here until she passed away and [another] has been here for three years. I couldn't ask for better care for [my relative]". A third person told us they observed a caring intervention: "X spilt some water all down his trousers. There was no fuss made they just came to X straight away and took him somewhere private to change him and put dry ones on. The staff are all caring towards everyone".

We saw people were washed, presentable and dressed appropriately for the weather and looked well cared for. Throughout our inspection we saw people were engaged and stimulated; staff had time to spend with people. A care worker told us, "It's all person centred. We are encouraged to spend time with residents. [The owners] are really involved, staff are good and friendly to residents". One visiting relative we spoke with agreed. They told us, "All the staff go well beyond care and support to every single person in here. I spent months looking for the right place for [my relative]. This place was like a breath of fresh air. I struggled to put [my relative] in care but this place is lovely and it has given him a new family. They care for him and he is so settled".

During our inspection, we saw that in the dining room, lounges and conservatory areas there was a relaxed, pleasant and informal atmosphere. People were free to walk between rooms, and staff would stop and talk to them in a pleasant and person centred manner. The staff (manager, carers, cook and housekeepers) were kind, patient, friendly and caring towards the residents and all demonstrated a good rapport. We observed carers and the registered manager/owner speaking to residents who were sitting alone so they didn't feel isolated.

When we arrived at the care home a number of people were already up and dressed, and eating breakfast. There were no set rising times, and people were being assisted to get up in their own time. We saw that as staff were assisting people to rise they would knock on their door and introduce themselves by name before entering and ask if the person was ready to get up. They continued to treat people in a caring manner throughout the day, and respond appropriately to their needs.

We saw that people were addressed by their preferred names and spoken to in a friendly manner making eye contact and touch where appropriate. Interactions between care staff and people who used the service were respectful and caring. On the first day of our inspection a visiting hairdresser was visiting the service and as people had their hair done, staff were complimentary and remarked on how well they looked. We observed that people were asked discreetly about their personal care. When people needed assistance with personal care we observed that staff ensured they closed doors in bedrooms and bathrooms.

Most rooms had ensuite bathrooms and we saw people had access to their own toiletries, flannels and towels which had been used that morning. This indicated that they were supported with personal hygiene

needs in the privacy of their own rooms. We asked about showering and bathing, and were told that most of the people who lived at Anbridge preferred showers, but a couple liked to have a bath. This was reflected in their care plans.

Rooms were personalised and reflected peoples taste and interests. For example one room was donned in the colours of the person's favourite football team, with football scarves, pictures and memorabilia, whilst other people kept small pets in their rooms. This provided an opportunity to engage in conversation on topics of interest to the individual. In each bedroom there was information about the person which detailed their likes, hobbies and interests. There was also a notice by each door explaining who the person's link worker was, with a photo of the person. A Link worker is a person appointed to work closely with an individual, for example, arranging and attending reviews, liaising with family and professionals or checking that the person has the right toiletries, or other items. We noticed for one person the link worker was not a care worker, and when we asked about this we were told that link workers were chosen on the basis of personality, interest and taste and so this was not exclusively a carers role. The registered manager believed it was important to establish a relationship with the key worker, so that the person who used the service felt comfortable with them.

One person who used the service told us that they still harboured hopes of returning to live independently in the community. When we looked at this person's care plan we saw that the service had advocated on their behalf and had pushed health services to provide better rehabilitation opportunities, including physiotherapy exercises to increase strength. The service had adapted the person's room to meet their needs and encourage self-sufficiency to assist the person to reach their identified goal.

Relatives we spoke to told us that they felt comfortable visiting Anbridge. There were no restrictions on visiting and people were made to feel welcome. Visitors we spoke to informed us, and we saw, that staff knew who they were, addressed them by name and were always welcoming. They told us they were offered drinks or could make their own in the 'café', or were invited to stay and sit with their relatives. They told us that their private conversations with their relatives were respected, and they could use the conservatory or go into people's rooms if they wished to talk with their relatives in private.

People's care records made clear what people required support with and what they could do independently. People and their representatives were encouraged to discuss goals about what they would like to achieve, and individual needs were recognised and accommodated.

There was evidence that people's wishes for their end of life care had been considered. Information provided in case records included personal preferences, such as funeral plans where appropriate, and we saw that most staff had received training in the 'six step pathway'. This is a programme of learning for care homes to develop awareness and knowledge of end of life care. We asked one member of staff about end of life care at Anbridge Care Home and they were able to give a good account of how people and their relatives were supported. They went on to give an account of a recent death in the home, "I stayed on because I didn't want [the person] to be alone, and helped make them comfortable, I helped them bathe, and changed their nightclothes, then it was turns, hydration and mouth care. They died with dignity and I am proud of that".

Similarly, staff were able to tell us how they would address any specific cultural or religious needs. For example, staff told us how they would respect the requirements to pray or fast, depending on their religion, and displayed awareness of different religious dietary requirements and how these would be addressed. At the time of our inspection there was nobody who had any specific cultural or religious needs.

People's belongings were treated with respect, for example, walking frames and hoist slings were labelled with the person's name. Any case notes or files relating to a person were stored securely to prevent unnecessary disclosure of information.

Good

Is the service responsive?

Our findings

People who used the service told us that staff responded to their needs and supported them in their daily activities. One told us, "I like it here, I feel safe and looked after but I've got the best room in the house. It is how I want to live, it couldn't be better!" A second person remarked, "The staff are very responsive, help comes straight away when I need it".

The people who lived at Anbridge felt that they had a say in how their care was delivered, and one visiting relative informed us, "[My relative] is included in the discussion of her care. There was a case conference meeting, with [my relative] a senior carer, and myself. We discussed everything about [my relative] from medication to end of life care".

Before people were admitted into the service the manager/owner informed us that he completed a pre-admission assessment either by visiting the person in their own home or hospital, or by inviting them into Anbridge Care Home, where they could stay for an afternoon and share a meal with the people who lived in the home in order to, "Get a feel for the place". If a place was available, he would seek further information from the person and people who knew them best, including family members and any professionals such as health workers, or social workers and begin to draw up a full assessment of needs and interim care plan.

After introduction into the home this care plan would be reviewed on a regular basis as the person settled into Anbridge, and a monthly review of care would be held with the person and their representatives to fine tune the care plan.

We looked at six care records. All were written in a person centred way and provided detail on both day and night routines, detailing how the person would like their care needs to be addressed. An 'about me' section gave good information about the person, their social and medical history, background and family ties.

Information contained in care files gave the reader a good understanding of the person's needs. For example, one care file we reviewed detailed issues with behaviour, and included clear handling guidelines and tips to manage aggression, and another showed a clear understanding of how behaviours had been triggered by previous life events. Care plans reflected the person's abilities to manage much of their own personal care needs whilst identifying the need to minimise anxiety, and instructed staff on how to support the person to maintain good mental health. There was evidence of negotiation with the person to minimise personal risk without reducing the person's autonomy and right to self-determination.

We saw that the service was open to imaginative ways to meet assessed need and minimise risk in the least restrictive way. For example, one visiting relative told us that after their relative had a series of falls at night, the staff asked about how the person's room was laid out in their last home, and then rearranged the furniture in their room to roughly correspond. By moving the bed to a different location the night time falls lessened.

Daily records were maintained and kept up to date. When we reviewed the entries these gave us an

indication of the activities and mood of the person, and included any issues out of the ordinary.

Night charts include checks to ensure alarms on pressure mats and crash mats were plugged in and checked. Two hourly checks were made and recorded unless it was indicated that people preferred not to be checked. Similarly, care files contained charts to monitor food and drink intake as required, and accident forms were kept on file, with a corresponding body map to indicate any cuts or bruises. This was cross referenced to a central folder of accidents and incidents.

There was evidence in each file to show care plans were reviewed on a monthly basis, with any change noted, and care plans were updated to reflect the changes. For example, in one care plan where weight had decreased over a two-month period the person's weight was monitored on a more frequent (weekly) basis, and a referral was made to the dietician for advice on diet control.

We saw that each person's care was holistically reviewed every three months, and people were involved in their reviews. In the welcome pack given to all people who lived at Anbridge information stated, "The review process is straightforward and designed to help you express how you feel about your stay or your life as you live it in this home. We invite you and your chosen family, friend or representative three to four times each year to discuss in a relaxed and reassuring environment how you feel. It's your choice to take part and we will assist you to participate". From case records we saw that this was happening, and people told us that they would attend their reviews along with family members.

We reviewed the complaints policy. Information provided, both in the welcome pack and on display in the foyer of the building included a one-page information leaflet about how to complain. This included information on what to do if the complainant remained dissatisfied with the outcome. The complaints information held in the foyer of the building asked that before making a complaint people should speak to the home first. We asked people who used the service if they knew how to raise a complaint, and they told us they would speak to the manager. One visitor told us, "We don't have cause to complain, but [the manager/owner] is always here, we see him every time we visit. He is approachable and we could go straight to him."

When we looked at the complaints record we saw that when complaints had been received by the service there was evidence that these were investigated and a response sent to the complainant. We were aware, however, that there was a complaint which was being handled by the local authority which at the time of our inspection had not been resolved.

Throughout our inspection we saw that people were stimulated and had access to some meaningful activities. An 'entertainment rota' was available and showed a number of activities people who used the service could participate in, and one care worker told us that the service tried to arrange for a visiting performer to visit at least once every month, and that this usually went down well with the people who use the service. In addition to singers and entertainers, recent visitors have included a falconry display, local school choir, the Princes' Trust and local singers and entertainers. Shopping trips and visits to Blackpool had been arranged.

The service did not employ an activity co-ordinator but care staff took turns to arrange a daily activity. Additionally a member of staff arranged an 'armchair workout' after breakfast each morning. This involved gentle exercises; we observed seven or eight people joining in with the exercises and all seem to enjoy the experience. People told us that the staff would arrange special events, such as barbecues and birthday celebrations, and they had begun to plan for a Halloween party. We saw one person was encouraged to go out each week to a local' Men In Sheds' group, and we saw other people who used the service would busy

themselves with tasks, such as helping staff to set tables, or dusting.

Good

Is the service well-led?

Our findings

When we spoke with staff they told us they enjoyed working at Anbridge Care Home. They said, "It's a good little home. You'd need to go a long way to find one as lovely as this. The staff are very good and we all get along. Everyone helps out and all are willing to lend a hand. It's more a home than a place of work, so coming to work is like coming to visit relatives!"

It is a requirement under The Health and Social Care Act that the manager of a service like Anbridge Care Home is registered with the Care Quality Commission. When we visited, the home had a registered manager, who also owned the service jointly with his wife, who was also active in the day to day running of the service. The registered manager was present throughout the inspection.

All the people who used the service and their visitors knew who the Manager was, and called him by his name. They said they would approach him if they had any concerns or complaints. One person who used the service told us, "There's nothing that could be improved here, the manager makes everyone welcome and comfortable and he handles the awkward ones well too". Another said, "[The manager] is always wandering round; he's very good and helpful". A relative told us that he was supportive and liked to look at improvements, "[The manager] is always making improvements here, like new radiator covers, putting murals on the walls to make it more dementia friendly. [My relative] uses the commode and he bought her this decorative toilet roll holder to make it more homely for her".

When we spoke with staff they agreed. One person told us, "He is a good manager. Polite, helpful, intelligent". Another remarked, "The [manager and his wife] are very hands on. They are lovely and really get involved; they are on the floor with us and are there to lend a hand". They told us he is very 'hands on', and likes to be involved, "He will listen to staff and support, for example changing shifts to accommodate work life balance."

The service had a statement of purpose that focussed on the values the service tried to uphold. These included rights to privacy, dignity, independence, security, civil rights, choice, fulfilment, diversity, quality care, and lifestyle. To promote the dignity of people who used the service the registered manager had appointed two dignity champions who would ensure that people were treated in accordance with these values.

We spoke to the registered manager/owner about the culture of the home. He told us, "We aim to be personal, and want it to be homely. We recognise that we all impact on each other, so I want each person to have a say and be involved, but I am aware of how individual relationships can have an impact". We saw that the service tried to involve people who lived at Anbridge in day-to-day decisions, not only about their own care but in the day to day issues that affect their life, for example, help to plan menus, and providing feedback for supervision and appraisal. The registered manager promoted a person centred approach to meeting need and tried to design the service to accommodate individual need. By way of example he told us about a person who used the service who tired during the day, so their main mealtimes had been changed.

He informed us that he is an active member of the local care home forum, and represents the forum on the Adult Safeguarding Board.

In order to overcome some of the difficulties faced in residential care homes around conflict between night and day care staff, he had restructured the staffing rota to allow for a longer changeover period between shifts. This allowed time for staff to work together especially early mornings which can be a busy time, and had led to greater communication and co-operation.

We saw systems in place which meant that any information which may be required in an emergency was easily accessible and stored in a 'Team Leader 'folder. This included personal evacuation plans, personal information about the people who used the service in case of emergency, such as admission to hospital, staff information, contact numbers for health workers and other professionals. It also included information about people who had a lasting power of attorney or were subject to any other authorisations such as deprivation of liberty safeguards or court of protection orders.

There was an effective system in place to monitor the quality of the service.
The registered manager/owner completed monthly audits for accidents and incidents, care plan documentation, cleaning schedules, petty cash and finances, kitchen and laundry services and general maintenance, with an annual report which summarised the issues caught through monthly review. Yearly audits were completed for environmental risk assessments, fire and emergency procedures, employee records, training and supervision. Information provided was produced in an annual report which in turn informed the business plan.

All policies and procedures were reviewed on a yearly basis, or more frequently to reflect changes, for example in legislation or local authority guidelines. We looked at a number of policies, including the safeguarding policy, which was up to date and reflected current legislation; the advocacy policy, which included details of local advocacy groups. Medication, whistleblowing, and health and safety policies were all up to date and reviewed. When we last inspected Anbridge Care Home we found a breach of regulations as there was no financial risk assessment in place for one person. We saw that following that inspection the manager/owner had reviewed the financial policy and implemented a new system to ensure financial information was a part of the pre-admission documentation, and reviewed as a part of the care planning process.

The service conducted an annual survey, sending out questionnaires to people who used the service and their relatives. We looked at the last survey. Comments and feedback included, "I am very happy. We are always kept informed and included in decision making for [our relative], and "[our relative] is very well looked after by all the staff. We are very happy with all the care". However, whilst most of the responses were positive there was no analysis or quantifying of the survey, so an opportunity to look at how the service could be improved was missed.

Staff were aware of their roles and responsibilities, and we saw delegation of tasks was well communicated. Team Leaders took responsibility for regular checks of case records, and conducted a daily tour of the building to ensure cleanliness and hygiene standards were maintained, and daily records, such as food and fluid charts, turning charts, were completed. Staff told us that they were involved in discussions about issues in service provision during team meetings and staff 'safety huddles', which were called to discuss specific issues as and when they arose. Minutes of staff meetings demonstrated that meetings were well attended and full participation was invited. Staff told us they found team meetings useful, and felt supported to raise issues and suggest changes they felt needed to be made. Meetings had been scheduled monthly, but we noticed that some of the more recent meetings had been cancelled. We were told that this was because the

safety huddles to address needs as they arose had meant many of the items for the agenda had been dealt with.

From 1 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. At this inspection we saw that the rating from our last inspection was displayed in the foyer, and on the service website.

The registered manager was aware of when notifications had to be sent to CQC. These notifications tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.