Anchor Trust

Tealbeck House

Inspection report

Tealbeck Approach
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Website: www.anchor.org.uk

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on 1 and 9 May 2018. At the last inspection in April 2017 we found the service was in breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service had made the required improvements.

Tealbeck House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection there were 45 people living in the home, which comprised two floors and communal lounge, dining area and conservatory.

There was not a registered manager in post at the time of the inspection, however the service had appointed a manager in February 2018 who was in the process of applying to register with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at the home and that there were enough staff to meet their care needs. Staff were recruited safely. Staff were trained in protecting people from abuse and there were processes in place to ensure issues were raised and investigated appropriately.

Medicines were stored, administered and recorded safely, and the premises were made secure, regular maintenance and equipment checks were undertaken. Risks to people were assessed appropriately and people were protected from infection.

Staff received appropriate levels of training and support through induction, supervision and appraisal. People told us they felt confident staff were well trained and competent to perform their duties.

People were supported to maintain a healthy and balanced diet and they told us they enjoyed the food provided to them. People's health and wellbeing was also monitored, and staff were proactive in requested advice and guidance from medical professionals where necessary.

People told us staff were kind caring and compassionate. Staff were able to describe how they supported people to remain independent and care plans provided further guidance on how to support people. Staff were also able to describe how they protected people's privacy and dignity.

Care plans were written in a person-centred way which took into account their likes, dislikes and preferences. Conversations around end of life preferences were not always recorded and followed up. We have made a recommendation about the recording of end of life care plans.

There were a range of activities on offer and efforts had been made to improve the range of activities and community links, however some staff said that this required further resource and improvement to ensure everyone could enjoy meaningful activities. We have made a recommendation about activities provision at the service.

Staff told us they felt well supported by the manager and confident in their leadership of the service.

The provider was able to evidence how it engaged with staff and people using the service through meetings and surveys.

There was a quality monitoring system in place which provided oversight and enabled the provider to analyse trends and themes, as well as provide support to the manager.

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.

There were enough staff to meet people's care needs and staff were recruited in a safe way.

Medicines were stored, administered and recorded safely. People received medicines in a way they preferred.

The service maintained the premises and equipment through a system of checks, audits and inspections.

Is the service effective?

Good

The service was effective.

The service was operating under the principles of the Mental Capacity Act 2005.

Staff received sufficient training and support.

People were supported to maintain healthy lifestyles and they had good access to health professionals.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and compassionate. The home had a warm atmosphere and people were visibly engaging with each other.

The service promoted people's independence and staff supported them to remain as independent as possible.

People's privacy and dignity was protected by staff, and people's cultural and spiritual needs were taken into account.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were written in a person-centred way and people were assessed appropriately. End of life discussions were not always recorded effectively or followed up.

There were activities available and activities provision was improving, although some staff felt there were not enough resources in place to ensure everyone could enjoy meaningful activities.

People knew how to raise complaints and they were responded to appropriately.

Is the service well-led?

Good

The service was well-led.

The service had quality monitoring systems in place which were used to identify shortfalls and drive improvement.

Staff told us they enjoyed their work and said they felt confident in the leadership of the service.

The provider gathered feedback from people and staff and used this to create action plans to further improve the service.

Tealbeck House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 9 May 2018 and was unannounced. We last inspected Tealbeck house in April 2017. At that inspection, we rated the service 'requires improvement' overall.

The inspection was conducted by 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.

Before the inspection we reviewed information we held about the service. This included reviewing information received from the service, such as statutory notifications. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with nine people who use the service, four relatives and seven staff, including the manager, team leaders, care staff and maintenance staff. We also spoke with a visiting health professional and a visiting social worker. We conducted a tour of the premises and observed a lunch time meal.

We also reviewed a range of documents relevant to people's care, this included six care plans, six medicines administration records, six risk assessments and four mental capacity assessments. We also looked documents such as quality monitoring processes, staff surveys, accident and incident reports, meeting minutes, five staff files and health and safety checks.

Good

Is the service safe?

Our findings

People and their relatives told us the service was safe. One person we spoke with said, "I like living here, people are nice, the food is lovely, the furniture is, and my bed is lovely so what more could you want?" Another person said, "The staff are all so good to me and they knock on my door regularly to see I'm alright as I like to stay in my room, so I feel very safe and even though I don't sleep well at night and get up. Staff will pop in to see I'm ok and always make me a cup of tea". A visiting relative we spoke with said, "Yes it's very secure, we have no worries."

Staffing levels were safe because people's care needs were met. The provider used a dependency tool to adjust staffing levels according to the needs of people living at the service. One staff member said, "At the moment there are enough staff. Dependency levels are not as high as they were, we are okay." Another staff member said, "As of late things feel rushed but everyone gets good care and nobody goes hungry, everyone is clean." Another staff member we spoke to said, "Yes, there are enough staff, it depends on who is on the shift. It's about morale. People's needs are always met. We used to have a high turnover of staff but now new starters are staying."

Staff were recruited safely. We reviewed a sample of staff files which contained professional references, interview notes, proof of identity and right to work in the UK as well as a Disclosure and Barring Service (DBS) check. The DBS is a national agency which uses the police national database to help employers make safer recruitment choices when appointing staff to work with vulnerable people.

We reviewed systems and processes around managing medicines. Medicines were stored in a locked room and in locked cabinets when not in use. Medicines were disposed of effectively. We saw that refused medicines were logged, countersigned and stored for disposal or return. Controlled drugs were stored in a locked cupboard, and when we reviewed stock levels we found these matched the controlled drug log book. Medicines boxes which had been opened had the date of opening written on them.

Medicine administration records (MARs) had pictures of each person on them, their allergies and preferences for taking medicines. For example, in one person's MAR they noted they liked to take their medicine with tea or juice. Medicines that were to be administered 'as and when' or 'PRN' such as paracetamol were recorded in separate PRN protocols which detailed why the person needed them, the time of dose and the maximum amount of doses allowed within a 24 hour period. This is good practice and helps prevent overdose. We saw this was used effectively, for example where a person was to be administered a painkilling drug staff noted 'Too close to the last dose' in the MAR and this medicine was administered at a later time. One person said, "I take paracetamol when I ask for it, it is nice here as they don't make you take medicines if you don't want them".

MARs were audited frequently, and staff told us they received feedback from them. One staff member said, "We get feedback on things like missing signatures or not using the correct code. We had a mini meeting and had discussions about this to resolve issues." When we spoke with staff they demonstrated a good understanding and knowledge of people's preferences and what medicines they took and why they needed

them.

The service also used a medicine's round time log, which recorded how long a medicine's round took and if there were any incidents that disrupted medicine's delivery, for example a fall or a person in a distressed state. Staff also kept notebooks to write their observations as they were conducting their medicine's rounds to ensure records were accurate and any issues could be raised.

People were safeguarded from abuse and harm. Prior to our inspection we observed a number of safeguarding referrals through our ongoing monitoring of the service. The manager informed us that under previous leadership, safeguarding policies and procedures were not always followed in a timely way. The new manager had retrospectively made safeguarding referrals to the relevant agencies and conducted investigations in line with the provider's policy and in partnership with other organisation such as the police and local authority.

Staff were provided training they considered mandatory on the subject of safeguarding vulnerable adults. Staff were able to describe different types of abuse and told us what measures they would take. One member of staff said, "It could be if I saw a staff member drag-lifting someone or shouting at them. I would go to the team leader first if it was another member of staff doing it, if it was the team leader I would go to the manager and if it was the manager abusing a person I would use the whistleblowing line." Another member of staff said, "There is information in staff areas on how to raise concerns and whistleblowing."

Risks to people such as falls, infections and specialised equipment were managed through assessments relevant to people's needs, and the service used nationally recognised tools such as the falls risk assessment tool. Accidents and incidents were reported and investigated appropriately, with action taken to mitigate the likelihood of further incidents. The service's accident form directed staff to conduct a full post-fall checklist for injuries, inform the person's next of kin and safeguarding authority where appropriate.

The service provided evidence of regular checks and inspection of the premises and to ensure they were fit for purpose either internally or with the assistance of an accredited external agency. These included gas and electrical safety certificates, fire safety risk assessments and equipment checks, window restrictor checks, 'silent' fire drills, legionella risk assessments and water temperature checks, and regular inspections of wheelchairs, lifts and hoists. We saw evidence that where equipment had fallen into disrepair or was no longer fit for purpose new equipment had been ordered.

We observed staff using personal protective equipment (PPE) such as disposable gloves and aprons when delivering care or providing food. The service held a log of all outbreaks of infection with actions taken to mitigate their impact. Between April 2017 and March 2018 there had only been one outbreak of infection. The local authority had been informed and fluid charts used following guidance from health professionals. Regular infection control audits were carried out. At the last audit in April 2018 the manager advised staff to wash their hands after wearing disposable gloves and requested hoists to be cleaned following their observations.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection in April 2017 we found the service was not always working under the principles of the MCA, because the service was failing to make DoLS applications for people living at the service whose liberty was therefore deprived unlawfully. At this inspection we found the service had made the required improvements. At this inspection we saw that DoLS applications, mental capacity assessments and best interest's decisions had been carried out in line with the provider's policy and under the principles of the MCA. Best interest's decisions we reviewed always involved people relevant to each person and the decision made, for example a person's next of kin or GP, and were specific to a certain decision such as wanting to leave the service to go into town. The service kept a log of each person who had a DoLS applied for and tracked the progress of that application, noting whether it was successful or no longer necessary.

We spoke with a visiting social worker who confirmed the service was now working under the principles of the MCA. They told us, "The service has sent in all eligible DoLS applications. They seem to be on top of it. I've recommended questions for them to use in their capacity assessments. They understand the principles of the act."
Elements of the estate were designed with dementia related conditions in mind, for example bathrooms were clearly signposted, and there were wall clocks which included the date as well as the time in large clear characters. People's rooms often had photographs of things that were important to them as individuals to help them recognise their rooms. We were informed by the registered manager that they had recently purchased 'memory boxes' for people's doors which would allow for more photographs and items people valued to be prominently displayed to help them find their rooms. The registered manager also told us they had plans in place to change the colour scheme of hallways to a more dementia friendly design.

People we spoke with told us they felt staff were well trained to look after them. One person we spoke with said, "There always seems to be training going on and the new staff get shown what to do when they come and look after me, so they seem to know what they are doing".

Staff were well supported through induction, training, supervision and appraisals. New staff undertook a 12 week programme of induction which involved reading care plans and 'shadowing' established staff. Training the service considered to be mandatory included fire safety, moving and handling, safeguarding vulnerable adults and basic first aid. The service used an electronic tracker to monitor what training staff had

completed and prompt staff to take courses that were due for renewal. The latest data we reviewed showed that overall the service was 86% compliant with all training modules.

Staff received regular supervisions and a yearly appraisal. Staff were given opportunities to reflect and discuss career development. One staff member said, "I've had one supervision so far from the new manager, I'm doing well, we discuss what I can improve and what I want to do for the future."

The service supported people to eat and drink enough to maintain a healthy nutritional balance. Everyone people we spoke with told us they enjoyed the food. One person said, "Yes, and they bring the snack trolley to tempt me with cakes and biscuits!" Another person we spoke with said, "The food is excellent. They put your gravy on the table rather than putting it on your food, so you can help yourself. I could make drinks in my room but I'm lazy and so I ask them and there's always plenty to drink!" One relative we spoke with told us, "When we took [Name] out to a restaurant for their birthday meal, they said they preferred the food at the service! She loves the food here, and when we are here staff ask us if we want anything as well".

Staff were knowledgeable about specific dietary requirements, and the kitchen staff received a daily sheet which listed each person, any food allergies they might have and their dietary requirements for example soft fork mashable food or gluten free food. Where necessary the service monitored people's food and fluid intake and used the Malnutrition Universal Screening Tool (MUST) to calculate the risk of malnutrition and act appropriately. For example, where one person's weight declined, they were prescribed high calorie drinks.

People were supported to access health professionals and staff were vigilant in observing and alerting health professionals if they observed deterioration in people's health and wellbeing. One staff member said, "For example, we fill in positional charts, if someone is in bed pressure sores are important, keeping an eye on dressings. We tell the team leaders who call the nurses if we notice anything." We saw pressure sores observed were recorded and managed well, with involvement of health professionals.

Care plans recorded every interaction with health professionals and reasons why, for example an observed degradation in a pressure sore and subsequent district nurse visit. One staff member said, "Communication is good, we can ring the surgery any time, they will give us a consultation over the phone or come out. We have regular Wednesday surgeries with the doctor and district nurses are good as well." We spoke with a visiting GP who told us, "People are well cared for here. They always raise things and let me know. They take directions well. With pressures sores they will alert me or the district nurse."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind, caring and compassionate. One person said, "Yes, they are kind and helpful, I like the staff they are very good, and when I ask for anything they look after you, they are all friendly people, I'm happy and settled". Another person said, "They are all nice and seem to understand what I need even though I haven't been here long yet". At the latest resident's survey, 100% of 39 people asked indicated they felt staff treated them with kindness, dignity and respect.

The service had a welcoming and warm atmosphere. People were visibly engaging with one another. One person said, "I was lonely before I came here and now it's lovely having all these folks to talk to".
When we observed a mealtime and post-lunch medicines round we saw staff getting down to eye level, demonstrating patience and staff clearly had a good rapport with people. Staff demonstrated a good knowledge of the people they cared for. One staff member was able to describe someone's life history, medical condition, and aspects of their care they wanted personalised, for example that they liked their towels folded a certain way and handed to them.

The service took into account people's cultural and spiritual needs. Care documents recorded people religious and spiritual preferences, and if they required support to practice these beliefs. The service organised church meetings if people requested these and all were welcome to attend. In one care plan it was written that, '[Name] is an atheist, but would like to be involved in Christmas activities.' The service also recorded what sensory support people required, for example one person requested a speaking clock in their own language because they had significant sight impairment. Other people's care plans noted if they needed eyeglasses and hearing aids to enable them to communicate effectively.

People were supported to maintain their independence. Care plans guided staff to support people to maintain their independence. For example, in one 'personal care' plan staff were instructed: 'I am able to wash myself with prompts. Help me to wash my back and lower legs. Outcome: Hygiene, dignity and independence.' Another care plan read '[Name] is very independent and would like to stay as independent as possible. He is able to change into his nightwear and get into bed himself.' One member of staff said, "Even when people have more advanced dementia and may not be communicative, at meal times we show them plated options of food and they can choose which one looks more appealing to them." Another member of staff said, "Body language is important, respecting their wishes if they prefer let them do what they need to do and prompt them to remain as independent as possible. Don't try and take over a situation."

Staff were able to describe how they protected people's dignity and privacy. One member of staff said, "For example if a resident was to fall in a communal area, we have a green screen to put around them to make sure no one is looking when we are helping them. When washing someone we will generally place a towel on their bottom half when we are washing their top half and vice versa. We always tell them what we are going to do and ask them if it's okay." Another member of staff said, "Well we would always make sure curtains are shut when delivering care, cover people up to their waist when washing, just talking to them and being polite helps a lot. We ask before we do anything and make sure they are aware."

The service provided information on how to access an advocate. Advocates are people who help vulnerable adults make decisions about their lives. The service's consent form ensured that people's data was protected, for example if people consented to their photograph taken.

Requires Improvement

Is the service responsive?

Our findings

Care plans were written in a person-centred way with clear guidance for staff on how to care for people in the way they wanted. We reviewed five people's care plans and supporting documents. People were assessed appropriately before entering the service. This included a medical history, brief background and life history, key contacts, and other important information such as transfer documents from hospitals or referrals from social services to show why they were moving to the service. Care plans recorded people's interests and hobbies, cultural and spiritual needs, and details such as what made them anxious and how they expressed any pain they might feel so staff could get to know how best to meet their needs and improve their wellbeing. Care plans recorded people's preferred daily routines, for example one person noted they liked to spend much of their time in their room reading but that they liked to eat in communal areas, as well as what snacks they liked during the day.

Daily notes and care plan logs captured what care had been given, their emotional state and what interactions people had. For example, the bath and shower care plan and log recorded people's washing preferences, when baths or showers had been offered and if they enjoyed themselves. Mobility care plans recorded how independently they moved, what assistance staff were required to give and what equipment people used. Where people used hoists, there was clear person-centred guidance on how to do this. Care plans were reviewed regularly to ensure they were effective or in response to an incident or decline in health. For example, one person was observed as having lost weight, they were referred to the speech and language therapy team and after input from medical professionals the care plan was reviewed to reflect a change in need. This included a best interest's meeting, an inclusion of high calorie drinks into their diet and increase in weight measurement to monitor any improvement.

During our review, all care plans we looked at either did not contain a record of people's end of life wishes, or did not conduct reviews where people indicated they did not wish to have a conversation about end of life at the time. One of the care plans we saw showed that a person did not want to discuss the issue in 2015 and that this was 'to be followed up in future' however there was no evidence of this being followed up. One care plan did not contain a completed end of life care plan, however when the care plan was reviewed the reviewer indicated that the end of life care plan was effective and required no change. When we raised this with the registered manager they said they would conduct a review of all end of life care plans to ensure they were up to date and reflected people's wishes.

We recommend the service review its systems of capturing people's end of life wishes.

We saw that where necessary, 'Do not resuscitate' forms had been discussed with healthcare professionals, staff and people's relatives. A visiting health professional we spoke with told us they had no concerns over staff practice and that staff took directions well.

We reviewed how the service supported people's wellbeing through activities and engagement. On the day of our inspection there was a church discussion group facilitated by volunteers, we observed people were engaged by this and contributed to a lively debate. People spoke positively of the activity afterwards. Staff

had procured 'rummage boxes' which provided sensory interaction for people with dementia and we saw people using these with staff. There were regular entertainers and seasonal events such as Christmas and Easter. We saw one person who wanted to access the town centre when they wanted but was assessed as lacking capacity to do so themselves, however staff made time to take them into town to buy new shoes. The activity log recorded that the person enjoyed this very much. During our inspection we saw people were supported to enjoy the warm weather. People were kept safe and cool with large hats, sun cream and a supply of frozen lollies.

There were two part time activities coordinators. People living at the service spoke positively of the activities coordinators. However, when they were not there for example annual leave, there were no extra resources in place to provide activities as other staff were expected to take on this role. Some staff commented that they felt this had an impact and that activities could be further improved, whilst recognising that some improvements had been made recently. One staff member said, "I know they are working on activities, people haven't been as mentally stimulated as they need to be. Things are changing; there is an activities book now. But there aren't enough of us dedicated to that." Another member of staff said, "I feel stimulation could improve. We need more resources. Care staff do get involved when we can, we have a sing and dance with people and we support people to access the community." Another member of staff said, "I feel people with greater capacity and mobility get good stimulation, it's hard to find group activities for the whole group, staff try their best."

We recommend the service continue to review and improve activities and engagement.

We asked the registered manager how they used technology and they showed us a newly purchased IPad tablet computer and app specifically designed for older people which included a package of music different eras, videos (for example, significant football matches from the past), newsreels and other nostalgic content. This was used at 1:1 interactions and reminiscence sessions. The IPad was also used by staff to help people make video calls to their families and loved ones.
Care plans included information around people's sensory abilities and any aids they required such as glasses and hearing aids that would enable them to communicate effectively with staff. This meant that the service was working towards the accessible information standard.

There was a complaints procedure in place and people told us they were confident they knew how to raise any issues they might have. One person said, "I feel very happy and have never felt there is a need to complain as everything is just as I want it to be but if it wasn't I would say something". A relative we spoke with said they had made a remark which the service recorded as a verbal complaint. They told us the provider acted and the issue was resolved satisfactorily. Complaints we reviewed were responded to in line with the provider's policy.

Good

Is the service well-led?

Our findings

We reviewed the service's quality monitoring systems and processes. The registered manager conducted a regular range of audits including care plans, medicine administration records and accident/incident reports. We saw that where shortfalls were identified, actions were taken, and improvement had been evidenced. For example, in a medicines audit conducted by the provider in February 2018, it was noted that a copy of the most up to date British National Formulary (BNF) book was not available. This document is regularly updated to provide healthcare workers with the latest guidance on medicines. We noted one had been ordered as a result. Furthermore, from a sample of MARs reviewed, actions identified and taken included ensuring staff signed the medicines administration's policy to confirm they had read it, improve signing of MARs for self-administered medicines and provide clearer directions for the use of a specific cream. There were 24 actions identified as a result. At the next audit in April 2018, we noted there were fewer actions required, which indicated improvement. Staff we spoke with told us they received feedback from audits where improvement was required.

The provider sent an annual survey to people and relatives of those using the service, and questions were given scores which were totalled up at the end of the survey to give an overall engagement score. This score was then compared with other services operated by the provider. The service did not perform significantly lower or higher than the average which indicated good engagement. The service also held regular resident and relative meetings. We reviewed the latest meeting minutes from February 2018 which was billed as a 'Cheese and Wine' evening. Issues discussed included an update to the situation of the garden which was going to be renovated, an introduction to new staff, and how the service had acted on feedback from previous meetings and surveys. For example, new lamps had been ordered for people's rooms.

The service did not have a registered manager in post, however they had appointed a manager who joined the service in February 2018 and they had sent a valid application to register with CQC in a timely way. The manager sent appropriate statutory notifications to CQC as required. Staff we spoke with were positive about the leadership of the service. One staff member said, "Morale has been really good, people welcomed the change [of manager]. It feels like things are coming together. It seems more professional now. It wasn't bad before but it's nice to have a fresh outlook." Another member of staff said, "At first we were wary of change, but people here get on, the manager introduced themselves, they are approachable with any issues." All staff we spoke with told us they were confident the manager was approachable and they felt comfortable raising concerns. One staff member said, "The manager is open, visible, approachable and will make time for anybody."

The service conducted staff meetings for each staff group, for example care assistants, team leaders and cleaning staff. One staff member said, "It used to be the case that meetings were six monthly, now they are more regular." Another member of staff said, "At the last one we did a group activity, wrote things we liked about the home and what we wanted to change."

The service also conducted a staff survey, and noted an improvement in the 'engagement score' from 17% in 2017 to 53% in 2018. We saw 82% of staff indicated training was good and that the service had clear

expectations of them. Actions from the survey included listening to staff through meetings, valuing staff through one to one meetings and supervisions, and empowering creative staff, for example where one member of staff had identified they had photography as a hobby they were encouraged to bring photos into the home to improve the decoration.