Anchor Trust

Trinity Lodge

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

Overall summary

We inspected Trinity Lodge on 8 October 2014 as an unannounced inspection. At the last inspection on 3 April 2014 we found that there were two breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. We found people were not protected against the risks associated with the administration of medicines. We also found the provider was not ensuring that persons employed were supported in receiving appropriate training and professional development. On this inspection we found the provider had made the necessary improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Trinity Lodge provides accommodation for up to 40 people who have a diagnosis of dementia.

There were 37 people living at Trinity Lodge when we inspected the service.

A requirement of the service's registration is that they have a registered manager. A registered manager is a

Summary of findings

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 and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection, however they were not present during our inspection as they were on leave. We spoke with two care managers who were temporarily covering the registered manager's responsibilities during their absence. We also spoke with the regional manager during our inspection.

We spent time in communal areas over the course of the day and saw interactions between people and staff were respectful, cheerful and kind. People told us they liked the staff. It was clear staff had a good understanding of people's communication abilities and adapted their approach accordingly.

People told us they felt safe. There were sufficient staff to meet people's needs. The managers and staff were knowledgeable about how to meet the needs of people in their care, and how to protect them from abuse.

There was a system in place to identify and manage risks, and staff were acting appropriately in response to identified risks.

Medicine administration was conducted safely. This meant people were protected from the risks associated with the administration of medicine.

Staff received suitable induction and training to meet the needs of people at the home. Staff also received regular supervision meetings and appraisals which supported them in identifying training needs, and assisted managers to identify any areas of staff development. This meant people were being cared for by suitably supported and trained staff.

There were appropriate policies and procedures in relation to the MCA and DoLS to ensure that people who could not make decisions for themselves were protected.

We saw that some people who were at risk of poor food or fluid intake were not having their food and fluid intake monitored closely. We saw that recording on fluid and food intake charts was not consistent and have asked the provider to improve record maintenance in this area.

Everyone we spoke with told us staff were kind and caring. We found that people's privacy and dignity was respected.

People and their relatives were involved in planning and agreeing their care. The care we observed matched the information on people's care plans, which meant people were offered support that met their individual needs.

The manager took appropriate action to minimise the risks to people's health and wellbeing, because appropriate risk assessments were in place and risks were being managed.

Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the home had completed an investigation to learn from incidents and to improve the service. This demonstrated learning was taking place to minimise the risk of them happening again.

The manager had sent notifications to us appropriately about important events and incidents that occurred at the home. They were aware of their responsibilities in notifying regulatory bodies and authorities about important events at the home, and were acting accordingly.

Staff told us they were well supported by the wider organisation, and that support was available from the provider when required.

The provider completed a number of audits to monitor the service, and to drive forward improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient staff to meet the needs of people living at the home.

People who used the service were protected from the risk of abuse because suitable recruitment procedures were in place, and staff understood their responsibilities for safeguarding people from abuse. There was a system in place to identify risks and protect people from harm.

Medicines were managed safely, and people received their prescribed medicines.

Is the service effective?

Good

The service was effective. People and relatives told us that staff were appropriately trained and offered people the support they needed.

There were appropriate policies and procedures in place in relation to the Mental Capacity Act 2005 MCA and the Deprivation of Liberty Safeguards (DoLS). These ensured that people who could not make decisions for themselves were supported by an appropriate representative.

Some people who were at risk of poor fluid intake were not having their fluid intake monitored closely enough. Recording on fluid intake charts was not consistent and we have asked the provider to improve record keeping in this area.

Is the service caring?

Good

The service was caring. Everyone we spoke with told us staff were kind and caring.

Staff respected people's privacy and dignity.

People told us they could spend their time how they wanted to and staff respected their decisions. Staff gave people choices about everyday decisions to promote their independence.

Is the service responsive?

Good

The service was responsive.

People who used the service or their relatives were involved in planning their own care. The care we observed matched people's care plans.

People and their relatives knew how to raise concerns with staff members or the manager if they needed to.

Is the service well-led?

Good

The service was well led. People were involved in meetings to gather their feedback, and the provider acted on the feedback they received.

The provider had a robust system to ensure they provided a good quality service. The quality monitoring system included regular visits to the home to speak with people, relatives and staff, and regular audits to check records were completed appropriately.

Trinity Lodge

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 8 October 2014 and was unannounced. This inspection was conducted by two inspectors and an expert-by-experience who had personal experience of using, or caring for someone who uses, a care home for people with a diagnosis of dementia.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we looked at and reviewed the Provider's 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.

Before the inspection we reviewed the information we held about the service. We looked at information received from relatives, from the local authority commissioners and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

We spoke with seven people who lived at the home, five relatives of people who lived at the home, and five care staff. We also spoke with a member of the housekeeping team, the chef, two care managers, a senior member of care staff, an operations manager, and a visiting healthcare professional.

We spoke with a dementia specialist who was visiting the service on the day of our inspection from Anchor Trust. The person offered advice and support to managers at the service, regarding up to date guidance on caring for people with a diagnosis of dementia.

We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We looked at a range of records about people's care and how the home was managed. We looked at four care plans of people who used the service.

Good

Is the service safe?

Our findings

People told us, or indicated to us through smiles and hand gestures, they felt safe. One person told us, “I feel very safe,” they added, “They are a good crew here, no problems.”

Care staff told us they had completed training in safeguarding and knew what they should do if they had any concerns about people’s safety or if they suspected abuse. Staff told us the policy and procedure around safeguarding formed part of staff induction so procedures were clearly understood. Staff understood the importance of reporting safeguarding concerns to their manager. One member of staff told us, “People are kept safe, If I suspected something I would report it immediately.” Another member of staff told us, “I would go to the team leader, the care managers or registered manager, or CQC if I had any suspicions or concerns.” This meant staff understood their responsibilities for keeping people safe.

We asked staff about whistleblowing procedures. Staff told us they were trained appropriately and understood their responsibilities under the whistleblowing procedure. One member of staff told us, “I would be the first to raise a whistleblowing. We are here to protect people. If there is something we are unhappy about I would speak to the manager, and if no action was taken I would use the whistleblowing option. Telephone numbers are in the office and I also have them in my mobile telephone.”

The care managers or registered manager notified us when they made referrals to the local authority safeguarding team. They kept us informed with the outcome of the referral and actions they had taken. The managers took appropriate action to safeguard people from the risk of abuse.

Staff told us and records confirmed suitable recruitment procedures were in place which included references, full employment history checks, and Disclosure and Barring Service (DBS) checks before staff started working at the home. The DBS is a national agency that keeps records of criminal convictions. This meant people were protected against the risk of abuse, as staff members were checked for their appropriateness before they began work.

We saw that there was a system in place to identify risks and protect people from harm. Staff members we spoke with told us people had a risk assessment in place for each risk to their health or wellbeing, which was filed in the person’s care file. We viewed care files for four people and saw that each risk assessment contained guidelines for staff on how to manage identified risks.

We saw from people’s care files that one person sometimes displayed behaviours that staff needed to pro-actively manage to protect the person and other people. Records from recent incidents showed that staff dealt effectively with the behaviours, in a manner that respected the person’s rights. We observed the person displaying these behaviours during our visit, a staff member approached them speaking to the person caringly and reassured them, which had a calming effect in accordance with their agreed care plan. This meant staff were managing identified risks appropriately.

Emergency plans were in place, for example around what to do in the event of a fire. One of the care managers was able to show us a emergency plan. This plan detailed the actions to take if an emergency took place that could mean the home could not be used. Staff told us they knew how to implement the emergency plan if needed. This meant that there were clear instructions for staff to follow, so that the disruption to people’s care and support was minimised.

People, staff and relatives told us there were enough staff to meet people’s needs. One member of staff told us, “Current levels of staff are satisfactory, we are busy at times but things are manageable. If two people need assisting we can call the ‘floater’ with our radios or staff from another unit to assist us.” Another member of staff told us, “I’m allocated to one unit, but we all work together. There is flexibility, which is better for people to meet their needs.”

A care manager told us the number of staff on duty depended on people’s needs. They told us they looked at people’s care plans to identify how many people needed support with everyday activities, such as dressing, walking and eating. We saw this information fed into a dependency tool. The tool was used by the management team to review the needs of each person on a regular basis. The tool assisted the managers in making adjustments to staffing levels when people’s needs changed. We saw evidence that staffing levels were changed when the dependency tool indicated it should be. This meant people were supported by the right levels of staff to meet their needs effectively.

We saw that when staff needed support from another member of staff they could call for assistance using a hand

Good

Is the service safe?

held radio device. Staff responded promptly to such requests and worked as a team. People we spoke with told us staff answered call bells promptly. One person explained, “The monitoring display tells staff who has pressed the call button, if the nearest member of staff is busy or on their own, staff use their radios to alert another member of staff to respond quickly.”

We saw people received the support they needed whether they spent time in the communal areas or alone in their bedrooms. We saw staff spent time in each of the communal areas of the home supporting people there and chatting to them. When a member of staff was called away to assist people in their bedrooms, we saw one staff member always remained in the communal areas of the home to monitor the needs of people there. This meant there was sufficient staff to meet people’s needs in all areas of the home.

At our inspection on 3 April 2014 we found people had not received some of their medicine. During this inspection we found improvements had been made to ensure people received their prescribed medicines. People told us staff supported them to take their prescribed medicines when they needed them. One person we spoke with told us, “The staff give my medicine at the same time every day.”

We found there was a safe procedure for storing and handling medicines including controlled medicines. We looked at how medicines had been dispensed by the pharmacy and saw they provided a medicines administration record (MAR) for each person. We looked at a sample of MAR sheets and saw that each medicine had been administered and signed for at the appropriate time. This meant people were protected from the risks associated with the administration of medicine.

We saw there was a protocol for administering medicines prescribed on an ‘as required’ (PRN) basis. For example, pain relief drugs may be offered to people if they are in pain, but are not given when people do not require the medicine. This meant people were protected from being given excessive medicine, or medicine when it was not required.

Good

Is the service effective?

Our findings

People and relatives told us that staff were trained and offered people the support they needed. One person told us, "Staff know how to do their job."

At our inspection on 3 April 2014 we found that people were not cared for by care staff who were fully supported to deliver care and treatment to an appropriate standard, because staff training was not up to date. At this inspection care staff told us their induction and training was up to date and gave them the skills they required to meet people's needs. In addition, two members of care staff told us they had completed nationally recognised qualifications in Health and Social Care. Others confirmed they were encouraged to undertake this training. This meant staff had the skills they needed to effectively support people at the home.

We saw care staff used a hoist and handling belt to move one person. They explained what they were intending to do, and gave the person an opportunity to stand on their own before they assisted them to move. This protected their rights to make decisions about their care where possible. One relative told us, " [Name] has their own sling which they are already sitting on it, which means it can just be hooked to the hoist." They added, "They are so good with [Name]." This meant care staff were trained appropriately in moving and handling people when they required assistance to mobilise.

Care staff told us that they received regular supervision meetings and appraisals to monitor their performance. These provided an opportunity to discuss personal development and training requirements to keep their skills up to date, and to provide feedback to their manager regarding the running of the home. Regular supervision meetings enabled care managers to monitor the performance of staff, and discuss performance issues. This meant people were being cared for by suitably qualified, supported and trained staff.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We saw there was an appropriate policy and procedure in relation to the MCA and DoLS to ensure that people who could not make decisions for themselves were protected.

We asked the care managers about their responsibilities under MCA and DoLS. They were able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation and their responsibilities to people. Several people at the home had a DoLS in place, and the care managers were reviewing DoLS assessments to take into account the most recent guidance. The care managers demonstrated they understood their responsibilities under MCA and DoLS and were acting appropriately.

We saw that where people were able to consent to their care and treatment care plans were signed by the person. Where people could not consent to their own care and treatment, people had received mental capacity assessments. Where decisions had needed to be made in a person's best interests, the person, their representatives, or healthcare professionals had been involved in the process. This meant that people, and others that were important to them, were involved in decisions made regarding their care to make sure it was in their best interest. One relative told us, "I'm involved in planning my relative's care, they wouldn't make any changes without letting me know."

We saw that some people who were at risk of poor food or fluid intake were having their fluid intake monitored by the use of charts. We looked at four charts. We saw that recording on the charts was not consistent. Staff had not filled in some entries, for example there was no record of fluid intake during the night. We reviewed the fluid charts for one person over three days. On the third day the drinks the person had received were recorded, but no amounts of the fluid intake had been noted. We saw these records were not always signed by care staff. Charts did not show a total amount of fluid, and therefore people's intake was not monitored against a set target on their care file. This meant records were not being adequately maintained, which could put people at risk of inadequate nutrition and dehydration. We have asked the provider to improve the monitoring of fluid intake records.

We saw that care staff sat with people and encouraged some people to eat their meal. We observed relatives were able to come into the dining room and assist with meals if they wished. One relative we spoke with told us, "Its excellent food, and staff are very caring. I go to kitchenette to make drinks, get snacks or food when I want." We saw people were given a choice of food at mealtimes. Menus were displayed on the tables in the dining area so that

Good

Is the service effective?

people could see food options. We observed one person being shown food preferences before the lunchtime meal so that they could visually choose what they wanted to eat. The staff member sat with the person and explained to them what they were offering them.

We saw that each person had a diet assessment completed which was located in the kitchen. This information included food likes and dislikes, recommended portion sizes, and diet types. For example, whether people required a 'soft' diet or high calorie food. This meant people were given food that met their needs.

Each person had a health assessment. The information was detailed and contained guidance for staff. For example, information on how people showed they were in pain, or needed specific assistance, when they were unable to communicate verbally. Records were up to date, and regular reviews took place. Staff told us, "Care plans change over time in accordance to individual preferences and changes to their specific needs."

Staff we spoke with told us they had a recorded handover meeting at the start of their shift which updated them with people's health and care needs. This supported them to provide appropriate care for people. Staff not present during handovers meetings could refer to the records. This meant staff were always kept up to date with changes, which protected people from receiving inappropriate care and treatment.

We spoke with a visiting health professional during our inspection. They told us they were confident the home met people's health needs. They told us they visited the service regularly to provide support to people at the home who suffered from diabetes, and to assist people with wound care where required. They told us, "People are clean and well cared for. Staff are helpful and know people well, and keep us up to date with any changes in people's health conditions."

We looked at the health records of the people who used the service. We saw that each person was provided with regular health checks, and they were supported to see their GP, optician, dietician, and dentist. We saw people were able to access other professionals in relation to their care such as the speech and language therapist. This meant people were supported to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

Everyone we spoke with told us staff were kind and caring. One relative we spoke with told us they were very happy at the home. They told us, "The care is excellent. Staff are lovely. I ask them to put something into place and it is done when I next come. I am always kept informed and offered information."

We saw people could chose where they wanted to spend their time during the day. The home had a number of communal areas including lounge areas and dining rooms. Some people chose to spend their time in the communal areas, and other people we saw chose to stay in their room.

People we spoke with told us they could spend their time how they wanted to and staff respected their decisions. One person told us they liked to get up at different times. We saw one person was still wearing their nightclothes at 10.30am. They explained that they had just got up. This meant people were able to make decisions about when they wanted to get up.

We observed care staff asked people if they would like assistance, and their wishes were respected. Where people had refused personal care we observed care staff returning to offer assistance later. This meant people were supported to make day to day choices on when they would like to receive care and these were respected.

We spent time in communal areas over the course of the day and saw interactions between people and care staff were respectful, cheerful and kind. People told us they liked the staff. It was clear care staff had a good understanding of people's communication abilities and adapted their approach accordingly.

We saw that care staff were kind and thoughtful towards people. We saw people responded positively to their offers of support. When one person expressed some anxiety because they were new to the environment, we saw care staff understood the cause of their anxiety. Staff spoke comfortingly to them, explained where they were, and involved the person in a conversation, which helped the person to calm down. We observed members of staff approaching the person regularly throughout our inspection to see how they were feeling. We saw at the end of the day the person was calm and seemed relaxed.

Care staff we spoke with explained to us how they treated people with dignity and respect whilst assisting people with personal care. One member of the care staff said, "When I am bathing or showering someone, I ensure the bathroom door is locked. I use a towel to cover the person to protect their dignity." Another member of care staff told us, "Privacy and dignity is very important. I always make sure that I speak in a low voice when I ask someone if they wish to go to the toilet so that the person's privacy is respected."

Staff knocked on people's bedroom doors and called out before entering. We saw care staff understood the importance of small details, such as explaining why they were entering their room, or waiting until people asked them to enter their room. This meant people were treated with dignity and respect.

Good

Is the service responsive?

Our findings

All of the people and relatives we spoke with told us staff were responsive to people's needs, one person added they were 'caring' and 'hard working'.

The relatives we spoke with told us they were involved in planning their relative's care, where their relative could not plan their own care. Staff and the records we reviewed confirmed this.

We looked at the care files for two people who lived at the home. Care plans were tailored to meet the needs of each person according to their support requirements, skills and wishes. Care records gave instructions to care staff on how to support people according to their requirements. During our inspection we saw the support care staff gave to people matched the information in their care records. For example, we saw how care staff supported people to move around the home using the specialist equipment that had been identified in their records. This meant people were receiving care that was responsive to their individual needs.

Staff explained to us how they promoted equality and diversity when supporting people. One staff member told us, "If you treat everyone the same then you are not promoting diversity, people have different needs that you should take into account."

We asked people about the support they received to take part in hobbies and interests according to their wishes. People told us they took part in some events in the home which met their interests. One person told us, "I know that activities take place but I don't always join in." We saw that a list of events were displayed on the noticeboard in the reception area, which showed a range of things happened each day. However, one relative told us, "There is a lack of activities, I have asked staff to make sure [Name] has a news paper, and that now happens."

The care managers told us on the day of our visit the designated activities co-ordinator was not at work, and so we were unable to talk with them. The care managers explained to us that the home organised support for people to take part in interests and hobbies that met their needs, and that they had recently recruited two new volunteers to assist with one-to-one activities with people and expand the types of activities that were already on offer to people at the home. They explained more dedicated time would be available to meet people's different needs.

People told us they knew how to raise concerns with staff members or the manager if they needed to. All the relatives we spoke with were aware of what to do if they were unhappy about anything, and all were confident that any issues would be resolved straight away.

We saw there was information about how to make a complaint available on the noticeboard in the reception area of the home, and in the service user guide that each person received when they moved to the home. One person we spoke with told us, "I have no complaints." We spoke with a member of care staff who told us, "If any of the people who use the service has a complaint to make they are encouraged to inform the staff or a manager, who will assist them to look into their complaint."

We saw there was a complaints procedure in place, and that where complaints were received they were documented and responded to in a timely way according to the procedure. Complaints and concerns were analysed by the provider to identify any ongoing trends that might require service improvement.

We saw a range of different meetings took place to gather views from people, their relatives and staff. The meetings were recorded and where improvements or changes had been suggested by people or their relatives these improvements had been written into an action plan, which as later implemented by the provider.

The care managers told us that the service ran yearly quality assurance questionnaires which were completed by people who used the service and their relatives. Information gathered from people in this way helped managers and the provider to analyse the quality of the service provision, and to drive forward improvements. This meant the provider was analysing the feedback they received regarding the service, and was acting appropriately to respond if there were concerns.

Good

Is the service well-led?

Our findings

People and their relatives told us they were able to be involved in developing the service they received. This was because they could leave their comments on feedback forms, or a comment tree, located in the reception area. The care managers explained that these comments and feedback were used to identify any areas of improvement. People were offered feedback regarding their comments in meetings and on display boards in the reception area.

We saw anonymised customer satisfaction forms were sent annually to people who used the service and their relatives. We looked at comments people had made and found that a high percentage of people were happy with the quality of the service provided. Comments we viewed stated, “I am highly satisfied”, “I would recommend this service”, and “I love the care I get here.” Where people had made comments regarding the improvement of the service, these had been analysed by the provider to highlight any areas that may need action taking. We saw improvement action plans were drawn up, and actions were being taken in response to comments people made. This meant people were able to express their views freely about how the service was delivered, and the provider made positive changes to the service in response to the feedback they received.

We asked the care managers whether they were well supported in their role by the provider. They told us they were, they added the operations manager visited the home regularly to offer them valuable support, especially during the registered manager’s leave. On the day of our visit the operations manager was visiting the home and met with us. They explained they were on hand to support the care managers whenever they were required.

Our observations of how the care managers interacted with people who used the service, staff and visitors showed us that the home had an open culture, where people could interact with the care managers on a daily basis and raise any issues of concern with them. For example, we saw one of the care managers walking around the home during our inspection, helping one person who lived there with a query they had, and offering advice and support to members of staff.

Staff told us that the care managers worked alongside staff at the home and they had the opportunity to talk with them if they wished, or to give them feedback. We saw the home gathered feedback from staff in regular meetings to help improve services. We saw where an issue had been raised, care managers had informed staff what action they would take to resolve the issue.

Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the home had completed an investigation to learn from incidents. Where investigations took place the managers reviewed where lessons could be learned to drive forward improvement. Information about this learning was shared with staff in meetings, briefings and handover information. This minimised the chance of them happening again.

The provider had sent notifications to us appropriately about important events and incidents that occurred at the home. The manager shared information with the local safeguarding authority and kept us informed of the progress and the outcomes of their investigations. The manager took appropriate action to minimise the risks to people’s health and wellbeing. This meant the managers understood their responsibilities, and followed procedures to involve other regulatory bodies and agencies in the operation of the home.

The care managers explained there were documented policies and procedures in place to assist with the consistency of care delivery, and to inform staff how they should respond in certain situations. Documented policies and procedures which were accessible to all staff formed part of staff induction, and assisted managers in measuring staff performance. Staff told us they had access to policies and procedures, which documented how they should respond to certain risks. Policies were regularly updated and were reviewed yearly by the provider to make sure they took into account any changes in legislation and guidance. These helped to ensure a consistency of approach in the delivery of care.

The provider completed a number of checks to ensure they provided a good quality service. For example regular audits and regular visits to the home to speak with people, relatives and staff, and check records were completed correctly. On the day of our inspection we saw the operations manager was visiting the home to make their regular check. We saw that where issues had been identified in previous checks and audits, action plans had

Good

Is the service well-led?

been generated to make improvements. These were monitored at follow up visits to ensure they had been completed. This ensured that the service continuously improved.