Rolfields Limited

Anchorage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Anchorage Nursing Home provides accommodation with nursing or personal care for up to 40 people. There were 36 people living in the home at the time of our visit.

People's experience of using this service
At this inspection we identified serious concerns with regards to the management of medication. Medication management failed to adhere to best practice guidelines published by the National Institute of Social Care (NICE) with regards to the storage, administration and management of medicines. This meant it was unsafe and placed people at risk of avoidable harm.

People's care plan did not always contain sufficient or accurate information about their needs and risks or the care they required. This placed people at risk of receiving unsafe or inappropriate care. People's daily records did not always demonstrate they received the support they needed. Records in relation to people's care were not always accurate or properly completed. This made it difficult to keep track of the support they received.

Staffing levels were not always sufficient to meet people's needs or to ensure staff were able to evacuate people to a place of safety in the event of an emergency such as a fire.

People's legal right to consent to their care was not supported in accordance with the Mental Capacity Act 2005. This meant people were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible and in their best interests.

Some of the communal areas in the home such as the dining room was not big enough to accommodate everyone's dining needs at the same time. The two quiet lounges were very small and were next to other communal areas which experienced heavy traffic from people, staff and visitors and were noisy. We have recommended the provider reviews the communal spaces within the home to ensure they accessible, suitable for purpose and of sufficient size. We also recommended that they review best practice guidance on creating dementia friendly environments to support people living in the home with dementia.

The service was not consistently well-led. Managerial and provider oversight of the service was also not robust and the systems in place to monitor the quality and safety of the service were not always effective in identifying and driving up improvements.

People and the relatives we spoke with all told us staff were kind and caring. They said they were treated with dignity and respect and felt. Staff knew people well and spoke with genuine warmth about the people they cared for. People had access to a range of recreational activities and social pursuits to occupy and interest them.

Rating at last inspection and why we inspected
At the last inspection the rating of the service was good (published 02 September 2017). At this inspection the rating has not been maintained. At this inspection, the service has been rated 'Requires Improvement'. This is because the provider has failed to ensure that regulations 11 (Need for consent), 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing) were met.

Follow up
Immediately after the inspection we requested an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor their progress with regards to this. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Anchorage Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was undertaken by an adult social care inspector, a specialist medicines advisor, a specialist nurse advisor 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 service.

Service and service type
Anchorage Nursing Home is care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority and other health care professionals to gain their feedback on the service. We used all this information to plan our inspection.

What we did during the inspection

We spoke with four people who lived in the home and three relatives. We spoke with the provider, registered manager, the deputy manager, a nurse, two care staff and the maintenance person.

We reviewed a range of records. This included four people's care records, a sample of medication records, four staff recruitment files and records to staff training and support. We also looked at records relating to the management of the service.

After the inspection
We asked the provider to submit an urgent action plan to CQC detailing the immediate improvements they intended to make to improve the quality and safety of the service people received.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

●Records relating to the amount, administration and disposal of medicines within the home were not always clear or accurate. This made it difficult to account for some medicines and tell if they had been given or, disposed of correctly.

● People did not always receive the medicines they needed. For example, one person needed medication to be administered when clinical checks on their wellbeing identified this was necessary to protect them from harm. Records did not always show this medication was administered when needed.

● Staff lacked sufficient guidance on how and when to administer 'as and when required' medications such as painkillers and prescribed creams. Records showed people's creams were not always applied consistently which meant we could not be assured their skin was cared for properly.

● Appropriate records had not been maintained in respect of the administration of medication prescribed to thicken people's drinks to prevent them from choking. This meant we could not be assured they had been given as prescribed.

●Information about the people's medication allergies was not always correct which increased the risk of them being given a medication unsafe for them to use.

● Medicines were not always kept secure or stored at safe temperatures. Medications can lose quality and their effectiveness if they are not stored at the correct temperature.

● The competency of some staff to administer medications had also not been appropriately assessed.

Unsafe management of medicines places people at risk from serious harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

● Some, but not all of people's risks were assessed. Moving and handling, skin integrity and nutritional risks were all assessed but risks in respect of medical conditions were not. For example, diabetes, chronic obstructive pulmonary disease and osteoarthritis. This meant staff lacked information on the risks these conditions posed, and the care people required.

● People's records did not always show they received the care they needed. For example, some people needed help to reposition in order to prevent pressure sores from developing but there was little evidence this was done as required.

● Another person required a pureed diet as they had trouble swallowing. During lunch this person was given a pudding that was unsafe for them to eat and we had to intervene. They also struggled to take their daily medication which was in tablet rather than liquid format. For some people with swallowing difficulties, tablet medication can increase their risk of choking. Despite this, this risk had not been assessed and there

was no evidence the possibility of liquid medication had been explored.
●Information about people's needs and risks was not always consistent. For instance, some people's care plans stated they were unable to walk yet their personal emergency evacuation plans stated they were able to walk with assistance. This lack of accurate information placed them at risk of inappropriate support during an emergency situation.

This lack of adequate risk management placed people at risk of harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The number of staff on duty to meet people's needs was not always sufficient. The information used to plan safe staffing levels was also not always accurate.
● At night, there were four staff on duty at night to support 36 people. Almost half of the people living in the home required two staff to assist them the majority of the time. This level of dependency had serious implications with regards to the ability of night staff to meet people's support needs as well as keep them safe in the event of a fire or other emergency.
● There was usually one nurse on duty alongside care staff at all times. A member of the nursing team and a care staff member both told us there were not enough nurses on duty to meet people's needs.
● Two out of the four people we spoke with during our visit told us at times there were not enough staff on duty to meet theirs. One person said, "Sometimes they are short staffed" and the other said "No, I think a couple more staff will make a difference, sometimes when I ring my buzzer it can take ages before they come".

Staffing levels within the home were not always sufficient. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment was safe. Checks were carried out prior to a staff member's employment to ensure they were safe and suitable to work with vulnerable people.

Preventing and controlling infection
● Most staff had completed up to date training in infection control to ensure that they knew what precautions to take to prevent the spread of infection.
● Access to personal and protective equipment such as disposable gloves and aprons was readily available in the home.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff received safeguarding training and records showed that appropriate action was taken to protect people from the risk of abuse.
● Accident and incidents were documented and monitored by the manager. Preventative action was taken to mitigate the risk of a similar accident or incident happening again.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
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. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Where there were doubts over a person's ability to make certain decisions, the MCA had not been followed correctly by the provider to ensure legal consent to make decisions on their behalf was obtained.
● Records showed decisions relating to deprivation of liberty safeguards, do not resuscitate orders and the installation of bed rails had been made without due regard to the MCA and people's right to consent.

People's consent had not always been obtained in accordance with the MCA. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities)

● During our visit, we observed staff seeking people's consent with regards to their day to day support. We heard them asking people politely if they wanted help before it was provided and respected their wishes if they did not.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed but staff lacked adequate information on people's medical conditions and the care they required.
● People's medicines were not managed in accordance with NICE best practice guidelines or guidelines issued by the Royal Pharmaceutical Society of Great Britain.
● People decision making capacity was not supported in accordance with the Mental Capacity Act 2005.

People's care did not always adhere to nationally recognised guidance. This was a breach of Regulation 12

of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff received training to do their job and had regular supervision
● Staff had an annual appraisal of their skills and abilities.
● Staff told us they felt supported by the manager and said staff morale was good.
● Feedback from people living in the home with regards to staff skills and experience was mixed. Their comments included " I was nurse and I think the staff are well trained nowadays" and "I think personally they are trained on the hoof. Some are thrown in at the deep end".

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs were assessed and referrals were made to the community dietician and the speech and language therapy team where appropriate.
● Some people required their dietary intake to be monitored. Their food and drink information however was not easy to keep track of. There was also little evidence that this information was reviewed by nursing staff or the manager to ensure people's intake was sufficient to prevent weight loss or dehydration.
● During lunch, people meals were of a good portion size and they had a choice of what to eat and drink. One person told us "The chef comes in and asks me what I want and if I enjoyed the food each day. You get a choice two mains and desserts. Today I couldn't eat pork, so they brought me something else".
● People's feedback on the food and drink provided was mixed. Comments included "I am very happy with the food as I don't like heavy meals. I like salad, we get healthy food and I love salads"; "It's great, really good, you get plenty" and The food is pretty good sometimes and sometimes its rubbish"

Adapting service, design, decoration to meet people's needs
● The dining area although nicely set was very small. This meant it was not possible for everyone to eat their meal in the dining room at the same time, if they wished.
● There were two quiet communal areas in the home for people to access. These were very small and it would have been difficult for staff to use a hoist to transfer people from wheelchairs to chairs in these areas. We saw that one accident in 2019 had occurred as a result of this.
● There was also a small room used for people to watch movies or 'Netflix'. ● Both quiet rooms and the 'Netflix' lounge were adjacent to the large communal lounge. There was heavy traffic in these areas from people, visitors and staff. This interrupted people's ability to enjoy a movie or television programme or have quiet time without constant interruption.
● The decoration of the home was adequate. The garden was a pleasant area for people to enjoy.

We recommend the provider reviews layout of the home to ensure communal areas are accessible, of adequate size and suitable for both the people living there and their purpose.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
● One person told us, "If am not well they get me the doctor, we have podiatrist to do my feet". Another said, "If I need to go to the dentist, they take me. The optician comes here to see me".

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; equality and diversity

- Staff were observed to be kind, compassionate and patient when supporting people.
- People spoken with, told us that staff treated them well. Their comments included, "Yes, they are good to me, we are like a family"; "Oh yes, it's the staff they keep an eye on you, you have nothing to worry about, they treat me very well, the staff are more like mates, they are brilliant" and "Oh yes, you hear of cases where people are not well cared for and it's not like that here". The relatives we spoke with felt the same.
- People's care plans contained information about what they could do independently and what they needed help with. People told us staff supported them to maintain their independence wherever possible.
- People's personal care needs were tended to discreetly and people told us their privacy and dignity was respected. One person said, "Oh yes, they make sure if I have a bath or shower it is done in private". Another person told us, "Yes, they close the door and they are very respectful actually".

Supporting people to express their views and be involved in making decisions about their care.

- There were opportunities for people living in the home and their relatives to attend 'relatives and residents' meetings where they could express their views on the care they received.
- People and their relatives were also encouraged to complete a satisfaction survey. The survey asked a series of questions about the service and people's care to obtain their feedback. We saw that nine surveys were completed recently with generally positive results.
- A newsletter was also produced by the home. This gave people information on important events or festivities, forthcoming activities and up and coming birthdays. This helped people keep in touch with what was going in in their home.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the care some people received did not always ensure their needs and preferences were met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

● The home employed an activities co-ordinator who provided a range of social and recreational activities. There was also a minibus to take people on trips out.
● On the days we visited, the activities co-ordinator was not in work. Just before lunch on the first day of inspection, a staff member started to undertake activities in the lounge. Music or radio city also played loudly at the same time and for most of the day. It was very chaotic and consequently the lounge and communal areas were not always therapeutic or relaxing.
● Some people who were unable to reliably communicate did not like loud or busy environments, yet they sat in the lounge for most of the day. There was little evidence that the manager or provider had considered the impact of the environment and noise levels on their mental well-being. Noisy environments can be particularly distressing and disorientating for people living with dementia.
● People's care plans were person centred but some of the information had not been consistently updated. The manager and deputy manager they told us they would address this without delay.
● People's bedrooms were personalised with the things that were important to them and people told us their families and friends were always made to feel welcome.

We recommend that the provider reviews guidance on dementia enabling environments such as that produced by the Social Institute of Care and 'Dementia Friendly Environments' and other associated reading.

End of life care and support
● No-one living in the home at the time of the inspection was in receipt of end of life care.
● People's care plans showed that they had been asked about their end of life wishes to enable staff to plan their end of life care as and when appropriate.
● Some people had declined to discuss their end of life care and this choice had been respected.

Meeting people's communication needs
Since 2016 onwards, all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's care plans contained some information on how people communicated and the best way to connect with them.
● When we spoke with staff, it was clear they knew people well. hey told us some of the techniques and

strategies they used to help communicate with people and build positive relationships. For example, one staff member told us they talked about events that were important to the person when they became upset or agitated. This helped the person relax.

● One person was unable to communicate verbally, and we were told they had a picture board to help them communicate their wishes. Some of the staff and people living in the home attended weekly 'Hoylake Hands and Voices' sessions which used Makaton. Makaton uses signs and symbols to help people communicate.

● There was a 'daily chat' magazine produced by the home that was printed in large, easy to read print for people to enjoy. This provided people with news, poems, 'down memory lane' stories and crosswords.

Improving care quality in response to complaints or concerns

● People told us they were happy with the support provided and had no complaints. People told us they knew who to talk to if they had concerns.

● Records showed that where complaints had been made, the manager had responded to them appropriately.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection, this key question was rated good. At this inspection, this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Some aspects of the planning and promoting person centred care required improvement. For example, improvements were needed with regards to the way in which people's medicines were managed; the assessment and management of risk; staffing levels; obtaining people's consent in accordance with the Mental Capacity Act, contemporaneous and accurate record keeping and the environment in which people lived. The governance systems in place to identify and address improvements in these areas were ineffective.
- The manager and deputy manager were clear about their role but did not always demonstrate they fully understood their regulatory responsibilities.
- Nursing staff had not always fulfilled their clinical responsibilities with regards medication management and there was a lack of sufficient managerial oversight in this area.
- There was a lack of understanding across the organisation about dementia friendly environments and the impact of noise levels on the sensory changes that people living with dementia may experience. This was concerning as a significant number of people living in the home lived with dementia.
- Care staff were clear about their roles and worked well as a team. They knew people well and people looked relaxed and comfortable in their company.

The governance arrangements in place were not always effective and the management of the service not always robust. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities).

Continuous learning and improving care

- Regular staff meetings took place to discuss issues associated with the service. Despite this, there was little evidence that the issues we identified during our inspection had been picked up and addressed by the management team or provider. This meant there were missed opportunities to improve care.
- The people we spoke with and their relatives were positive about the home and the manager. They told us that the manager was approachable and friendly.
- Both during and after our visit, the provider, manager and deputy manager were responsive to our feedback. They submitted an action plan to CQC on the actions they intended to take to address the concerns we had raised. It was clear they were committed to improving the home and took the concerns we identified seriously.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager had notified CQC and the Local Authority appropriately in respect of serious injuries and potential safeguarding incidents.

● Accident and incidents, safeguarding and complaints were properly investigated and responded to.

Records showed both the manager was open and honest in acknowledging and addressing any shortfalls in the service and people's care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People's health and welfare needs were met by a range of local healthcare providers, social work teams and community services. People were supported to access healthcare appointments to maintain their well-being.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always obtained in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was unsafe. People's risks were not always fully assessed or managed. People's care was not always provided in accordance with nationally recognised guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to govern the service and mitigate risks to people's health, safety and welfare were not effective. Managerial and provider oversight was not robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not always sufficient to

Treatment of disease, disorder or injury

meet people's needs and keep them safe.