Mrs E Voce

Annandale Rest Home

Inspection report

1 Victoria Road West
Crosby
Liverpool
Merseyside
L23 8UG

Tel: 01519243162

Date of inspection visit:
01 February 2017
02 February 2017

Date of publication:
22 March 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 1 & 2 February 2017 and was unannounced.

Annandale Rest Home provides accommodation and support for up to ten people. It is situated in a residential street, close to bus routes and shops. The building is a converted Victorian property with steps to the front and rear entrance. Communal areas include a large lounge and a separate dining room. There is a chair lift to the upper floor. The accommodation consists of one double and eight single bedrooms.

The home was last inspected in December 2015. During this inspection we identified a breach in relation to assessing people's capacity to consent to care and treatment. This was because some people were being deprived of their liberty without appropriate referrals being in place also the registered manager was not confident in accessing mental capacity or the process for acting in people's best interest. The 'effective' domain of our report was rated as 'requires improvement.' Following this inspection the provider wrote to us to tell us what action they were going to take to ensure this breach was met. We checked this as part of this inspection.

On this inspection we found that improvements had been made and people living at the home had had their capacity re-assessed for individual decision and applications to the local authority had been when needed. In addition, the registered manager and the staff team had familiarised themselves with the Mental Capacity Act (MCA) 2005 by attending additional training. The MCA is the legislation that underpins mental capacity and how it is applied in care settings. The service was no longer in breach of regulation.

A registered manager in place. 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.

There were safe practices in place to ensure people received their medications safely and on time. Medications were stored in a designated area of the home and were only given out to people by staff who were training to do so.

There were recruitment checks in place to ensure that staff were safe to work with vulnerable people. There had been no new staff recruited to work at the home since our last inspection, and the staff that worked at the home had done so for a long time.

Staff were able to describe the course of action they would take if they felt someone was being harmed or abused in any way. This included raising and reporting safeguarding concerns. Staff also said the home's whistle blowing procedure was discussed regularly with them, and they would not hesitate to enforce this procedure if need be.

Risk assessments were up to date and contained good information for staff to follow to minimise any risks to people's safety. Risk assessments were reviewed every month or when people's needs changed as a result of a medical condition or diagnosis.

Incidents and accidents were recorded and analysed monthly for any emerging patterns or trends.

Rotas showed there were enough staff on duty at any one time to keep people safe. We observed a calm, relaxed environment.

Staff had the correct skills and training to support them in their role, which included a range of courses in mandatory subjects as well as access to external qualifications. Staff were supervised in line with the providers policy, and had an annual appraisal.

Meals were served in the dining room, and people were provided with a menu which showed meal choices for a week based on a four weekly programme. Meals were home cooked and people said they enjoyed the food.

People were supported to access medical treatment when they required it. The home was taking part in a pilot scheme which involved them being able to access support from the community matron when required.

We observed staff delivering support and they were kind and compassionate when working with people. They knew people well and were aware of their history, preferences and dislikes.

Care plans, with regard to people's preferred routines and personal preferences were well documented and plainly written to enable staff to gain a good understanding of the person they were supporting. Care plans contained a high level of person centred information. By 'person centred' we mean the service was tailored to meet the needs of the person, and not the service.

Complaints had been responded to by the registered manager and appropriately dealt with including any changes which needed to be implemented because of the complaint. There were no new complaints since our last inspection.

Quality assurance procedures were robust and identified when actions needed to be implemented to drive improvements. We saw that quality assurance procedures were organised and adopted an honest approach to identifying shortfalls in service provision.

Feedback had been gathered from people who used the service in the form of questionnaires. This was presented in a way people understood, containing a mixture of words and pictures. There was a poor return with this; however, the service gathered feedback informally most of the time from people and relatives.

We received positive feedback about the registered manager and the home in general.

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 safe practices in place to ensure people received their medications safely and on time.

Staff were recruited safely and only offered employment subject to satisfactory checks being carried out.

There were processes in place which ensured staff were aware of how to protect people against the risk of abuse, and the practicalities of raising a safeguarding concern.

Is the service effective?

Good

The service was effective.

The service was working in accordance with the MCA and associated principles and staff were aware of their roles and responsibilities in relation to this.

Staff had the skills and knowledge to support people in the home. This was demonstrated in staff training records and training course certificates.

Staff were well supported and engaged in regular supervision and yearly appraisals.

People were supported to access they healthcare they required and which met their needs.

Is the service caring?

Good

The service was caring.

We observed kind and warm interactions between staff and people who lived at the home.

People told us they were supported to express their views and opinions, and were involved in decisions regarding their care and support.

Staff were able to describe how they ensured they protected people's privacy and dignity when providing personal care and support .

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and contained information about people's likes, dislikes and preferences.

There was a complaints procedure in place and it was accessible for people who lived at the home. People told us that they knew how to complain.

There were activities available and people could choose what they did with their time.

Is the service well-led?

Good

The service was well-led.

Everyone we spoke with was complimentary regarding the registered manager.

There was a system in place for auditing (checking) service provision. We saw audits took place weekly and monthly. Action plans were drawn up in response to any areas of concern.

There was a calm, compassionate culture at the home. The registered manager led by example, and supported staff well.

Annandale Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 & 2 February 2017 and was unannounced. The inspection was conducted by an adult social care inspector.

Before our inspection, we reviewed the information we held about the home. We looked at the notifications and other information the Care Quality Commission had received about the service.

We carried out a Short Observational Framework for Inspection (SOFI) SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

We spoke to three people who lived at the home, three relatives by telephone, the registered manager, and two support staff. We looked around the home, including the bathrooms, kitchen, lounge areas and, with permission one person's bedroom. We looked at three care plans, three staff recruitment folders and other documentation relating to the running of the home

Good

Is the service safe?

Our findings

We asked three people living at the home if they felt safe and secure. One person said, "Oh yes." Someone else said, "I have no reason not to." Another person just answered "Yes." We spoke to some family members of people who lived at the home and asked them for their opinions. One family member said, "It is a lovely warm, cosy place." Someone else said, "It's just like being in your own home." Other comments included, "The building is older, but that doesn't affect the feel of the place," and "It's a lovely home."

We reviewed three files relating to staff employed at the service. There had been no new staff employed at the home since our last inspection. Staff records viewed demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had references on file prior to commencing work.

The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the registered manager to assess their suitability for working with vulnerable adults. This confirmed there were safe procedures in place to recruit new members of staff.

Staff had received training in the principles of safeguarding and also the practicalities of how to raise an alert with local safeguarding teams. Staff were able to describe how they would raise concerns about people's wellbeing, and who they would speak to. Staff also explained the provider's approach to whistleblowing, and told us they would be encouraged to report any bad practice or concerns. We saw information regarding safeguarding for people who used the service and relatives was readily available on the noticeboards in the hallway and the service user guide. People and relatives we spoke with confirmed they knew how to raise concerns should they have any. This demonstrated the registered manager had ensured safeguarding principles were understood by staff and people who used the service.

The registered manager provided us with an overview of how medicines were managed within the home. Processes were established for receiving stock, monitoring stock and the disposal of medicines. Medicines were held in a locked room. Medication requiring cold storage was kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily to ensure the temperatures were within the correct range. This is important, because if medications are stored incorrectly it can affect their ability to work.

The medication administration records (MAR) included a picture that was sufficiently large enough to identify the person. We saw that the MAR charts had been completed correctly and in full.

Arrangements were in place for the safe storage and management of controlled drugs. These are prescription medicines that have controls in place under the misuse of drugs legislation. Some people were

prescribed topical medicines (creams). These were stored safely and body maps were routinely used to show where topical creams should be applied.

Some people were prescribed medicines only to be taken when they needed it (often referred to as PRN medicine) and had a plan in place to guide staff about when this medication should be given. PRN medicine was mostly prescribed for pain or if people showed signs of anxiety. The manager confirmed that the people without a PRN plan had full mental capacity to recognise when they needed the medicine and requested it.

The care records we looked at showed that a range of risk assessments had been completed and were regularly reviewed depending on people's individual needs. The records we looked at for each person included a needs assessment, admission procedure, a task risk assessment which showed what level of support the person needed for particular tasks, a mental health risk assessment, diet and fluid charts and weight charts. People who were at risk of falls or malnutrition had additional risk assessments completed which explained what support that person needed and highlighted the impact of the risk the person could be exposed to. For example, we saw that one person was at risk of falls, this was identified on the pre-assessment. There was a falls risk assessment in place; however the person had not experience a fall since moving the Annandale, so the risk assessment was updated monthly to include this information.

Rotas showed the number of staff on duty at the home appeared to be consistent. During our inspection we observed people receiving assistance in a timely manner and there were always staff available in the communal areas of the home to help people if they required it.

A Personal Emergency Evacuation Plan (PEEP) had been developed for each person living at the home and the method of assistance required had been personalised to meet the need for each person. There was a fire and emergency plan displayed in the hallway.

We checked to see what safety checks were undertaken on the environment. We saw a range of assessments and service contracts, which included gas, fire safety, electric and legionella. We spot-checked the date of some of these certificates. Procedures were in place for responding to emergencies and in the event of a fire.

We saw that incidents and accidents, such as falls and possible reasons for challenging behaviour, were well recorded and the registered manager as part of their auditing process, was analysing these for any trends and patterns.

Good

Is the service effective?

Our findings

During our last inspection in December 2015, we found the service in breach of regulations associated with consent to care and treatment. This was because the registered manager was not accessing people's capacity to consent to certain types of decisions in line with the Mental Capacity Act 2005 (MCA). People who presented as having no capacity to make decisions were being deprived of their liberty without the appropriate authorisation. The registered manager was unsure of their role with regards to the MCA. This domain was rated as requires improvement. Following the inspection, the provider wrote to us to tell us what action they were going to take to meet requirements and we checked this as part of this inspection.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that all the staff team had received training in the principles associated with the MCA 2005 and DoLS. We found staff understood the relevant requirements of the MCA and put what they had learned into practice. Records showed two applications had been authorised, and were being kept under review, subject to individualised capacity assessments taking place with people which explored the least restrictive way to keep the person safe.. For example, for one person, we saw that the registered manager had assessed their capacity with regards to crossing the road if they were to be out alone. As this posed a high risk to the person we saw that the application to deprive them of liberty was the safer choice, based on the registered managers assessment. We saw that family members had been involved in this process. We checked to see if there were any conditions on the person's authorisation, but there were not any.

We saw that consent was sought in line with the MCA, and clearly documented in people's care plans. Where people could not sign consent themselves, we saw that family members had done this were they were legally allowed to so. For example, one person's family member had Lasting Power of Attorney (LPA) for health and finance, and this was documented in the person's care plan along with copies of the paperwork. These examples showed that the provider was no longer in breach of this regulation.

We saw from looking at records relating to people's medical and clinical needs, that a full description of people's visits from healthcare professionals was being maintained by the staff. Appointments were scheduled into people's daily activity plans and staff were allocated to support that person to attend the appointments. We saw staff completed documentation when they returned from the appointment with that person to show the outcome and additional information (such as any medication changes) which the staff would need to know.

We checked staff training. We saw that staff had undergone training in range of subjects such as end of life, MCA, safeguarding, medication, and moving and handling. Training was a mixture of e-learning and practical based sessions for moving and handling and medication. We saw that all staff had either been enrolled on, or had completed a nationally recognised qualification, such as a NVQ, in health and social care. Staff told us they felt well equipped to do their jobs. One staff member said, "I know I am all up to date, we get told when we have to attend training ." Staff told us they were supervised at least every eight weeks by the registered manager and had had an annual appraisal. Records we looked at confirmed the dates the supervisions had taken place. We checked these dates, but did not look at the content of any of the staff's supervisions.

We reviewed the provisions and planning of food and menus as part of this inspection. We observed that food was served in a well presented dining room which had been redecorated. The tables were laid with table clothes and there were a selection of condiments on the table for people to choose from. We saw the menu was varied and catered for all diets and preferences, including vegetarian and those who needed a fortified diet; this means food where milk, butter or cream have been added to help sustain a healthy weight. We asked one person if they liked the food at the home and they said, "It is very nice, they keep me full up." People were given hot and cold drinks with their meals and regular tea and coffee was being offered throughout the day.

We looked around the home and saw that since our last inspection various refurbishments had taken place, such as the lounge area, dining room and most people's bedrooms. We saw that to aid a dementia friendly environment, doorframes of bedrooms and toilets had been painted contrasting colours, and there was directional signage on all of the doors. The meant that people living with dementia would be able to find their way around easier in the home. The registered manager told us there was still some work to do in the home, but this was due to be completed soon.

Good

Is the service caring?

Our findings

We spoke to two people who lived at the home and asked them if they liked the home and the staff. One person said, "Oh yes, they are grand." Another said, "They are fantastic." We spoke to family members of people living at the home and they were positive about the caring nature of the staff and the home in general. One family member said, "The staff are just always so nice, they really care about the people living there." Someone else said, "You don't feel like you are in a home, you just think it is their house, that's how the staff create a homely environment." Another person said, "It is excellent."

We spoke to staff and asked them how they felt they provided dignified care which was in line with peoples preferences. One staff member said, "You get to know and learn what their individual likes and dislikes are. No two people are the same." Also, "I always ask them if they want me to help with personal care, instead of just assuming that they do. It's just polite."

We saw from looking at people's care plans, they were either signed by the person themselves or their relative if they had permission to do so. Family members told us they were involved in care plan reviews and were often contacted to discuss changes to the care plan.

For people who had no family or friends to represent them contact details for a local advocacy service were available, we saw that one person was receiving advocacy support at the time of our inspection.

We observed throughout the duration of our inspection that staff would knock on people's bedroom doors and ask permission to enter. Dialogue between people who lived at the home and the staff was respectful and familiar. Staff used positive words such as 'choice', 'promote' and 'independence', as well as respectful language such as 'would you like' and 'may I help you.'

Good

Is the service responsive?

Our findings

We checked to see if the home was providing care which was person centred. Person centred care means care which is coordinated around the needs of the person, and not the home. We looked at people's care plans. We saw that these were completed individually for each person, and included information such as people's likes, dislikes, preferences, and routines. We saw that care plans were respectfully written, and contained words and phrases such as 'I would like the staff to help me choose my clothes.' For one person, for example, there was a care plan if they became forgetful We saw that this stated the following; 'when I sometimes forget things, I would like the staff to gently remind me of what I was doing.'

In addition to this, we saw that the registered manager had improved their initial assessment process since our last inspection. This now contained a list of things that the person being assessed could and could not do for themselves, and what they could remain independent with, and how the staff could support them to do this. One phrase we saw in one person's care plan, for example, said, 'it is important that you put me in charge of me.'

There was information included in people's care plans such as what time they liked to eat their breakfast, wake up, or whether they preferred a bath or a shower. We saw that care plans were being reviewed every month, and new information was added when needed and taken out if it was no longer applicable to the person.

We asked about the homes complaints policy and saw that there had been no new complaints since our last inspection, so there was nothing for us to follow up.

We asked about activities in the home. One relative told us, "It is not the fault of the home, there just never seems to be much going on." We observed the people living at the home, some were reading, others were watching TV. We asked the registered manager about activities and if there was a varied programme of entertainment. We were shown a planner which included tried and tested activities which some of the people living at the home said they did not like. One staff member said, "They [people who live at the home] love the bingo and the quizzes. We have also had some people come in to do some aromatherapy which they all liked, but other things, such as singers, most of the people here don't like that; it can be quite loud." We asked people if they were ever bored in the home, no one said they were.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been at the home since it opened in 1983.

We spoke to the registered manager and they were aware of their role and responsibilities regarding reporting any notifiable incidents to the Care Quality Commission (CQC). We also saw that the ratings from the last inspection were clearly displayed as required.

The culture of the home was warm, relaxed and friendly. Staff and people who lived at the home were complimentary about the registered manager and the provider. One staff member said, "[Registered manager's name] is great" and, "The culture here is different to other places I have worked at, it's so person centred, I have been here for years." The staff we spoke with said they liked their jobs and enjoyed working at Annandale and would recommend the home to other people. One staff member said, "It's a family."

The home had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, independence, respect, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance. We saw that polices had last been reviewed in 2016.

There were audits for the safety of the building, finances, care plans medication and more regular checks like the water temperatures. The registered manager took an honest approach to quality assurance, and we saw that where issues where identified, such as the décor in some of the rooms, this was actioned with a realistic time scale for completion. Most of the actions had been completed.

The owner and registered provider frequently visited the service and conducted checks on the paperwork and the environment. Staff spoke positively about the provider.

We looked at how the registered manager used feedback from people living at the home and their relatives to improve the service. We saw that feedback was mostly face to face due to the small size of the home. We saw however, that some different feedback forms had been developed and these would be sent out to people and their families. There had been a poor return in the past with regard to documented feedback. All of the relatives we spoke with told us they could raise anything anytime, and they knew it would be 'sorted out'.

We saw that team meetings took place every month, and resident meetings took place every week. We saw minutes of these meetings, and agenda items such as menus, new activities and décor were discussed as part of the agenda for people who lived at the home. For the staff meetings we saw agenda items such as training, supervision and health and safety were discussed.