Mr. Malcolm Haigh

Anley Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service responsive?	Good

Summary of findings

Overall summary

This focused inspection was unannounced and took place on 4 May 2016. The last inspection at Anley Hall Nursing Home took place on 14 May 2015 and the service was meeting all of the regulations we assessed at that time and was given a quality rating of 'Good.'

This inspection was carried out to follow up on concerns which had been raised with CQC. The person raising the concerns wished to remain anonymous. They made the following allegations:

- People were being left in a soiled condition,
- People not being bathed,
- Peoples health risks not being dealt with,
- Lack of staff training,
- Staff starting work without the relevant pre-employment checks,
- Falsification of medicine records,
- Medicines not being stored correctly,
- Medicines not being given as prescribed,
- People not being supported with dietary or hydration needs,
- People being moved around the service without just cause, and
- A spike in deaths during March 2016.

This report only covers our findings in relation to the above topics and focuses on whether the service was 'safe, effective and responsive.' You can read the report from the inspection in May 2015 which was a comprehensive inspection, by selecting the 'all reports' link for 'Anley Hall Nursing Home' on our website at www.cqc.org.uk

At this inspection we found that the registered provider was meeting the requirements, apart from some minor improvements needed with regard to specific care records which were discussed with the registered manager at the end of the inspection. The registered manager agreed to deal with these matters as a priority.

Anley Hall is registered to provide nursing care for up to 54 people, some of who may suffer from memory impairment, dementia, a physical disability or be terminally ill. The home is divided into two separate units; one is specifically used for people who are living with dementia. The home is a stone built country house, previously a private dwelling, and is situated in a rural setting on the outskirts of the market town of Settle, in the Yorkshire Dales. There are communal areas for dining and relaxation. Car parking is available in the grounds. On the day of our inspection 45 people were living in the home.

Anley Hall had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us the service was kept clean and we saw this was the case when we carried out a tour of the building. Equipment, including wheelchairs and soft furnishings were also clean.

People told us they received a good standard of care. We saw detailed information in care records which showed that people were receiving care and treatment which was planned or based on their current needs. Information was up to date and relevant.

The registered manager had made statutory notifications which are required by law. Statutory notifications are matters such as safeguarding incidents, serious injury, expected and unexpected deaths.

People told us they were safe and well cared for and this view was shared by the staff and relatives we spoke with. The service had sufficient staff to meet people's needs and staff had the time to ensure people were provided with a good standard of care.

Medicines were managed safely and people received their medicines at the correct time and as prescribed by their doctor. Staff giving medicines were well trained and competent. The service had safe systems to store, administer, order and dispose of medicines.

People told us the food was well prepared, good and tasty. People were given choices at each meal and had a varied menu. Staff, including the chef and catering staff, knew people's individual likes and dislikes. Care staff understood the importance of people having enough to eat and drink and we saw people being regularly encouraged to eat and drink throughout our visit.

The service was working within the principles of the Mental Capacity Act 2005 and staff routinely sought consent from people and supported them to make their own choices.

People had access to routine health care professionals and where they needed more specialised support, this was sought as appropriate.

All of the staff we spoke with told us they enjoyed supporting people and this was clear in their interactions with people, which were patient, kind and warm. Staff told us about their commitment to make sure people were well supported, comfortable and happy.

Staff we spoke with told us they felt well supported by the registered manager and provider and had access to regular training and supervision. Staff morale was described as good by those we spoke with and there was clear evidence of staff working as a team for the benefit of people living at Anley Hall.

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.

All areas of the home, including equipment, were clean and tidy. There were no mal odours.

Staff and the registered manager were aware of the types of abuse and what to do if they suspected abuse. The registered manager had notified CQC of safeguarding incidents within the service as required. Staff knew about risks to people and how to monitor these. Details of the risk assessments were in care plans and were detailed and up to date overall. Two care plans required additional information in relation to the needs of two people.

People told us they felt safe and they gave positive feedback about the care provided.

Medicines were managed safely and properly.

The service had sufficient staff to meet people's needs and they had been recruited safely.

Is the service effective?

Good

The service was effective.

The service was consistently applying the principles of the Mental Capacity Act 2005. Consent was sought from people who used the service, and where people were unable to make their own decisions, we saw appropriate best interest decisions were recorded.

Staff had access to regular and planned supervision, and they told us they felt well supported by the registered manager and the provider. Staff had access to training to support them to deliver effective care. Training was well organised and staff told us their training was up to date.

The service ensured people received support from health and social care professionals as required.

People told us the food was good and that they enjoyed a varied and nutritious diet. People's preferences were catered for and staff encouraged people who needed additional nutrition to take advantage of the snacks and drinks available between scheduled meal times.

We noted an abundance of hot and cold drinks being offered throughout the day to people in communal areas and those spending time in their own rooms.

Is the service responsive?

Good

The service was responsive to people's needs.

Care plan records were informative, well ordered and although some would have benefitted from additional detail, they were easy to follow and gave clear instructions to staff. Regular reviews were held to make sure the home was meeting people's needs.

The environment and activities supported people, including people living with dementia, to be occupied, engaged and stimulated.

People told us they were well cared for and care staff knew people and their care needs and preferences well.

People told us the registered manager was approachable. The complaints policy was displayed within the service. The service had dealt with one formal complaint in the last 6 months. This was on-going and appropriate action was being taken.

Anley Hall Nursing 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to specifically follow up on concerns which had been raised anonymously with CQC.

This inspection took place on 4 May 2016 and was unannounced. The inspection was carried out by one adult social care inspector. Also present during the inspection were an executive nurse from the local Commissioning Care Group, a social care assessor and a quality assurance and procurement officer from North Yorkshire County Council. Information was shared following the inspection in accordance with joint working protocols and the safeguarding of people using services.

As part of this focused inspection we also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

During the inspection we spoke with nine people who used the service and two visitors. We also spoke with the registered manager, three members of care staff, a registered nurse, an administrator, a resident liaison officer and the training co-ordinator. Anley Hall Nursing Home accommodates people who are funded by both the County Council and Clinical Commissioning Group. The County Council is the lead agency with regard to safeguarding in the area. All of the allegations made had been referred to the County Council though our sharing of information protocols, which exist to protect people using services. These agencies also provided information and evidence to support the findings in this report.

We reviewed ten care plans and associated records. We completed a tour of the building and walked outside in the garden. We looked at three staff files, which contained employment and training records. We also looked at documents and records that related to people's care and support, and the management of the home, such as training records, audits, policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I am alright, I don't worry about anything. They are all very kind." Another person said, "I feel very comfortable and safe here."

We looked at the circumstances and notifications we had received in the last six months, including recent deaths and incidents. The concern raised with us suggested there had been an increase in deaths in the home during March 2016, and this coinciding with an outbreak of vomiting and diarrhoea. We reviewed the care records of six people during that time and at the time of their death. We found no evidence to suggest that people had not received appropriate care during their time at Anley Hall. Some people had been admitted to receive specific care which was well planned and delivered. In these instances appropriate detailed end of life care plans had been put in place. Other people had shown a gradual expected deterioration in their condition and had been regularly reassessed and visited by their doctors and other health care professionals. We also noted good practice around 'Do not Attempt Cardio Pulmonary Resuscitation' instructions, and good communication with relatives and other agencies where appropriate. We noted that where medicines had been prescribed for anticipated symptoms (anticipatory medicines) these had been used appropriately and to the benefit of the person being cared for. All of the deaths reviewed had been certified by the persons own doctors practice.

People's bedrooms, individual bathrooms and communal lounges were found to be clean and tidy. Staff were aware of the infection prevention and control measures and were working towards this by using robust cleaning schedules and good routines. An infection control audit of the service, carried out in November 2015 had shown that overall compliance was 97%, with some minor improvements required. An action plan was in place to address this.

The service employed a team of cleaning staff who told us they had time to keep the service clean and looking tidy. Overnight care staff also completed domestic and cleaning tasks in between their caring duties.

Staff told us about the equipment they used to ensure people were moved safely. Records showed they had received training in this and equipment was maintained and working well. Staff told us about taking their time with people, so that they could retain their independence whilst also keeping them safe.

Staff spoke knowledgably about areas of risk and they correctly explained what they would do if they witnessed or suspected that abuse had taken place. Safeguarding notifications had been sent to CQC as required. Staff demonstrated a good understanding of how to safeguard people who used the service, they were aware of the types of abuse and how to report concerns. Staff told us they would ensure immediate action was taken to keep the person safe and then they would share the concerns with the registered manager. The service had a safeguarding policy, which offered guidance to staff. All of the staff we spoke with told us they had received safeguarding training and training records we saw confirmed this.

We saw some risk assessments in care plans. However, we discussed with the registered manager that risk assessments needed to be improved in some care plans, relating to personal care, bathing, mental health

needs and supporting people with mealtimes. Despite this, we saw risk assessments for such areas as physical care needs, clinical care (including pressure ulcer prevention) and mobility and dexterity. Staff understood the needs of each person and the strategies which had been agreed to protect them from harm. For example, where someone had a risk of developing pressure ulcers, action was taken to make sure they were regularly repositioned, whether sitting in a chair or in bed. Equipment, such as pressure relieving mattresses, specialist cushions and profiling beds, had also been provided to minimise risk.

Risk assessments for the environment had been completed and were regularly reviewed with the changing needs of the people who lived at the home. There were no obstructions or risks to people moving about the home.

The registered manager analysed information relating to untoward incidents and accidents and used this information to plan for future care. All incidents were recorded and an outcome based plan was included to minimise the risk of future occurrence.

We did not find any evidence to suggest that medication was not being given as prescribed or falsification of medicine records. We reviewed the current medication policy which was in date, having been reviewed in April 2016 and ratified for a further 3 years. This replaced a previous policy which expired in May 2016. The policy was clear, easy to follow and very informative.

We also reviewed the latest audit as part of the policy, that had been carried out at the end of February 2016. The audit had raised issues and we found the action plan was not detailed enough. We discussed this with the registered manager who was aware of this and had taken appropriate steps to involve the local pharmacist who had agreed to visit the service and complete a full audit.

We had received information that people were not being given their medicines as prescribed and that administration times had been changed from bedtime to teatime. We looked specifically at the medication used to treat symptoms such as anxiety and restlessness. We saw evidence in the medicine records that medicine administration times had been altered but this was in full agreement with the person's doctor and/or the pharmacist and was done to meet people's needs. For example, people were given their medicine to coincide with their preferred bed time. We also reviewed medicine administration for medication given 'as required' (PRN), in particular drugs used for sedation. We found that these medicines were being used appropriately and other actions had been taken before the use of medication was considered. For example, distraction techniques were used and medication was being offered as a last resort. In the majority of examples we looked at there had been no usage of the PRN medication to sedate or calm the person. One member of staff said, "I have never seen or overheard any of the staff say anything about giving medication to calm people down. If anything lots of people have been taken off drugs."

We noted some good practice around medication management including an incident where a nurse had realised that new medication was labelled incorrectly. The nurse had contacted the pharmacist and the doctor to gain clarification and nothing was administered until clarity had been sought.

We observed people being given medicines by the nurse or a senior member of staff. These were given patiently and safely. The member of staff ensured the person had taken their medicines before they completed the medicine record. This demonstrated the member of staff was following the service's own medicines policy which was in line with good practice guidance.

There were daily records of temperature checks in the medicines room and the medicines fridge. These were within the recommended range and this meant people's medicines were stored in line with the instructions

from the pharmacy.

The service had sufficient staff to meet people's needs. We observed staff had time to spend with people; none of the interaction was rushed. One member of staff we spoke with said, "The staffing levels are good. We try our best to give 100% all of the time." Another member of staff told us, "It can be hard work if we can't get cover, but that doesn't happen that often." Staff told us they would talk to the registered manager or provider if they were unhappy about staffing levels and felt confident they would be listened to and concerns would be resolved. People we spoke with told us they had not had to wait for attention when they needed it, and this included during the night. One visitor told us, "They are looked after here, I know who to speak to if I wanted to complain but have never had to. Very satisfied."

The service had effective recruitment and selection processes in place. We looked at three staff files and saw completed application forms and appropriate checks had been undertaken before staff began work. Each member of staff had two references recorded and checks through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with people who needed personal care and may be vulnerable because of their individual circumstances.

Training was delivered using a variety of methods, including watching DVD's and completing a competency test or working through a work book with the training co-ordinator. Training such as moving and handling was delivered face to face. Staff had received up to date training in areas relating to safety such as, moving and handling; safeguarding of adults; risk assessment; whistle blowing; fire safety; infection control; diversity and human rights and medicine handling. The registered manager told us that they reviewed the training provided and had created the training co-ordinator role to make sure this was given a high priority. Staff confirmed that they received support and encouragement in their training. Training was delivered both in house and through external training from the local authority, community pharmacy and district nurses.

Good

Is the service effective?

Our findings

People told us that staff were knowledgeable and that their needs were being met. One person told us, "The staff know me well. I didn't want to come to a nursing home but sometimes you don't have a choice. But we are alright here." Another person told us, "The staff try to please us all, I don't envy them – it can't be easy sometimes." A member of staff told us, "We have a team spirit, it's a nice atmosphere at work." Another member of staff said, "I love being with them [the people using the service], we are like a family to some of them, those without visitors." A visitor explained how the staff were alert and attentive and that they thought care was of a good standard.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The staff we spoke with understood the overarching principles of the legislation. They were able to explain to us how they supported people to make their own decisions on a day to day basis and they understood the need for DoLS. Further training was arranged for all staff as part of their evidence based care certificate qualification. At the time of our inspection 27 people had a DoLs authorisation in place.

Staff routinely sought consent from people who used the service and offered people choices. Where people were assessed as being unable to consent to a particular aspect of their care there was a clear best interest decision recorded and we saw people and their relatives, along with relevant health and social care professionals were consulted. The need to keep people safe was balanced with their right to freedom.

Staff had access to regular and planned supervision, and they told us they felt well supported by the registered manager and the registered provider.

People told us the food served at the service was varied, of a good quality and appetising.

We observed lunch in one of the main dining rooms and saw people enjoyed their meal and dessert. Some people chose to eat in the lounge and others in their bedroom. Their choice of where to eat was respected. Some people required assistance to eat their meals or gentle prompting from staff. This was done in a discrete and patient manner. Where people needed a visual prompt to choose their main meal, plated choices were shown to them so that they could decide what they wished to eat.

People were given regular drinks and snacks throughout the day. We observed care staff checking with people that their drinks were still warm enough to enjoy and asking people whether they wanted a refill. Staff told us about the importance of encouraging people to have a good fluid intake to reduce the risks of

urinary tract infections, which can cause people to be disorientated and feel unwell.

People were offered a choice of meals and the chef was aware of people's preferences and dietary requirements. We saw some people were provided with alternatives to the planned meal of the day.

Care plans showed that people had been seen by a range of health care professionals including doctors, dentists, hospital consultants and district nurses. We saw from the records that staff contacted health care professionals to resolve issues, including the Community Mental Health Team (CMHT) were necessary. One referral was discussed with the registered manager and although a visit had been requested for one person, a two week waiting time was proving difficult. This was taken up by the executive nurse present at the inspection who agreed to contact the CMHT to discuss the referral.

We noted that not all relevant information was recorded in care plans, despite staff having a good knowledge of each person's needs. We discussed this with the registered manager who agreed to address this matter with staff and make sure all information was recorded with sufficient detail. For example, where a person is reluctant to take a bath or shower. Information needs to detail the amount of support the person needs to make sure their personal care needs are being met and what approaches work well when arranging to bath the person. There also needs to be a record of the dates and times the offer of support was given and the response.

Despite the reluctance by some people to be supported to bathe, those we met were found to be well groomed and well-presented suggesting that they were able to carry out some of the tasks independently to maintain their own hygiene and dignity. We could see that people were attended to promptly when they needed support and staff were careful to preserve people's privacy and dignity when offering and providing the assistance needed. We found no evidence that people were left in soiled conditions.

The premises were well maintained and adaptations had been made to accommodate peoples specific care needs. Work was continuing outside to provide a secure outside area for people to use. One area, adjoining a conservatory was well used by people who used the service and access was available throughout our visit.

Good

Is the service responsive?

Our findings

The registered manager completed a pre admission assessment before people could move in to the service. This included information about the person's current needs and how the decision had been reached that the person needed to be supported in a 24 hour care setting. This meant the service considered whether they could support the person before they agreed they could move in. The registered manager also told us she considered the impact on existing people and the dynamics of each unit before agreeing to admit someone to the service.

We received information that people were being moved around the service without 'just cause.' We asked the registered provider to provide us with details of who had moved rooms within the service since January 2016 and the rationale behind the moves. We were told that there have been a total of 9 bedroom moves. One had been at the person's own request, two were due to service users needing to be assisted with a hoist and their bedrooms not being spacious enough and the remainder being due to the person needing care towards the end of their life or requiring more general nursing. The arrangements around accommodation and in particular the room being used is outlined clearly in the service user agreement which was provided to CQC.

Care staff knew people well. This was clear from observing interactions and the feedback we received from people about the care they received was positive. Care staff could tell us about people's lives and their individual preferences.

Care plan records were reviewed every month, or more regularly as needed. Care was delivered in a person centred way and was in accordance with each individual.

People were provided with meaningful activity or stimulation which was based on their individual needs. On the day of our inspection, there was a variety of activities planned, including one to one time, a church service and we saw people playing a game of dominoes. There were also links with the local community, including local businesses and volunteer groups.

The registered manager told us there had been one formal complaint made in the last 6 months. They explained they offered an open door policy and encouraged people and their relatives to share any concerns with them as soon as possible so they could work together to resolve them quickly. There was information available in the service explaining how people could raise a concern and staff told us they would support people to do that.