Anchor Carehomes Limited

Montrose Hall

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Montrose Hall on 11 January 2017.

A comprehensive inspection was last carried out on 19 May 2015, when we rated the service as 'requires improvement' overall. We found no breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, however we did make one recommendation in relation to the safe storage of medicines, including controlled drugs at that time.

Montrose Hall is a modern, purpose built home situated within a local community in Wigan. It provides residential care for up to 41 older people, including people living with dementia. Accommodation is provided over two floors with lift access between the floors. Each floor has a main lounge with dining area and a second smaller lounge. On the day of the inspection there were 35 people living at the home, with two more people currently residing in hospital.

At the time of inspection the home had a registered manager. 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.

We found the home was clean throughout and had appropriate infection control processes in place. Hand hygiene guidance and equipment was located in all the bathrooms and there were posters encouraging the use of hand gels and regular washing to prevent the spread of infection on display.

Each of the people we spoke with told us they felt safe. Relatives expressed no concerns about the safety of their family members and were positive about the level of care provided. We saw the home had appropriate safeguarding policies and procedures in place, with instructions on how to report any safeguarding concerns to the local authority. Staff had received training in safeguarding vulnerable adults, which was regularly refreshed and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

Staffing levels were determined by the needs of people living at the home, with a dependency tool being used each month to ensure levels remained safe and effective. We saw the home had sufficient numbers of staff to meet people's needs and both people and relatives we spoke with confirmed this.

We saw medicines were stored, handled and administered safely and effectively. We noted some inconsistencies with the recording of 'as required' medications such as paracetamol, specifically with regards to the recording of occasions when people had not required these. Staff responsible for administering medicines were trained and had their competency assessed up to three times per year.

All staff spoken to demonstrated a good knowledge and understanding of the Mental Capacity Act 2005

(MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider had followed the requirements in the DoLS and related assessments and decisions had been appropriately taken.

Staff were complimentary about the training available, telling us there was a mix between practical sessions and e-learning. All staff had completed a comprehensive induction programme lasting two full weeks and on-going training was provided to ensure skills and knowledge were up to date. Staff confirmed they received regular supervision and annual appraisals, which along with the completion of regular team meetings, ensured they were supported in their roles.

We observed meal times to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people, explained the choices available and provided support where needed. People we spoke with were complimentary about both the quality and choice of meals available.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. Both people who used the service and their relatives were complimentary about the attitude of the staff and the standard of care received.

We looked at six care files which contained detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained. We did note some gaps in documentation, particularly relating to bath and shower charts which the registered manager had already identified and scheduled a staff meeting the following day to address.

We have made a recommendation about the recording of information within care records.

The home had a comprehensive activity schedule in place. The home did not employ an activity co-ordinator, believing all staff should be involved in this role. Everyone we spoke with was positive about the variety and frequency of activities available. We saw the activity schedule catered for all interests and abilities and suggestions for either outings or activities made by people were acted upon and implemented.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly and monthly basis and covered a wide range of areas including medication, care files, infection control, health needs and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

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.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe living at Montrose Hall.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed regularly.

Is the service effective?

Good

The service was effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in the care plans.

The dining experience was positive and we saw nutritional needs were being assessed with appropriate care plans in place.

The environment was 'dementia friendly' with a range of aids, adaptations and pictorial signage in place.

Is the service caring?

Good

The service was caring.

Throughout the inspection we observed positive interactions between staff and people. Staff members were polite and respectful and took their time to listen to what people had to say, with appropriate physical contact used.

Both people living at the home and their relatives were positive about the care and support provided.

People were able to make choices about their day such as when to get up and how to spend their time. Staff understood the importance of promoting people's independence.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed. Relatives stated they were involved in decision making and had open access to care plans.

The home had a comprehensive activities programme in place. Everyone we spoke with was positive about what activities and outings were available.

The home had an effective complaints procedure in place, with all complaints whether written or verbal being investigated and outcomes documented.

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported by management.

Staff commented on the home having a positive culture, which encouraged honesty and openness.

Team meetings were held regularly to ensure that all the staff had input into the running of the home and were made aware of all necessary information.

Montrose Hall

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.

The inspection took place on 11 January 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also spoke to the quality assurance team at Wigan Council.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of the service provided at Montrose Hall, we were only able to speak with three people who used the service to ascertain their views about the care and support provided. We also spoke with four relatives and seven staff members, which included the registered manager, deputy managers and four care assistants.

We looked around the home and viewed a variety of documentation and records. This included six staff files, six care plans, eight Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Good

Is the service safe?

Our findings

We asked people living at the home and their relatives if they had any safety concerns regarding the home. One person told us, "I feel safe here. There are always staff about and they are happy to help when I need it." A second person told us, "I definitely feel safe. I've had a couple of falls but staff keep checking on me." One relative said, "[Person] is safe. It's good here, they wouldn't still be here if not." Whilst a second told us, "No worries at all."

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained detailed reporting criteria along with copies of all necessary documentation. This ensured that anyone needing to report a safeguarding concern could do so successfully. We noted that the home completed analysis of all safeguarding concerns. The analysis looked at how many incidents a person had been involved in over the last month and the last 12 months. It also covered the type of incident, any contributing factors, what measures were in place to mitigate further incidents, whether a care plan had been implemented and if all required people, both family and professional had been informed.

The staff we spoke with said they had undertaken safeguarding training and displayed a good understanding of how to report concerns. One staff member told us, "Yes, we do this every six to 12 months. I have been on an external safeguarding course as well." Another staff member said, "Safeguarding could be financial, physical, and emotional. If it was a member of staff accused of the abuse, I would remove the member of staff whilst it was investigated and report it to my manager." A third staff member told us, "Safeguarding could be physical, emotional, neglect, sexual, financial. I would inform the manager and complete a safeguarding alert to the duty team. Depending on the nature of the incident, inform CQC."

Staff also confirmed knowledge of whistleblowing, telling us that the procedure was clearly displayed in the staff room for reference. One staff said, "If I had concerns the manager wasn't dealing with the safeguarding, I would go to CQC. I've whistle blown in the past when I had concerns at another home."

We looked at six staff personnel files to check if safe recruitment procedures were in place. We found robust checks were completed before new staff commenced working at the home. The files included; an application, interview notes, proof of identity, two references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people. We saw staff were only sent an offer of employment once the recruitment checks were completed.

During the inspection we completed a walk round of the building, to look at the systems in place to ensure safe infection control practices were maintained. We found the premises were clean throughout and free from any offensive odours. Bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available, along with personal protective equipment (PPE) such as gloves and aprons. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use.

We asked both people living at the home and relatives for their views on staffing levels at the home. A person

told us, "There's enough staff. There are always a lot around." One relative told us, "There seems to be enough. There are always a few staff upstairs and I never have to look far to find a staff member." Another said, "There appears to be, no concerns at all with waiting times." Whilst a third stated, "Oh yes, there's plenty staff on all the time."

A staff member told us, "We have enough staff. We can meet people's needs and there's a bit of a contingency if a person is ill which has made a tremendous difference." A second staff member said, "We have enough staff and if we need more because people's needs have increased, we ring the area manager and they agree additional staff. It's flexible and about meeting people's needs." A third staff member said; "Staffing is based on people's needs. We are always looking at people's needs. We have enough on currently because a few people have just gone to nursing."

The manager told us the home ran with seven staff during the day and four staff at night. The home had a dependency tool in place, which they used to calculate the number of care hours needed to be covered each week and the amount of staff required to do so. We looked at the last four months data, which evidenced that enough staff had been on duty to meet people's needs. The tool also showed that whilst dependency levels in the home had fallen over the last two months, staffing ratios had stayed the same.

We looked at how accidents and incidents were managed at the home. We saw the registered manager had a robust system in place for monitoring and managing accidents and incidents. There was a policy on file which defined what constituted an accident/incident and the procedure to follow. Staff had signed to confirm that they had read this protocol. An accident monitoring log was in place which identified the injury type, accident type and the actions taken. For example; a person had fallen four times and was referred to the falls team. A person whose behaviour had escalated resulting in assaults on other people had been re-assessed as requiring a nursing placement and moved.

The registered manager undertook an analysis of accidents/incidents each month. The monthly accident log detailed the number of falls that month, falls in the last 12 months, where the accident occurred, nature of injury sustained, contributing factors, for example; if the person forgot to use their Zimmer frame, what measures had been put in place to prevent further falls/accidents. This meant the registered manager had systems in place to monitor trends in accident/incidents in order to put strategies in place to mitigate the risks of future re-occurrence.

Each of the care files we looked at contained a range of risk assessments, including falls risk assessments (known as falls risk identification) and where applicable, use of bed rails risk assessments. We saw that were people had been assessed as being at risk of falls, a falls prevention plan had been put in place. Following a fall or accident an observation tool had been completed every 15 minutes for up to 72 hours.

We looked at medicines management within the home. Each person had an information chart in place which contained their name, date of birth, doctor's details and start date of each medicine. A medicine identification chart was also in use which included a list of medicines, a picture of what they looked like, the dosage to be given and when to be administered. Each person also had Medicine Administration Record (MAR) chart in place.

We viewed eight M.A.R charts during the inspection and saw that all but one prescribed medication had been administered and signed correctly. The one anomaly related to a person's laxative medication, which we saw had run out but not been re-stocked for three days, until new medication that had been ordered had been received. We checked the person's care records and saw no adverse effect had been experienced as a result of not taking their laxative medication.

Topical medicine charts, for creams and lotions were in place and had been completed and we saw a running tally was kept for all boxed medicines. The home implemented short term care plans for newly prescribed, temporary medicines such as antibiotics. These explained what the medicine was, why it was prescribed and how/when it was to be administered. This ensured staff had the necessary information to safely and effectively administer this medicine.

The home had when required medicines (PRN) protocols in place. These explained what the medicine was, the required dose and how often this could be administered, what it was needed for, if the person was able to tell staff they needed it and if not what signs staff needed to look for. This ensured 'as required' medicines were being administered safely and appropriately. We noted that the recording of 'withheld' medicines; these being medicines which had not been given as the person did not require them, such as paracetamol, had not been documented consistently. The home had two recording systems in place for some 'as required' medicines, with a separate administration log kept alongside the MAR chart. Whilst every administration had been recorded on one of these systems, both had not been filled in consistently. We also noted the administration times for paracetamol were recorded on the MAR chart as morning, lunch, tea and supper. Actual times of administration had not been recorded on the MAR chart, which meant we were unable to ensure the required four hour gap between doses had been maintained.

We checked the controlled drug (CD) cupboard and saw this was locked with the key stored separately. We checked the stock levels of two people's medicines in the CD cupboard and saw that these tallied with the CD register. We also noted that all entries were supported by two staff signatures as is required.

The home had detailed, up to date medicines policies in place. We saw that all the staff authorised to give medicines had completed training in this area and had their competency assessed before doing so. A staff member told us, "We complete medication training and have three competency assessments a year." A second staff member said, "Deputy managers do medication once a week to make sure there are enough stocks and things are running okay."

Good

Is the service effective?

Our findings

We asked people living at the home for their views on the food. One person told us, "I've only been here, so I have nothing to compare the food to. I think it's very good. I'm usually in praise and let the chef know when I've enjoyed something. The stew is good and cooked properly. The steak is succulent. I get enough to eat and tea/coffee when I want." A second person said, "The food is nice, I couldn't say anything different. It's lovely. I particularly like the stew. We get a choice and if there is something that you don't like, you can have something else."

A relative told us, "The food sounds nice and it must be good. [Person] has put weight on. The staff are good at encouraging people to the dining room for their meals." A second relative said, "The food is very good. [Person] has put weight on since being here."

During the inspection we observed a positive meal time experience on both floors of the home. Dining tables were set up prior to meals being served, with each one containing a table cloth, napkins and cutlery. Printed menus were available and presented to people, with meal choices being made at point of service. People were able to eat wherever they wanted to, such as the lounge or their room; although on the day the majority had decided to use the dining room. Staff took time to explain the menu options to people and we noted that as well as two main meal options being available, people could also choose between mashed or roast potatoes and a selection of vegetables.

We looked at how the home managed people's nutrition and hydration needs. Each person had a Malnutrition Universal Screening Tool (MUST) in place; this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated timely to reflect people's changing needs. Nutritional plans were detailed and contained sufficient information to guide staff on each person's individual requirements. For example, one person's nutritional plan indicated they had to avoid grapefruit due to the medication they were prescribed. Another person was put on a fortified diet and had food and fluid monitoring introduced as well as an individual risk assessment, following a change in their MUST score. This meant staff had the required information to manage and mitigate risks

We saw people's weights were closely monitored. Weights were recorded weekly and the files we saw showed this had been completed consistently. We saw people had been referred to the community dieticians and provided milkshakes three times daily when identified as losing weight. The registered manager maintained a monthly weight loss action plan which recorded the amount of weight loss, nutritional risk assessment, Waterlow risk, community dietician involvement, district nurse involvement, GP involvement, care plan evaluation and whether family involved. We saw that individual specific action had been taken based on people's weight loss and needs.

All the staff we spoke with were able to identify people's specialist dietary needs. For example; people who were diabetic, or required a soft diet. Staff were knowledgeable regarding what this meant for people. Staff identified that a soft diet was fork mashable foods and reeled off the foods that this referred too. One of the

relatives we spoke with told us, "[Person] has got Crohn's disease; we discussed this with the chef and explained the types of food they could eat. This was soon sorted and they have had no problems with their diet at all."

We looked to see how the home managed people's pressure care. We saw pressure risk assessment tools were consistently completed. Body maps detailed people's skin breakdown and graded the nature of the sore to enable continued monitoring. When people had been identified as at risk, we saw they had the necessary equipment in place to provide a reduction in pressure on vulnerable areas such as heels and the sacrum. We looked at two people's care that had been identified with pressure areas. We saw both people had been referred to the district nurse timely. One person's pressure area had reduced in size but the other person's remained the same, despite treatment in place which was in accordance with their needs. The registered manager maintained a pressure audit; this included the name of the resident, where the sore was acquired, nutritional assessment score, Waterlow, grade this month, grade last month, whether reported to CQC, pressure relieving equipment, whether position change chart required, whether care plan in place and reviewed. This ensured people's pressure care needs were being met and monitored accordingly.

We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), chiropodists, district nurses, mental health services (CPN's) and speech and language therapists (SaLT).

The people who lived at the home and their relatives told us staff had the right knowledge and skills to provide effective care. One person said, "They seem to know what they are doing. They get on with it and do it right." A relative told us, "The staff certainly seem to know what they are doing." A second relative said, "They seem very well trained. They don't mess about which is what I like. They are quick to call the doctor and seek medical attention when [person's] got a cough or when they are off side before it develops in to something worse."

We looked at the homes staff training documentation which was stored electronically. The training matrix showed that staff had received training in a number of areas relevant to their role, including dementia, moving and handling, nutrition and wellbeing, health and safety and first aid. The matrix was colour coded to indicate training that was in date, was due to expire and had expired. We saw evidence that staff had been enrolled on refresher courses for any training that had or was due to expire.

Upon commencing employment each staff member completed a two week induction programme, before they could work with people living at the home. A staff member told us, "It was a two week course which covered everything, taught me all I needed to know to start the job." Another said, "Yes, induction was two weeks, had to complete this before I could go on the rota." We saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015. We noted the care certificate had been incorporated into the home's induction training programme.

We asked staff for their opinions on the training provided by the home. One member of staff said; "We definitely get enough training. We also do refresher training. We have been to other homes doing face to face training and we do 17 units of training on e-learning." A second member of staff told us, "We have a lot of training. It's closely monitored to ensure we are kept up to date."

Staff told us they received regular supervision. One staff member told us, "Supervisions are approximately every four months and we have an annual appraisal in addition to this." A second staff member told us, "Supervision is supportive and a chance to discuss things that are also going well. Supervision is every six to

eight weeks and we have an annual appraisal." A third member of staff said, "My supervision is slightly overdue but it's due to the outbreak we had and is scheduled."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One staff member told us, "Mental capacity is a person's ability to make decisions for themselves, taking in to account and understanding their safety. We have a lot of people needing DoLS due to their dementia, key pads, alert mats, and bed rails." A second staff member said, "Assume people have mental capacity unless deemed otherwise. In these instances, decisions are made in people's best interests."

At the time of the inspection, 32 DoLS applications had been submitted to the local authority. We saw 19 assessments had been carried out by the local authority and 18 people had a DoLS in place. We saw evidence that action had been taken to chase up the outstanding applications. We saw the registered manager completed a referral planner, which included whether each person had capacity, if restrictive practices were in place, date DoLS had been requested, date authorised and the expiry date.

Within people's care files we saw that potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention being utilised. For example a meeting had taken place to decide whether it was in one person's best interest to reside at Montrose Hall or live at home and continue to receive homecare.

We looked at how the home sought consent from people. Each care plan contained consent forms, which had been signed by either the person themselves or their representative. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like to participate in the activities on offer. One person told us, "The staff ask you what you want and explain things to you. They get my agreement before doing anything."

Observations during inspection showed that consideration had been given to ensuring the environment was dementia friendly. Corridors were well lit with plain flooring and walls, which had contrasting coloured handrails to make them easier to identify. Pictorial signage was located on all bathrooms and toilets, along with directional signs which indicated where the lift, bedrooms and toilets were situated. This would help people living with dementia navigate around the building independently.

Good

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be caring. One person told us, "The staff are marvellous. I'm friends with them all. I can call them a friend." Another person said, "The staff are kind. They are all lovely. There is no nasty person here." Whilst a third stated, "The staff hold your hand and they hug and kiss us. They care about us. I'm quite happy here."

We asked relatives for their views. One told us, "You only need to observe the interactions between people living at the home and staff to know the staff are kind and compassionate. The way staff interact with people is absolutely lovely." A second relative said, "[Person] loves the staff. The girls are always smiling and laughing. They are absolutely, genuinely caring and kind. They care about people. Staff were so upset when a [person] died. I'm pleased to see staff when I visit so I know how people living here feel about them."

People told us they were treated with dignity, respect and were given privacy at the times they needed it. One person said, "They knock on the door and shout round before coming in to my room." A relative told us, "They definitely treat [person] with privacy and dignity. [Person] needed their hygiene attending and the staff were so discreet. They changed [person] without exposing any of them. We can't do it but we are so happy with how the staff care for [person]."

We asked staff members how they ensured people they supported were treated with dignity and respect. One told us, "You need to be aware of people's preferences and choices first. Always ask people before doing anything. For example; would you mind if I do this? Get the person's consent. Close doors. Talk through what you're doing." A second staff member said, "When supporting with personal care, I follow the care plan. Make sure curtains and doors are closed. Tell the person what you are doing, speak all the way through. Include people in conversation; never speak over the person to a colleague." A third stated, "When getting people ready, talk to person, support to choose own clothes, keep people covered up and doors closed."

We asked staff how well they knew the people they cared for and how they knew what they wanted. One told us, "Ask them, if they want anything they will tell us." Another said, "Look in the care file, ask family, friends and the resident themselves."

Over the course of the inspection we spent time observing the care provided in all areas of the home. We saw staff interaction with people was warm, friendly and respectful. We observed several instances of staff members kneeling down to ensure they were at eye level with people before engaging in conversation. We observed appropriate physical contact between staff and people; for example hugging, rubbing people's arms and holding hands. Each of these interactions was received warmly by the person, who smiled in response.

In all areas of the home, we noted a pleasant atmosphere. People were observed in communal areas, interacting with staff and laughing. We witnessed a staff member supporting a person to change their doll, which the person referred to as their baby, and discussing what clothes the person wanted to put on them.

Staff's handling of people's dolls was as if they were holding a new born. They put highchairs next to people for their doll to use during dinner. One staff member was heard stating, "Here you are love, here are your babies. Once they have had their tea, shall we take them for a walk?"

We looked to see how staff promoted people's independence and offered them choices. A person told us, "The staff let me do what I can and they always do what I ask of them because they know I'm not able. There's no fuss." A staff member told us, "We are just here to assist people. We get people to do for themselves what they can. We don't chose people's clothes; we ask people what they would like to wear." A second member of staff said, "We try our best. It's not just about people getting themselves dressed. We have people that want to help with washing up after meals, setting tables, hoovering. We let people be involved in as much as they would like." A third said, "I'll wash people's backs but pass them the cloth to do their own face."

At the time of the inspection no person using the service was in receipt of end of life care, however the staff members we spoke with told us they had all received training in this area. One said to us, "Yes, we do training in this; I have just done my level 3 via Wigan college." We saw that attempts had been made to discuss end of life plans with people, with their responses documented.

Good

Is the service responsive?

Our findings

We saw that people received care that was personalised and responsive to their individual needs and preferences. Prior to any new admission a pre-assessment was carried out with the person and their relative(s). People's support needs and wishes were documented on their care plans so that staff knew exactly how each person wanted to be cared for.

A relative told us, "We needed the placement as a bit of an emergency. A manager came out and assessed [person], with me and other family members present. They also asked us for a history of [person's] life and told us it was so they had something to start conversations with them." A second relative said, "The staff visited and did a full assessment of [person's] needs and asked me and other family members for as much details as possible."

Relatives we spoke with also stated the care proved was person centred. One told us, "They look at this aspect very closely." Another said, "[Person] has a choice, they can decide what they want to do and when. The home never pushes anyone into things; it's all about what each person wants."

We asked staff how they knew what was important to the people they cared for. One told us, "get to know them, what means a lot to them." Another said, "Speak to people, ask them. This information is also in the care plan."

Each care file we viewed contained a personal details page, which included the person's ethnicity, religion, preferred contacts and whether they wanted their relatives or next of kin to be involved in care planning and have access to their care file. The files also included a 'my life story' section, which provided personalised information about their life, background, work history and aspirations. This was supplemented by an 'about me' section, which provided additional personalised information about the person and their wishes. This section also contained the 'my daily record' document, which staff used to record the care that had been provided to people each day.

We looked at how frequently each person's care was reviewed and who was involved in this process. We saw that care plans were reviewed monthly, although it was not consistently documented if the person and/or their representative had been involved. A staff member told us, "Staff do a review of people's care needs every four weeks and quarterly with family or whoever the person wants in attendance." People we spoke with could not remember whether they had been involved in planning or reviewing their care. However one relative told us, "As a family we feel very involved. We sign the care plans, attend reviews and know we can speak to [person's] care worker anytime." Another said, "I have seen the care plan and can look at this anytime. They discuss this with me and I am involved and consulted about everything."

Both people who lived at the home and their relatives told us the service was responsive to their needs. One person said, "You can live here and go at your own pace. Do what you like. I tend to do the same things, like go to bed at a certain time because I have my own routines and I like to watch television in my own room in the evenings." Another told us, "I get up when I want, go to bed when I want. I just have to ask for a bath or

shower and I get one." A relative stated, "The staff are great at meeting people's emotional and social needs." A second relative told us, "We have been shown where [person's] care plan is and been told we can look at their care plans any time. We are amazed. Everything is always written down. It's got everything in it that you would need to know to look after [person] how they want."

Each care file contained a number of individual care plans covering areas such as mobility, nutrition, sleep and rest, communication and social activities. We noted that each care plan captured the person's needs and preferences and indicated what staff needed to do in order to meet the person's needs. Each care plan used personalised language such as I can, I prefer and I would like.

Each person had a personal care plan which indicated how frequently they would like to wash and what their preferred method was, for example a bath or a shower. In each of the six care plans we viewed, we saw that bath and shower charts had not been completed consistently. In some instances we noted gaps of between ten and fourteen days, were no intervention had been recorded. We spoke to the registered manager about this who told us were people had been offered but refused to either bathe or have a shower; a full body wash was carried out. We saw this information had also not been recorded consistently which had resulted in the afore mentioned gaps in personal care records. The registered manager had already identified this issue and had it as an identified agenda item for the staff meeting the following day. The people we spoke told us their personal care wishes were met, and if they requested a bath or a shower at any time this was facilitated.

We recommend the service assess the methods used to record personal care tasks, to ensure all care being provided is captured consistently.

As part of the inspection we looked at the activity programme provided by the home. We asked people for their views on what was available. One told us, "I'm happy with the activities. I love the pamper room. I enjoy getting my nails done and relaxing." "A second person said, "I enjoy the pamper room. I also enjoy when it's nice weather being out in the garden. It's nice to get out. Thing are happening daily. We do have some fun. We're not just sat about."

A relative told us, "There does seem to be regular things going on, so there is enough going on for [person]." A second relative said, "There is always something going on. The manicurist is in on a Wednesday. [Person] loves it, getting pampered in the sensory room with the light changes and music. It's very relaxing. We can have a drink with [person] in the quiet room and it feels like we've gone out to a café. In summer the doors are flung open and people are outside. The activities are varied, I've seen people playing games, doing quizzes, flower arranging for the table centres, baking and at Christmas, the residents made the decorations." A third relative stated, "I was worried about this when [person] came here as they used to visit a day centre, but there is more than enough going on. They have a programme of activities for both the mornings and afternoons."

We saw both floors of the home contained events boards, which were used to advertise the daily activity schedule along with upcoming events or outings. Activities were offered morning and afternoon, seven days per week. Both floors provided the same activities, although alternated the day on which they were offered. These included song and dance, reminiscence, balloon exercises, Oomph, games and quizzes. We noted that over the following four weeks, three events were scheduled, which included a musical duo visiting the home and a trip to Wigan museum. Through questionnaires asking for people's views, it had been identified that people would like to have a themed evening in January. In response to people's wishes a wine tasting evening had been arranged. We also noted that in response to requests for the home to set up a 'book club', a library area had been created in one of the corridors. This included decorating the walls in 'book effect'

wallpaper, providing reading chairs and a large bookcase, containing a range of different books. We saw this area being used throughout the inspection.

A weekly activity log was in place for each person which detailed the activity, who provided it, whether it was a group or individual activity, how the person responded along with more detailed written information about the activity. The home also completed an activity and participation report for each person, which included the number of activities they had engaged in per week along with action points were any issues or concerns had been noted. The records we viewed showed that the advertised activity schedule was being adhered to on a weekly basis.

We looked at how complaints were handled. The home had effective systems in place for people to use if they had a concern or were not happy with the service provided to them. We saw there were only minor complaints received and the registered manager maintained a verbal complaint record. This detailed, the date of the complaint, name of complainant, address, nature of complaint, supporting evidence of the complaint, outcome and recommendations, discussion with complainant, outcome of meeting, if complainant is satisfied or not with the outcome, what action is being taken. We saw complaints had been resolved within the specified timeframe and the actions clearly listed. For example; both missing teeth and glasses broken through being laundered had been reimbursed by the home.

We asked people and their relatives about making complaints. One person told us, "I've nothing to complain about." A second person said, "I've no complaints. I've never had any." A relative said, "We've not had to make any complaints. I feel comfortable to just ask for something. [Person's] nails got a bit long but they can refuse things so this may have occurred due to this. Anyway, it was actioned and they were cut." A second relative told us, "We've had little things but I wouldn't call them complaints because they have always taken prompt action and been resolved."

We looked at twenty compliments received from friends and relatives since our last inspection. The compliments were all dated and included; "A sincere thanks for all your kindness towards [person]. It's a comfort to me that [person] was so happy and content. That is testament to your warmth and friendliness." "I just want to tell everyone how deeply grateful I am for the wonderful care and support you gave to [person] and me. I didn't expect [person] to have the years they did. I thought putting them in a care home could be a disaster and it was emphatically not. That is down to the care you all gave." "Thank you is such a small word to express my gratitude. There simply aren't words to express my gratitude for the care you provided." "Thank you for everything you did for [person], it was above and beyond." "The staff are fantastic at Montrose and provided wonderful care to [person]. "You went above and beyond, you should be proud of the environment and the wonderful team. Your kindness helped me so much."

We saw meetings had been conducted consistently each month with people living at the home. Topics discussed across meetings included; the food and menus, environment and activities. The registered manager had discussed the Wigan innovation fund and asked people if there was anything they would like requesting which would make their life better living at the home. A person asked for more colour in the garden so it was asked whether people would like various stalls in the garden. People felt this was a good idea and requested they were different colours. People had asked to go out of the home on more outings. The registered manager maintained an action following each meeting which was named, 'you said' and 'we did'. We saw the outcome of people asking for more trips had resulted in a trip to Rivington barn and Blackpool to watch the world champion fireworks. People had also asked for themed nights and the possibility of their relatives eating a meal at the home with them in the quiet room which was being trialled.

We saw relative meetings were conducted but they were not well attended and the registered manager was

looking at ways to better engage families. The last meeting had discussed; personal funds, laundry, mealtimes, visitors and fire regulations, care plans, family meetings/support group, surveys, activities and lost property. The registered manager was trying to develop a support group for relatives but so far there had been little take up on this initiative. A relative told us, "We are invited to relative meetings, but we have only attended one when the home was changing to Anchor."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The home had a clear management structure in place, with the registered manager being supported by two deputy managers. A shift leader was also in place to oversee each floor throughout the day. The district manager was present in the home during the inspection; and we were told they were a frequent presence in the home, offering support to the registered manager and other staff.

The staff we spoke with felt that the home was well-led and managed and they felt supported. One member of staff said, "This is definitely a well-led home. The manager does a good job. They are firm but fare. The manager tells you what needs to be done and they pull you up if you've done something wrong. There are no grudges though." Another staff member told us, "I think it's well-led. The registered manager is great. I feel the whole team respect them." A third stated, "I feel supported, you can go to the manager whenever and have chat about things."

People living at the home and the relatives we spoke with, also felt the home was well-led. One person told us, "The manager is great. Lovely person and has time for you." One relative said, "I think it is well-led. Staff seem happy and we always feel welcomed in to the home when we visit." Another told us, "It's absolutely well-led, the manager is brilliant. All the team are. They are all so welcoming to visitors. We are involved in the fayres and made to feel very welcome at the home." Whilst a third stated, "[Manager] has a good understanding of what goes on here, they are definitely approachable."

We asked people living at the home and their relatives if they would recommend the home to other people requiring the level of care provided. One person told us, "All the staff and people that are here make it the home that it is. I'd definitely recommend it. It's lovely here." A second person said, "I like it here. Everybody is lovely. I'd recommend it to others needing a home for themselves or family. They look after the home. Maintenance do a good job." A relative told us, "We would definitely recommend the home to others. We had looked at a few homes and Montrose was recommended to us by a friend. We haven't looked back. Another relative said, "It's fabulous. We are so happy with this home. We wouldn't hesitate to recommend it."

Staff told us they enjoyed their jobs and there was a positive culture within the home. One said, "The manager is approachable. Since they took over, the atmosphere changed. We all get on as a team. It's lovely. There are no differences between staff, night or day." A second told us, "The registered manager has cultivated a culture to be open and honest. I feel I could approach any of the management." A third stated, "The home has an open culture, staff can contribute and are able to voice their opinions."

We saw that team meetings were completed on a regular basis and covered the following areas; handover,

care plans, controlled drugs, staff meals, bath and shower records, encouraging people to get involved with household tasks, documentation, policy of the month, laundry, MCA/DoLS, rotas and Christmas party. Staff told us they were able to attend team meetings where they felt listened to and could raise concerns. A staff member said, "The manager conducts team meetings in the evening so night staff also have the opportunity to attend." Another told us; "Team meetings are every eight to twelve weeks but sooner if there are things we need to know. " A third added, "The team meetings are regular and we have them more often if there are changes or issues to be discussed."

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copy were always available. Staff were made aware of key policies and any changes through training and team meetings.

We saw systems in place to monitor the quality of the service. The district manager had recently completed a comprehensive audit of the service which covered a range of areas under a number of different headings, these included 'People' which looked at safe recruitment practices, supervision and appraisals, meeting completion, complaints and feedback from people who lived at the home; 'Information' which included use of signage around the home and information on display; 'Assets'; which included the standard and suitability of the environment and grounds; 'Practice' which included the standard and quality of service provision and completion of documentation and finally 'Compliance' which was based around the CQC's five 'key questions' - is the service, safe, effective, caring, responsive and well-led. This allowed the home to monitor whether it was meeting the required standards. We noted that an action plan was in place which detailed the area being assessed, the action required, who was responsible for this, date for completion and section to be signed off upon completion.

Alongside this, the registered manager also completed a variety of audits in a range of areas. A checklist was in place which detailed each individual audit and the timescale of completion. We saw that these ranged from daily audits of medication through to six monthly audits of the homes menus. Other areas audited included infection control, health and safety, catering, care plans, accidents, complaints and meeting completion. All audits contained action plans and feedback on what had been done to address any issues.

We saw both the home and provider distributed quality assurance questionnaires to people and their relatives to gather feedback about the service. Both surveys and 'welcome your feedback' leaflets were available within the home for people to complete. One relative told us, "I have been asked to complete a questionnaire which came through the post from Anchor; I have also done one for the home as well."

We found accidents; incidents and safeguarding had been appropriately reported as required. We saw the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and copies of all notifications submitted were kept on file.

The home was a member of the Relatives and Residents Association, which is a national charity for older people who are in or in need of care, along with relatives and friends who provide support to people. Information about the charity was clearly displayed on the notice boards on both floors.