Anchor Trust

Elizabeth Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Elizabeth Court provides residential care for up to 59 people who are elderly, frail or are living with dementia. At the time of our inspection there were 49 people living in the home.

This was an unannounced inspection which took place on 2 March 2017.

The home was without 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. There was a new manager in post who had started the process of applying to register with CQC.

We carried out an inspection to Elizabeth Court in March 2015 where we found breaches in relation to staff not following the requirements of the mental capacity act and a lack of contemporaneous records held about people. Following that inspection the provider sent us an action plan on how they planned to address our concerns. We carried out this inspection to check that the provider had taken the appropriate action. We found improvements had been made, however we identified concerns in other areas during this inspection.

There was a lack of appropriately deployed staff to meet people's needs and staff did not feel valued or supported. People were not provided with enough activities to keep them stimulated and there was a lack of opportunity for people to go on outings. People's individual preferences in the way they wished to be cared for were not always recognised by staff and people may not receive responsive care because information relating to their needs was not always included in their care plan.

Staff did not follow safe medicines practices and where people were at risk of harm these risks had not always been addressed or recognised by staff. Regular audits of the service were carried out to review the quality of the service provided. However, not all actions identified were addressed.

The manager and provider had not always notified CQC of important events, such as safeguarding notifications. Accidents and incidents were not monitored to identify trends relating to people.

A complaints policy was in place and people knew how to make a complaint. Residents and relatives told us they were involved in the running of the home through residents and relatives meetings. However we noted recurrent issues raised by residents/relatives which had not all been resolved.

People were cared for by staff that were attentive and showed kindness and empathy towards them. People's dietary needs were respected by staff and should they have a change in their health needs, staff engaged advice and input from appropriate healthcare professionals. People were supported to maintain relationships with people who were important to them.

Staff understood the requirements of the Mental Capacity Act 2005. Staff ensured people were supported to make their own decisions and these were respected by staff. Training was provided to staff and staff received supervision and staff appraisals.

Staff understood how to safeguard people and knew what steps they should take if they suspected abuse. Prior to starting work at the home recruitment checks were completed to help ensure only suitable staff were employed. There was a contingency plan in the event of an emergency and evacuation plans had been written for each person to help support them safely in the event of an emergency.

During the inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We also made two recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was a lack of appropriately deployed staff to care for people.

Risks to people's safety were not always assessed and guidance was not always in place for staff.

Safe medicines practices were not followed by staff.

Arrangements were in place to help safeguard people from abuse and the home held a contingency plan in the event of an emergency.

Recruitment processes were in place to help ensure only appropriate staff were employed to work in the home.

Is the service effective?

Good

The service was effective.

People's dietary needs and preferences in relation to food and drink were respected by staff.

Staff understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff had completed training to give them the skills and knowledge to meet people's needs. Staff received regular supervisions by their line managers.

People had access to a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

Individual staff were caring and treated people with kindness and attention.

Staff treated people with kindness and consideration.

People's privacy, choices and independence were protected.

People were supported to maintain relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with a range of activities that were suitable for their needs or interests.

Care records did not always contain sufficient information to guide staff on the care and support people required. People may not receive responsive care as their individual preferences were not recorded.

Procedures were in place for receiving, investigating and managing complaints about the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager and provider were not always aware of their statutory responsibilities in relation to notifying CQC of important events.

Records were not always completed as they should be.

The provider had systems in place to monitor the quality of the service provided. However, actions identified were not always addressed.

Staff did not feel supported or valued.

People, relatives and staff were involved in the running of the home but we read of repeated complaints in relation to some aspects of care.

Elizabeth Court

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 2 March and 6 March 2017 and was unannounced. The inspection was carried out by four inspectors.

Prior to the inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

During our inspection we spoke to the manager, the provider's area manager, 13 staff members, 18 people, two relatives and one healthcare professional. Following the inspection we received feedback from another health care professional.

We reviewed a range of documents about people's care and how the home was managed. We looked at six care plans, medication records, risk assessments, accident and incident records, complaints records, six recruitment files and documentation in relation to quality assurance.

We last inspected Elizabeth Court in March 2015 where we found two breaches of regulation.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Elizabeth Court. One person said, "It's good here. I always feel safe." Another told us, "I do feel safe here. It's a nice atmosphere." A relative said, "It's the way he's looked after." Another relative told us, "Yes, I think it is safe here for my mother, they do look after her."

Despite these comments we found that people may not always be safe from the risk of harm. There was evidence that some risk assessments were in place for some people and plans in place to mitigate the risk. However, staff had not considered all the risks to people. One person walked around their unit all day with either one slipper on or none at all. We noted from the records that this person had frequent falls however there was no risk assessment in place for this person to assess whether or not their footwear was a contributory factor. Another person's skin integrity was assessed as '10' (low risk) in February 2017, but '24' (high risk) in March 2017 and yet there was no explanation as to the sudden increased risk and as such no risk assessment in place to ensure this person was being cared for in an appropriate way by staff. Another person who displayed behaviours which may cause a risk to themselves or others did not have an appropriate risk assessment in place in relation to this to guide staff on how to react to or de-escalate these behaviours. One person had lost a considerable amount of weight during a period of two months and although this person was on a fluid chart, there was no record of their daily food intake or an increase in the monitoring of their weight. We spoke with the area manager about this who told us that due to the weight loss they would expect this person to be weighed weekly, but this was not happening. We noted in the area manager's action plan they recorded in January 2017, 'ensure risks are discussed and recorded and updated during monthly reviews' however from what we found it would appear staff were not always doing this.

Other people were at possible risk of harm because staff were unable to provide sufficient attention to them. One person required a mobility aid to support them when walking but on occasions we saw them try to stand up and walk without it. Staff working in the unit were very busy and we observed they were unable to always check this person did not walk unaided. A staff member told us that several people required two staff to hoist them which meant there were times that staffing levels were low on units because two staff were assisting. They said this meant people who required a close eye to keep them safe did not always receive it.

Safe medicines management systems were not always in place. Each unit had their own storage area where medicines trollies were stored. Although there was a thermometer in this storage area, staff were not checking or recording the temperature each day to check that medicines were being stored at their optimum temperature. In addition, where medicines were required to be stored in a fridge, the fridge temperatures were not being checked. This was important as incorrect storage could have an adverse effect on the effectiveness of a medicine.

Where people were prescribed PRN (as required) medicines, although there was a description of why a medicine may be needed, guidelines for staff on what signs to look out for (should the person become unwell) were not included. This was important for people who were living with more advanced dementia as they would be unable to describe to staff why they needed the PRN medicine. We found three people did not have protocols in place for some of their PRN medicines. We also found that one person had not

received their medicinal supplements for a period of seven days and staff where not able to tell us why this was the case. The manager was unaware of this and as such this had not been raised as a safeguarding concern or actioned by the manager. We noted following our inspection that the manager raised this with the team leaders in a meeting with them.

The lack of assessing and mitigating the risks to people and the lack of good medicines management practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received the medicines they required. One person said, "I do get offered pain killers for my leg. I don't like to take them but sometimes I do, but they (staff) always ask me."
Each person had a Medicines Administration Record (MAR) which contained a photograph, known allergies and information about their doctor. Medicines were stored in locked cabinets and kept securely. MAR charts were signed following the administration of medicines and no gaps in recording were seen. We observed a member of staff administer medicines and heard them ask people for their consent before giving them medicines and not signing their MAR until they were satisfied they had taken them.

We asked people about staffing levels and received mixed responses. One person told us, "I do most of my care myself so I don't often ask for staff help. The staff are good when they do help me." Another person said, "I don't think there are enough staff. You don't see them around much. People have accidents and fall. I fell twice in one day." Other people told us, "I don't think there are enough staff. Bells are always going off and no one is answering them. You call the bell and no one answers it." One person told us they used the bell when they needed the bathroom and at times it was too late by the time staff got to them (because they had to wait so long).

One staff member told us, "There are two of us on the unit and if it gets too busy we ask the floating staff to help out." However, another staff member told us, "It depends on the needs of people. If people are mobile it's okay, but things can change so quickly." We noted this staff member was on their own for a period of time whilst their colleague was on their break and they had not requested the floating member of staff to come and assist. A third staff member told us, "We work the floors but I honestly don't think there are enough staff. Mornings are worse. The biggest impact is in the units where people have the most advanced dementia and behaviours. You need staff to walk with people."

We observed there was an insufficient number of suitably deployed staff to meet people's needs. We observed a new member of staff assisting people on their own in one unit. They had only worked in the home for two days and were on shadowing duties. They told us, "I am shadowing but yesterday it was very busy so I just helped clearing tables and things like that." However we saw on two separate occasions this staff member sitting with a resident who was on a fork mashable diet (and as such at risk of choking) unsupervised by an experienced staff member. We also noted that they were alone for 10 minutes whilst a second member of staff was in the kitchenette preparing drinks. This was because the other experienced member of staff was on a break and there was no floating staff member available. In another unit we saw that the two staff members were very busy and spent a lot of their time reacting to people who were walking around. One person got up from their chair on two occasions and each time a staff member coaxed them back to their chair saying, "(Name) can you sit down please." A staff member said one person who kept standing up had lots of falls. They told us this person should be on a one to one. They also said that when they were covering the unit on their own that one person had left the unit and the building unnoticed and was found in a nearby shop.

Before lunch time in one unit a staff member went on their break for 20 minutes leaving one staff member to

support 12 people. We spoke to staff about staffing levels in the unit and were told, "I feel we are understaffed. People are not getting the attention from us. There could be an emergency with people." We asked if it was normal practice for one staff member to be on their own when the other took a break and we were told, "We are told only to call the team leader in an emergency. Sometimes there are only three carers between the two units. This happens two to three times a week. The lack of staff is stressful and there is a lot of pressure on us. We cannot do our jobs properly." A staff member told us, "Staffing levels are based on numbers of people and not on their needs." They told us concerns were raised at meetings but they were just told to, "Fill the voids." Another staff member said, "With more staff residents would have increased stimulation, they would be more engaged and there would be less (challenging) behaviours." Several staff told us they were behind on paperwork because they did not have time due to staffing levels.

The manager was unable to explain to us how they determined the number of staff on duty each day. They told us that they based it on, "Voids and knowledge of people" and said they were unsure whether or not there was a dependency tool to support their assessment. They also told us they did not analyse call bell response times to check whether or not staff were responding to call bells within an appropriate length of time which may indicate whether or not there were sufficient staff on duty. We found in the records a dependency tool had been completed by staff but it was clear that this was not being used for the purposes it was intended, for example, to ensure sufficient staff were on duty to meet the needs of people. The area manager told us it was their role to look at dependency levels and revise them. They shared their dependency tracker with us following the inspection. We noted from the three months' of information they provided us with that in one unit the number of people with a high dependency had increased from four to seven and in a second unit from three to seven people and yet the staffing levels had remained unchanged.

Although accidents and incidents were recorded, the manager did not carry out an analysis of these. They confirmed they did not analyse the accidents and incidents by units and did not use this information to determine staffing levels or look for trends. A staff member told us, "There will always be a risk of accidents and incidents but the risks are greater with the staff levels as they are." We noted that information surrounding incidents in people's care plans was minimal and although there was a 'falls log' within care plans these did not always reflect what was on the monthly falls register. We reviewed the accident/incident information for a period of two months (January and February 2017) and found that the two units with the highest numbers were those in which we had received concerns from staff about staffing levels. The concerns we found in relation to staff deployment related to two units in particular where people had the highest dependency needs. The other units appeared to have sufficient staff to meet people's needs as people were more able and less dependent on staff for help and support to remain safe.

The lack of suitably deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were checked through a recruitment process to ensure their suitability for the role. Application forms and interview records were completed and references were obtained from previous employers. Disclosure and Barring Service (DBS) checks were completed for all staff. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with people who use this type of service. Staff confirmed that they were not allowed to commence work until the DBS and references were completed.

Staff had been provided with training on how to recognise abuse and were able to demonstrate their understanding of the different categories of abuse, signs to look for and reporting procedures. One staff member told us, "I would go to the team leader, who would investigate the matter. I know we would need to get statements from witnesses, check for injuries. I know that the manager would contact their higher

manager. We must ensure that people are kept safe." Another staff member said, "We are always told to report or speak out in confidence and I feel comfortable to do that." One person told us, "I'm not worried about how staff are going to treat me."

In the event of an emergency there were arrangements in place to help ensure people's care would continue with the least disruption possible. There was a contingency plan in place which gave information to staff on what to do in the event the home had to close for a period of time. Each person had a personal evacuation record in their care plan and staff carried out regular fire drills and received fire training which helped them to understand what they should do in the event of a fire.

Good

Is the service effective?

Our findings

People told us they liked the food and were able to make choices about what they had to eat and drink. One person said, "The food is usually good." Another told us, "I like the food. There is plenty. Today it was Shepherd's pie which was nice." A third person said, "We are offered wine on Sundays or special occasions."

People's dietary needs and preferences were known and respected by staff. The chef had a clear understanding of the various types of food people may require, from pureed to people's individual likes and dislikes. They told us they would fortify foods with cream or butter and make up milkshakes to help ensure people maintained a healthy weight. People were offered a range of foods as part of the daily menu and if someone wished something other than this it was provided for them. We heard the chef discussing with one person what they would like in their salad. The chef took time to make suggestions of different ingredients to help ensure the person had a salad of their choice which they would enjoy.

During lunch time we observed that people enjoyed their meal. Meals were served in an appetising way and those people who were unable to make choices based on the menu were given visual options to assist them. One person said, "It is lovely" when we asked them if they were enjoying their meal.

People who required assistance to eat were provided this in an unhurried and attentive way and people could choose where they sat to have their meals. One person remained in the lounge area to eat their meal and staff regularly came to check they were happy with the food and whether or not they required assistance. Other people had adaptations to assist them in eating independently, such as plate guards. Those people whose nutritional needs had changed were supported to receive appropriate assessments in relation to this. A staff member told us, "(Name) has been assessed by the Speech and Language Therapy Team, as he coughs a lot. He now has pureed food and drinks with thickener."

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). A staff member told us, "I know it's about things such as locked doors and wheelchair straps. It's anything that stops people doing something. They must have a best interest meeting to discuss the matter if they don't have the capacity." Another said, "It's about people's rights to make a decision. We have to let them, but stand by and make suggestions if we feel they are going to be unsafe because of their decision."

At our inspection in March 2015 we found a breach of regulation in relation to obtaining consent from people as staff were not following the legal requirements of the MCA. We found at this inspection things had improved. Where people did not have the capacity to make decisions for themselves staff had followed the principals of the MCA. Decision specific mental capacity assessments had been carried out and where

appropriate best interest decisions had been made in conjunction with the person's relative or representative and any health or social care professional involved with the person. One person who did not have capacity to make certain decisions had the supporting assessments and best interest discussions information in their care plan. Where people had capacity we noted they had signed their 'consent to care' form to show they were happy to live at Elizabeth Court and receive the care from staff. We observed staff ask people what they wanted, rather than just assume.

Staff told us they received regular supervision. The manager told us they were pulling together all the information of when staff had undergone supervision in order to get an up to date picture in relation to this. They provided us with evidence following our inspection to show that on the whole staff had received regular supervision. One staff member said, "I haven't had supervision yet, but if I have any concerns I will speak to the care manager." A second told us they met regularly with their team leader and said, "We can talk about training and ask if we want to do anything."

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Training records were maintained which evidenced that staff had completed mandatory training including safeguarding, health and safety, infection control and moving and handling. One staff member told us, "The training is spot on here. It's important." Another staff member said, "I have had moving and handling, dementia, fire safety, food hygiene, safeguarding and emergency evacuation training." A third staff member told us, "I have had the mandatory training. I have also had dementia and sensory training."

People were supported with their healthcare needs and had access to a range of healthcare professionals. We saw records which demonstrated to us that staff involved the GP, chiropodist and optician as well as other healthcare professionals. One person had been ill for some time but they were positive about the care they had and so was their relative. They told us, "They (staff) knew I was ill and got the doctor and I went to hospital. The staff are very good and they have looked after me." Another person told us, "I have a rash all over and they (staff) did call the doctor. I have cream to use. My doctor visits me here." A healthcare professional told us, "Staff know that they are not allowed to change any dressings. We provide staff with guidance which they are good at following. If someone has a skin tear staff have protocols in place that they follow until we arrive." They told us that staff referred people appropriately.

Good

Is the service caring?

Our findings

People and relatives told us they felt the staff were caring. One person told us, "It's good. The staff are lovely." Another said, "It's good. The girls are lovely and they help me." A third person told us, "The staff are very kind to me and I always feel they care." Another told us, "Staff are quite kind."

We found that individual staff interacted with people in a kind, caring and attentive way. During lunch we saw staff offering choices of drinks and meals to people. Staff knew what each person liked. A staff member said to one person, "I know you like your meat, so I will give you extra." The staff member picked out the meat part of the Shepherd's pie for this person. Two people were seen to walk around a lot and one in particular appeared very restless. We saw staff walk with them and chat to them whenever they could. We heard a member of staff say to one person, "Are you alright (name), please use your stick when you are walking." Another said, "It's thirsty work walking around, try a drink, is that better?"

People received meaningful interactions from staff. One person had a dog living with them and staff took time to ensure the dog was walked each day. We heard staff talking to this person about their dog. They told us, "I know what people like, it's important to make them feel special, rather than just offering different things, but to know what they like best." One person told us, "The staff are extremely caring. Nothing could make it better (here)."

People were encouraged to be independent and make choices. We saw a staff member encourage one person to help them clean the tables. It was evident this made them feel included and gave them a purpose. Another person was invited to have some fresh air by staff, but they declined as they did not have any shoes on. Although the staff member offered to fetch their shoes, the person said they did not wish to go out and the staff member respected this. One person told us, "I eat in my room and they bring me what I like."

Staff showed an interest and were patient with people. A staff member sat beside someone and encouraged them to share a poem they knew. When the person lost the words, the member of staff (who had learnt the poem) reminded them. When the person stopped, the staff member said, "It doesn't matter, that was lovely" to which the person smiled. Another person was going to the GP for an appointment and we observed a staff member check they were appropriately dressed and comfortable. The staff member and person had a private joke together and the staff member apologised when they had to ask the person to stand up again so they could adjust their wheelchair strap. A staff member told us, "I love the residents and I love the staff. There is a bond with all of us. They are good staff here, they care."

People were shown respect and they were responded to by staff. One person had problems with their hearing aids and a member of staff responded straight away to try and sort this out for them. We heard staff use people's preferred first names and watched as one staff member sat and chatted with people over a drink mid-morning. Staff checked if people wished to watch the television or put music on and in one unit when the music was switched on a staff member talked to people about the music.

Staff showed people empathy. One person was anxious about their medicines and staff reassured them and

took time to help them understand that their medicines were available for them. Another person was waiting for their relatives to visit and kept on asking staff when that would be. We heard and watched a staff member talk this person through what would happen when their relative visited and reassure them that they would definitely come. The staff member suggested this person walk with them whilst they delivered something to another unit and they chatted to them as they went along the corridor.

Staff respected people's choice to spend time in their rooms or in communal areas. We saw people moving around their units unrestricted and returning to their rooms when they wished. One person liked to look out of the window at the end of a corridor to the open woodland and we saw them do this whenever they wished. People lived in an environment that they were able to personalise and their rooms contained photographs and items that were familiar to them.

People were supported to maintain relationships with their families and other people who were important to them. Throughout the day we were aware of relative's visiting people. One person had a board in their room on which relatives recorded when they were visiting as the person frequently asked. We observed staff check the board and tell the person when their family member's would be coming.

Requires Improvement

Is the service responsive?

Our findings

We asked people and relatives if there was enough going on in the home and we received mixed responses. One person told us, "Sometimes they (staff) come in and chat but not often as they are busy." A second said, "We don't get much attention from staff. They don't bother to pop in and check I'm okay or have a chat. I got more attention in the last home than this one." A third said, "The activities were very good and then the girl left. We rarely have entertainers." A further person told us "I like country walking, there isn't a lot going on here. I get bored." However, other people were positive about the activities and said, "There are some trips. I went to Marks and Spencer that was good" and, "Depends what you want to do. They do have things. I can't say I get bored." A relative said, "The only thing about activity is the staff may tell (name) an activity is happening in the afternoon first thing in the morning but most people aren't going to remember. Staff don't come to tell people just before it is happening to remind them." Another relative told us, "The only problem is that he gets bored. He'd like staff to come and talk to him, but they don't have time."

We heard from people and staff that there was an issue finding a driver for the home's minibus which meant external trips had not taken place for some time. A relative told us this was raised at the last residents meeting and relative's had been told the home was looking for a volunteer to drive the vehicle, but in order to do so they would need to attend training in Scotland. The relative told us, "Who is going to do that?" One person told us, "We don't have trips out as there is not driver for the minibus." They said the minibus was bought from residents' fundraising and they said it, "Grieves" them that it was not being used. We spoke with the area manager and manager about this at the end of our inspection. They told us they were working hard to resolve this issue.

Although people had records of their interests and hobbies, we found that this was not always recognised by staff. One person liked 'musical shows and group discussions'. However from their daily notes there was nothing to suggest that any of this happened. Their notes indicated they watched a lot of television. We noted for another person that since January 2017 there was only two indications that they had undertaken any type of activity. It was clear in a third person's care plan that it was very important for them to read a particular broadsheet newspaper each day. We noted that they were not being provided with this and instead were offered someone else's tabloid paper. We spoke with staff and the manager about this. Staff told us, "They share (name's) paper each day, but maybe we could think about getting them the one they like." The manager told us, "We will need to check if this is okay financially wise because (name's) money goes through a solicitor." However, the area manager assured us this would be resolved.

Staff did not always take time to take into account the environment in which people sat. We saw a staff member trying to talk to one person, however the juke box was on and a member of staff was hoovering, so it was difficult for them to have a conversation. One person said, "I can't hear the tele because of the music in the hallway. I know there's writing on the screen (subtitles) but I can't read that quickly." This person added they would like more activities as they got bored saying, "I've done the same puzzle over and over." On another occasions the juke box played the same song for 20 times in a row before we raised this with staff as staff had not noticed. There was little in the way of sensory items for people. Most people walking around units could have done with areas of interest to stop, play with or touch. Most memory boxes outside

people's rooms were empty which did not help orientate them back to their own rooms.

There was a programme of activity and on the day it was supposed to be word games and scrabble, but we saw about 12 people watching a film. We were told by the activity staff, "I asked and people didn't want to do that, so we are watching a film instead." They told us there was a main activity and supporting activities that staff undertook. They said they tried to encourage staff to do those, but it was difficult as they were so busy. We saw some ad-hoc activities taking place during the day. We saw staff doing a jigsaw with one person and another staff member putting on someone's favourite music, however there was large periods of time when staff were not engaged with people. During a period of one hour, apart from staff giving people a cup of tea staff made no effort to make conversation with three people who were sitting in a communal area. At one point a staff member was with them for 15 minutes but did not speak to them.

We asked the area manager and manager if they felt that one activity staff was sufficient for the number of people who lived in the home. They both told us, "No." The manager said, "The impact could be less stimulation and I see this." A staff member told us, "The activities coordinator hasn't had an impact here. He talks a lot about things he wants to do but nothing is happening." The area manager told us they had just advertised for another part time activities lead for 20 hours per week. We read in the residents and relatives meeting minutes that people complained about the lack of activities and we also noted two formal complaints in relation to this.

People's individual needs may not always be responded to. One person had diabetes; however there was no diabetes care plan giving details to staff on the signs to look out for should this person's blood sugar levels should drop. Another person was recorded as, 'needs to feel stimulated and occupied. Without meaningful interaction it does have an impact on his behaviour'. We did not see a lot of interaction between staff and this person during the day and we noted from the records they had had numerous episodes of 'challenging' behaviour since July 2016. Another person's records recorded that they had low blood pressure, but there was no further information or guidance in relation to this for staff. A further person was noted as being visually impaired in their pre-assessment however their care plan did not mention this any further and there was no risk assessment or guidance for staff relating to this. One person was confined to bed because there was not a suitable chair available for them to sit in safely without sliding down in it. This had been the situation for several weeks.

People's preferences in relation to their care was not always recognised by staff. One person was noted as asking for, 'a shower on alternate days and a full body wash in between, in the mornings before breakfast'. However, their bathing records showed that they received a full body wash only for a period of 21 consecutive days and on most occasions this occurred late morning, after breakfast. A second person's care plan stated, 'has chosen to have a female carer for all personal care and toileting needs'. This was clearly important to this person as it was written in red in their care plan. However, we noted from the daily records that on 13 occasions over a period of 51 days they had a male carer.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other people's care plans there were records of their likes, dislikes and preferences and we found these were recognised. One person was noted as, 'likes to dress his Sunday best' and we saw that they were dressed smartly. Another person liked tea with powdered milk and we found powdered milk was available for them.

People's backgrounds were included in their care plans which helped staff to get to know them. A staff

member told us about three new people to the home and said they could look in the care plan but that staff spoke to each other to get to know someone. Another staff member said, "There is a lot of information in the care plan about people. It helps you get an understanding about what they need. You get to know people by talking to them and their family as well."

There was a complaints policy in place. This was displayed in the hallway of the home. One person told us that a member of staff had been a bit brusque with them and they had spoken to staff about this. As a result they had not had the same member of staff again. Another person said, "I know to complain, but I would just talk to the staff." A third person told us, "I could complain, but I have nothing to complain about." A relative said, "Yes, I probably was given information (on how to complain) but I am not worried because if anything is wrong I would have no problems telling them."

We looked at the complaints log and found that relatives had complained of a shortage of staff at a recent special event meal which had resulted in them having to assist with the serving of food. A second complaint related to a lack of stimulation for one person and eating alone when they preferred company. The manager told us this complaint had been resolved, however the complaints log indicated the manager had yet to take some action in relation to this. The manager provided us with some further evidence following our inspection, however this still referred to the manager requiring to take some further action.

We recommend the registered provider ensures complaints are dealt with promptly and records in relation to complaints are kept up to date.

Requires Improvement

Is the service well-led?

Our findings

We asked people and relatives for their views on the home and management. One person said, "I don't see (the new manager) much." However another person said the manager came to talk to them. Despite the manager having been in post for four months we found several times during the inspection the manager was unable to answer our questions or find the information we required. We also discovered during our inspection that two people had MRSA and although they were receiving barrier care (to minimise the risk of spreading infections) by staff, we had not been informed of this by the manager when we arrived. We read in the minutes of a relatives/residents meeting that a relative had reported they did not feel the manager had an 'open door' policy and it was commented that relatives did not see the manager in the home as much as they'd like to. We also noted in the area manager's action plan that they had identified in February 2017 a, 'lack of management presence during the day'.

At our inspection in March 2015 we found a breach of regulation in relation to records. We found at this inspection that some improvement had been made but further work was required. Although staff knew people's needs records were not always maintained accurately when changes to their needs were identified. One person had a falls risk assessment carried out in August 2016 which recorded them as being at low risk of falls. However, they had subsequently had three falls but the assessment had not been updated. We spoke with staff about this who told us the risk assessment should have been reviewed. This same person had lost weight and although they had since gained weight their nutritional score had not been updated to reflect this and this person's skin integrity information had not been reviewed since September 2016 although this should have been done monthly. A further person was recorded as being able to mobilise and leave their room however this was not the case as they were confined to bed. A staff member told us they had to prioritise their work as they covered the entire floor. They told us they would come in on their days off and do overtime to complete paperwork. Another said, "We need more time to do the paperwork. We cover for carers and I get worried and concerned about the paperwork." A third told us they felt taken advantage of as they were left on their own in a unit to do the medicines, give meals and do the care plans.

Regular audits were completed to monitor and improve the quality of the service provided; however actions identified were not always addressed. An external medicines audit in May 2016 had highlighted the need to record the temperature of the room that medicines were stored, but as we found during this inspection this still was not being done. The health and safety checks highlighted actions which had not been fulfilled. A safety check in January 2017 noted that light bulbs needed changing, lounge chairs required a clean, the first aid notice needed to be updated and the extraction fans in people's room required attention. We read from the audit in February 2017 that some of these were still outstanding. Other audits included a window check, a recording of water temperatures and a call bell inspection log. Although the call bell log was printed out this was not audited on a regular basis and the manager told us they would only refer to this if, "A customer has a fall and I need to see how long it had taken staff to answer their call bell." We noted in the area manager's action plan they had recorded in February 2017, 'it is important the management team checks call bell printer to evidence response times'.

Provider audits took place and the area manager held an action plan in relation to Elizabeth Court. We

noted these audits included all aspects of the home and were in line with CQCs five domains of Safe, Effective, Caring, Responsive and Well-Led. We noted the area manager had identified aspects of the service that required further monitoring or improvement by the manager such as records, training, supervision, involvement of people in the home and activities. The area manager worked with the manager to review the actions to help ensure these were addressed. We noted some of the areas highlighted in the most up to date action plan related to some areas we had identified at this inspection, such as risk assessment recording and call bells auditing. However, other areas such as suitably deployed staff had not been picked up by these audits.

The lack of good governance within the home was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider was not always aware of their responsibility to inform CQC of important incidents. We read records indicating that safeguarding incidents may not always have been reported appropriately to the local safeguarding team. We read of one person who had 54 episodes of behaviours in a six month period, many of which were aggressive behaviours towards other people living at Elizabeth Court but as such these had not been notified as potential safeguarding incidents. Another person was noted to have had seven accidents/incidents within a five month period. At least one of which resulted in a cut to their head. However, we had not received a notification in respect of this.

The lack of notifications of other incidents was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We received mixed views from staff about how supported they felt. One staff member said, "The job is stressful and the pressure is on us. We cannot do our jobs properly." Another told us, "(The new manager) is a nice person, but she is still learning." A third told us, "There are extreme pressures. Everything that goes wrong we get the blame for. We struggle and we don't always get thanked. We need to have strong leaders." However other staff told us, "We have a good team here. We have good carers," "The manager is very good. You can speak to her and she goes around (the home)" and, "I think they (management) are alright. I feel confident to approach the manager and I have confidence that she would listen." A further member of staff told us, "You can talk to (the manager) and she listens to you."

We recommend the registered provider takes into account the views of staff in relation to the support they feel they receive.

Staff meetings took place which gave staff the opportunity to discuss any issues, concerns or raise suggestions. We noted good attendance at meetings and a range of topics discussed. However staff told us that although they had raised the lack of staff at these team meetings, they had not felt listened to. Other meetings held included team leader meetings and a catering staff meeting. The manager used these meetings to discuss all aspects of the home and cascade information relating to Anchor. The manager sent us minutes of a staff meeting held after our inspection which showed that they had discussed our initial inspection feedback and findings with staff.

People and their relatives had opportunities to give feedback on the service provided. One person told us, "We have meetings now and again and we are able to feed back about the food." This was confirmed by the chef who told us, "I try to walk around twice a week to ask people about the food. I keep a comments book and go to residents meetings or get feedback from them. I get daily feedback from staff about what people liked or what they didn't and we change the menus." We noted that there had been discussion about the home's mini bus during two recent resident/relative's meetings and this had still to be resolved. A staff

member told us, "They are looking for a volunteer to drive the bus. No one is going to do that. Who would take on that responsibility as a volunteer? Also they need to go to Scotland to do the training." We spoke with the area manager and manager about the minibus at the end of the inspection and asked why Anchor were not employing someone to drive the bus, rather than looking for a volunteer. The area manager told us that the main issue in relation to the minibus was organising the training as currently it was only available in Scotland. They assured us they were working hard trying to resolve this issue. However, we heard from people and staff this had been going on for some time and in the meantime, people had no arrangements had been made to give people the opportunity to take trips out.

Residents/relatives meetings were held bi-monthly and we noted from the January 2017 meeting that people were unhappy with the food, the arrangements on Christmas Day and the lack of driver for the home's bus (which had still not been resolved). They had also commented they felt some areas of the home were short staffed. We noted the manager had arranged a meeting with the catering staff to follow up on residents and relatives comments about the food.

Customer satisfaction survey responses were reviewed and collated quarterly. We noted the comments from the last responses included comments on the home being short staffed, visitors having to wait for the front door to be answered as reception desk was unmanned and the minibus not being used. The manager had responded to these comments in the most recent residents/relatives meetings. The responses showed that the manager felt there were sufficient staff on duty and she informed residents/relatives of times when the receptionist should be expected to be at the front desk and that there was a chair in the lobby for people to use should they have to wait in case staff were busy.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not always ensured that the requirements of registration were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not always ensured that people received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that risks to people had always been assessed and that staff followed good medicines management practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not always ensured there was a suitable number of deployed staff available to meet people's needs. The registered provider had not always ensured staff felt supported.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not always ensured that records held for people were contemporaneous and that good governance was carried out in the service.

The enforcement action we took:

We have issued a warning notice to the provider and given them a fixed timescale to take action in order that they can demonstrate they have met this regulation.