Elizabeth Court Rest Home Limited

Elizabeth Court Rest Home

Inspection report

4 Hastings Road
Bexhill On Sea
East Sussex
TN40 2HH

Website: www.ecrh.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Elizabeth Court Rest Home on and 7 and 8 June 2016. This was an unannounced inspection. The service provides accommodation, care and support for up to 24 people. People were at risks of falls and living with long term healthcare needs such as diabetes. On the day of our inspection there were 24 people living at the service. The age range of people living at is 50 – 98.

We last inspected Elizabeth Court Rest Home on 14 May 2014 where we found it to be meeting all the legal requirements within the areas we inspected.

A registered manager was in post. 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 and associated Regulations about how the service is run.

Although people told us they felt safe living at the service we found the provider had not taken adequate steps to ensure people's safety in relation to the number of care staff working, medicines and risks related to a person using specialist equipment. We found kitchen staff had not consistently followed basic food hygiene principles in relation to the storage of food.

Staff had a clear understanding of safeguarding and were able to identify different types of abuse; however the registered manager had failed in their responsibility to inform the local authority where there had been allegations of abuse.

Meal times were poorly organised which resulted in an inconsistent dining experience for some people. People with higher support needs at meal times did not always receive the assistance they required. However people were provided with a choice of healthy food and drink and people's feedback on food was positive.

Staff received training and had an understanding of the Mental Capacity Act 2005 and were seen to act in accordance with its principles; however care documentation did not clearly identify how people who lacked capacity for specific decision had been supported to reach a decision that was in their best interests.

People's dignity and confidentiality was not consistently protected by the provider in regard to meal times and people's care documentation being left in communal areas.

The provider had not taken steps to ensure there was always clear guidance available for staff to enable them to support people living with more complex health needs such as diabetes.

The provider had systems in place to monitor and drive improvements in the quality of the service; however we found shortfalls with areas of quality assurance which meant the provider did not have consistent

oversight of the service.

Appropriate checks had been undertaken when new staff were recruited to ensure they were safe to work within the care sector.

Care staff were responsive to people's changing needs. People's health and wellbeing was monitored and the provider regularly liaised with healthcare professionals for advice and guidance.

People told us staff were kind and we observed positive interactions between people and staff. Staff had a clear understanding of their roles and spoke enthusiastically about working at the service and positively about senior staff.

The provider had a complaints policy; this was displayed in a communal area. People and their relatives told us they knew how to complain.

We found breaches in Regulations. You can see what action we told the provider to take at the back of the full version of this 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 safe.

The provider had not protected people's safety by ensuring there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

People were not protected by the safe management of medicines.

We found some basic food hygiene principles had not been consistently followed.

The registered provider had not ensured allegations of abuse were reported to the appropriate body.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work within the care sector.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Although staff understood their responsibilities in regard to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards the provider had not effectively evidenced how best interest decisions had been reached.

The provider had not ensured all people had appropriate support with regard to eating and drinking.

Care staff had undertaken essential training as well as additional training specific to the needs of people and had regular supervisions with their manager.

People had access to external healthcare professionals such as their GP when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although people told us they felt well cared for by kind staff we found examples where people's dignity and confidentiality had not been respected.

People were routinely encouraged to make their own choices about all aspects of their daily lives.

People were encouraged to maintain relationships with relatives and friends.

Relatives were able to visit at any time and were made to feel very welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider did not have a consistent approach in how provided guidance for staff to support people with more complex support needs.

People told us they enjoyed how they spent their time living at the service and had the opportunity for regular social interaction throughout each day.

The provider sought feedback from people and their representatives about the overall quality of the service.

There were systems in place to respond to comments and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had some systems for reviewing the quality of service however these had failed to identify the areas of concern we found.

The audit process was not being consistently used to drive improvement within the service.

Staff felt supported by management, said they were listened to and understood what was expected of them.

Elizabeth Court Rest Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 8 June 2016. It was undertaken by two inspectors.

We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records at the home. These included staff files which contained staff recruitment, training and supervision records. Also, medicine records, complaints, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at four care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained information about their care and treatment at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we spoke with 12 people, two people's visitors and one visiting health care professional to seek their views and experiences of the services provided at Elizabeth Court Rest Home. We also spoke with the registered manager, their deputy, five care staff and three ancillary staff. On this occasion we had not requested a provider information return (PIR) from the provider.

We observed the care which was delivered in communal areas to get a view of the care and support provided across all areas. This included the lunchtime meals. As some people used non-verbal

communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Although people told us they felt safe and that they thought there were sufficient staff available to support them we found there were occasions during our inspection when the number of staff available to support people impacted on people's safety.

Staff rotas confirmed three care staff worked between 8am to 8pm to support the 24 people living at the service. Staff told us lunch time was often 'very busy.' At this time one senior carer undertook medicines which left two carers to support people with their meals. The majority of people ate in their rooms and as such care staff took these people their meals on trays. Staff told us one person usually chose to eat in one of the home's lounges; this lounge was located at a far end of the home. Staff closed the door which connected this lounge from the rest of the home; staff told us they did this to prevent people's pets being in the dining room during mealtimes. However this meant this person was on their own in the lounge for an extended period. This person had in recent months been assessed as at high risk of falls, although their care documentation indicated this risk had reduced, we observed they were unsteady whilst moving in and out of a toilet. They were making multiple trips to the toilet throughout the day. The deputy manager told us this was a recent 'new behaviour' for them. This person did not have a call bell close to them or an alarm pendant to alert staff if they required support. Staff were not routinely checking on this person during the lunch time period on the first day of our inspection. On another occasion a person who was living with a visual impairment was seen by an inspector entering a 'staff only' room. The registered manager told us this room was not suitable for people to be in without staff support. An inspector brought this to the attention of staff who supported the person to leave the staff room. We saw, one person's friend assisting them to stand using an unsafe lifting technique, this was in a communal area and there were no staff in the vicinity to intervene.

When a trained member of care staff is supporting people with their medicines it is good practice that the staff member does not get interrupted with routine tasks so as to reduce the risk of medicine errors. On the first day of our inspection, during the busy lunch time period, the senior carer, whilst undertaking medicines, was seen bringing people's plates back from their rooms and answering the front door.

The above issues related to sufficient numbers of care staff is a breach in Regulation 18 HSCA (Regulated Activities) Regulations 2014.

We found medicines were not always managed safely. Medicines, although stored securely, were not well organised. Within one of the home's medicine trolleys we found two medicines that did not have people's names on them and staff were unable to confirm who they belonged to.

It is good practice for staff to put the date when people's prescribed creams are opened. This is because manufacturers often stipulate medicines are most effective during a specified timeframe once opened. We found multiple examples of medicines which had been opened by staff which had not been dated. This meant that if medicines had a 'use by' date once they had been opened staff would not know if these medicines would be as effective.

Homely remedies are non-prescribed 'over the counter' medicines used for minor ailments. We found three people living at the service were supported with homely remedies. However the registered manager told us they did not contact people's GP's to seek reassurance these would not interfere with their prescribed medicines. Some homely remedies may alter the effectiveness of prescribed medicines or could have other unwanted side effects.

One person had recently been prescribed a controlled drug for pain relief. This had been prescribed as PRN which means it can be taken for pain relief 'as required'. However there was no PRN guidance available for staff to support them with the management of this medicine. For example knowing when to offer a higher or lower dose. We spoke to the registered manager regarding medicines who acknowledged improvements were required and they committed to work with senior staff to review all medicine systems and processes.

We found one person who had been assessed at risk of skin breakdown was using a specialist airflow mattress. We found their mattress was set incorrectly for their weight. This meant the equipment would not be as effective at protecting this person's skin integrity. We raised this issue with the senior staff who corrected the setting.

We found examples within the home's kitchen where safe food hygiene principles had not been consistently followed. For example we found several consumable and perishable items stored in the fridge which had not been marked with the dates they were opened. This meant there was an increased risk that people may consume out of date food which could cause them harm.

The above issues related to people's safety were a breach in Regulation 12 HSCA (Regulated Activities) Regulations 2014.

Although care staff confirmed they had received safeguarding training and understood their own responsibilities to keep people safe from harm or abuse we found senior staff had not consistently reported safeguarding incidents appropriately. We found two examples of incidents which met the threshold whereby the registered manager had failed in their responsibility to report these to the Local Authority. One was related to a medicines error and the other was related to allegation of financial abuse. We spoke to the registered manger regarding these incidents, they acknowledged this had been an over sight and took retrospective corrective action.

The issues related to safeguarding people are a breach in Regulation 13 HSCA (Regulated Activities) Regulations 2014.

Suitable checks had been undertaken to ensure the safe routine management of the environment including areas such as electrical systems and legionella. Maintenance and servicing of equipment such as fire alarm, portable appliance testing (PAT) and boiler were seen to be routinely undertaken. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "Things don't get left for long if something is broken we report it and will get fixed quickly."

There were procedures in place for fire; these included personal emergency evacuation plans (PEEP). Staff had been trained in fire safety and could identify their role within an emergency. There were systems in place to check the fire alarm and equipment operated effectively.

Staff were recruited in line with safe practice. For example, employment histories had been checked, suitable references obtained and staff had undertaken Disclosure and Barring Service checks (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working

with people who use care and support services. Staff described the recruitment process they had gone through when they joined. One said, "I was clear from when I started what was required and the importance of being open and honest."

Requires Improvement

Is the service effective?

Our findings

People spoke positively of the food they ate at Elizabeth Court Rest Home. However we found the meal time experience was inconsistent. For example one person who used a plate guard on the first day of our inspection was not offered this on the second day; this resulted in them dropping food into their lap. A plate guard is a specialist piece of equipment that provides people with a higher level of independence whilst eating. A member of care staff interrupted this person whilst they were eating so they could be supported to take their medicines. This person had difficulty taking their medicines and so the interruption lasted four minutes by which time the person did not return to eating their main meal. Staff deployment impacted on the effectiveness of the meal service. For example, on the first day of our inspection, during the busy lunch time period one member of staff was sent on their own break. We spoke to the registered manager regarding meal services and they told us they had identified meal times required improvements. They told us the recent purchase of a bain-marie would allow for a more staggered café dining approach. A bain-marie is a piece of catering equipment that is designed to hold food at a fixed temperature for an extended period of time. The issues related to meal times require improvement.

People's nutritional risk assessments were up-to-date and reflected when people may require additional support or more careful monitoring if they were deemed at risk of weight loss. People who required their weight to be monitored had been weighed regularly and staff were aware that any changes in people's weight required prompt action. One person's records identified they were awaiting input from a dietician.

The Care Quality Commission (CQC) is required by law to monitor how providers operate in accordance with the Mental Capacity Act 2005 (MCA). The MCA requires assessment of capacity must be decision specific and must also record how the decision was reached. People's care documentation provided some clarification and guidance for staff on people's ability to make decisions on their daily living routines. However there was limited evidence as to how people's capacity had being assessed using the MCA principles. For example, some people who had been assessed as lacking capacity for decisions related to their medicines were seen to be supported by staff with their medicines however it was not clear who had been involved to establish this as a best interest decision.

One person who was living with dementia had a long standing friend visit them regularly. This person's care documentation identified that a family member had Lasting Power of Attorney (LPA). However their care plan indicated the long standing friend could also 'advocate' for them. However this person did not have the appropriate authority to do this. We spoke to the registered manager regarding this issue who acknowledged this care plan required clarification so as to provide accurate guidance for care staff as to who can advocate for this person.

Care staff had received training and broadly understood the principles of the MCA and gave examples of how they would follow these in people's daily care routines. Care staff were aware any decisions made on behalf of people who lacked capacity had to be in their best interest. During the inspection we heard staff ask people for their consent and agreement to care. For example we over heard a staff member ask a person if they could assist them to sit more comfortably, the person declined assistance and the staff member

respected their wishes. We heard another staff member ask a person, "Are you ready to take your medication?"

Staff were able to explain the implications of Deprivation of Liberty Safeguards (DoLS) for people they were supporting. DoLS forms part of the MCA. The purpose of DoLS is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. We saw the registered manager had made applications to the authorising body. Where an authorisation had been granted the conditions were adhered to by staff.

Although all care and ancillary staff were having regular supervision there was no formal supervision being undertaken for one senior member of staff. However this staff member had autonomy and oversight of some aspects of the service and as such it would be good practice for their performance to be formally managed and recorded. Care staff who underwent regular supervision told us they found this helpful. Staff told us the registered manager was approachable and felt supported in their roles. One staff member told us, "I really do enjoy working here, it wouldn't suit everyone but it works really well for me."

Care staff told us the size and dimensions of some people's rooms and some communal corridors was a challenge. One staff member said, "Since we have been using wheelchairs more, you notice how narrow things are in places." Another staff member said, "When residents can walk unaided there are no problems but if they need more support it can be tricky." We saw one person who self-propelled in their wheel chair had some difficulty leaving their room to access a communal area. A visiting health care professional said, "If I could change one thing it would be the size of the rooms, it can be very cramped." We spoke to the registered manager regarding this issue; they acknowledged the age and layout of the building impacted on the types of support needs they were able to accommodate. They committed to continue to carefully monitor and assess people's changing support needs so as they were able to provide effective care.

Staff underwent training to assist them to be able to support people. Throughout our inspection we saw staff appropriately supporting people who required assistance. There was additional training for staff to enable them to support people living with dementia and behaviours that challenge. One staff member said, "I have learnt a lot about how to deescalate potential challenging situations by verbally and through body language." Another said, "Training is pretty good, most of it is done through workbooks, but I quite like it that way."

People received effective on-going healthcare support from external health care professionals. People commented that they regularly saw their GP, chiropodist and optician. Friends and relatives told us staff were effective in responding to people's changing health care needs. Staff recognised that people's health could change quickly especially for people living with a progressive conditions, such as dementia. One staff member told us, "I can tell if a resident isn't well as their behaviour changes, I will always report it." We spoke with a visiting health care professional who spoke highly of the home and the responsive attitude staff had to early intervention. They said, "The staff here have always been very good at following guidance and checking in with us if they spot any problems."

Requires Improvement

Is the service caring?

Our findings

Although comments from people about Elizabeth Court Rest Home were positive and they spoke highly of the care they received we found examples where the service provided was not consistently caring.

One person had been assessed as requiring additional support whilst eating. During the lunch time meal service on both days of our inspection we saw care staff both standing over them and leaning across a table to assist them with their meal. Another person who required prompting with their meal was assisted by three different staff as they moved to and from people's rooms with meal trays. On the second day of our inspection, whilst people were eating their lunch, cigarette smoke was drifting back into the dining area from where a person was smoking outside. We found occasions when people's confidentially was not consistently protected. For example people's care documentation was left unattended in a communal corridor. Another person had written some of their concerns down on a piece of paper which had named other people. Staff had left this in a communal area in the dining room. These issues related to dignity and confidentiality requires improvement.

However during the inspection we also observed many positive, caring and kind interactions between people and staff. Staff demonstrated they were knowledgeable about the individual personalities of people they supported. Staff shared people's personalities with us during the inspection and they talked of people with respect and affection. One care staff member said, "Our residents are all unique, real characters and personalities." We observed occasions when staff were supporting people; they worked at the person's own pace and did not rush them. We saw staff routinely addressed one person with a hearing impairment from one side when they spoke to them. Staff were seen chatting and there were relaxed, light hearted conversations taking place with people whilst support was provided. One person said, "The staff are wonderful people." One relative told us, "It's been a really positive move them coming to live here." We saw ancillary staff taking time to chat and engage people whilst they were undertaking their tasks such as cleaning and laundry. People were relaxed in their company and enjoyed the interactions.

People were supported to maintain their personal and physical appearance in accordance with their own wishes. People were dressed in clothes they preferred and in the way they wanted. One relative told us, "Staff do their best but at the end of the day if they choose to be a bit scruffy they can." We observed one person calling for assistance to go to the bathroom. This was attended to promptly and in a discreet way. Staff were patient and responsive to people's moods and dealt with situations in a calm and kind way.

People's rooms had been personalised with their belongings such as photographs and ornaments. One person said, "I enjoy having my photographs around." People were able to spend time in private in their rooms as they chose. One person said, "I come and go as I please, suits me just fine."

Visitors were welcomed throughout our inspection. Relatives and friend spoke of the caring nature of staff and that they felt comfortable visiting the service. One person's friend told us they visited every day and that staff always made them feel welcome, this visitor spoke with real affection for the service and how staff had made a special effort for their birthday. One relative said, "The manager has offered us the use of a lounge

area to host a party for my dad's upcoming birthday."

Requires Improvement

Is the service responsive?

Our findings

Although people told us they were happy with the care they received we found the service was not consistently responsive to people's needs.

People's care documentation did not provide up-to-date guidance on all support needs linked to their behaviours. For example, one person who in previous months had been assessed as at high risk of falls had undergone an assessment by a health care professional who determined their falls may be linked to a mental health behaviour. Although there was evidence this health care assessment had taken place, the outcome had not been recorded to enable care staff to have an understanding of their potential behaviour patterns. Not all care staff we spoke to were aware of this potential behaviour pattern. We found some people's care documentation did not contain information relating to their social and life history. Staff told us they found out information about people through providing care but they did not always have records to review. It is helpful for staff to have an understanding of people's past and life history so as they can personalise the care they deliver. On the second day of our inspection one person was very animated to see an old friend when they visited. It was evident this person was of real importance to them however there was no mention of this friendship within their care records. Care staff were overheard asking this person who their visitor was after they had left. The shortfalls in person centre care planning are an area that requires improvement.

However other aspects of people's care plans provided detailed guidance on a broad range of care and support needs. People and their relatives told us they had been involved in the design of their care plans. One relative told us they knew of a care plan and had been asked to contribute to it. One person said, "I have been asked and involved in my care." Before moving into the home a senior member of staff carried out an assessment of support needs. We looked at a completed pre admission assessment where information had been gathered from a variety of sources including healthcare professionals. Daily care records provided information for each person and staff could see how people were feeling and what they had eaten and drunk. Most care plans contained information on people's background, interests and likes and dislikes.

People spent their time as they chose. People sat in the dining area reading newspapers; others chose to spend time in their room whilst others spent time in communal areas. People told us they enjoyed the range of activities available to them whilst living at the service. A movement and motivation class was attended by nine people on the first day of our inspection. One person told us, "I enjoy it, always makes for a bit of fun and laughter." There was a planned schedule of activities provided by external companies such as musical entertainment and an art group. A cabin in the garden had been converted into a 'coffee house' where people could sit and chat and watch television, this facility was seen to be popular with people. Other people told us they preferred to spend most of their day in their rooms, one person said, "I have got my laptop, tablet and the internet and I'm happy." Another person was enjoying undertaking a military model kit.

People told us that the 'homely feel' to the service was in part down to the pet animals which formed an important part of the home. People had brought their cats and dogs to live with them at the service. The

home also had suitable facilities in the garden which housed rabbits. Some staff brought their own pets to work with them. People spent time interacting with the animals and were seen smiling when they passed by and others were heard telling anecdotes about specific pets. One staff member said, "It is so lovely having the animals around, it attracted me to work here." One member of staff had responsibility and oversight of pet welfare and was seen replenishing food, cleaning areas and changing cat litters.

The provider had a complaints policy and procedures in place; this was displayed in a communal area. The complaints policy included clear guidelines on how and when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the CQC. People told us they felt confident in raising concerns or making a complaint. One person's said us, "Oh yes, I know how and who to complain."

The provider undertook various surveys to check on overall satisfaction levels. We saw people, their relatives and health care professionals had been canvassed. Although the findings were awaiting collation the individual returned forms we reviewed were all seen to be positive.

Requires Improvement

Is the service well-led?

Our findings

A range of quality assurance systems had been established however their effectiveness at driving improvement and providing oversight of the service had not been consistent. For example a weekly medicine audit was undertaken by a member of care staff, the previous four weeks of records indicated that missing signatures on people's MAR have been identified. We were told the staff member undertaking the audit left a note for their staff colleague who had not signed to remind them to do so. Records were not being kept of the staff who were not signing and why they had not followed guidelines, which meant individual staff member's poor practice was not being addressed in an attempt to improve their practice. Shortfalls in staff signing people's MAR had not been suitably managed by the registered manager. The registered manager's medicine audit was also found not to be identifying all corrective practice. For example there were two staff signatures missing from the medicines 'sample signature' sheet. It is good practice to record the name and signature of all staff authorised to administer medicines. These two missing staff 'sample signatures' had been ticked as correct and in place by the registered manager in their most recent audit.

Although people's care plans were regularly reviewed and updated if there had been a change in a person's support needs; care plans did not routinely undergo a quality audit. This meant any gaps or shortfalls in the content of people's care plans were not routinely identified. For example, one person living with diabetes had chosen to disregard most of the lifestyle advice they had been provided. Although their care plan identified in several different sections how diabetes impacted on their care they did not have a specific diabetes care plan in place to provide clear guidance for staff. Such as recognition that this person's choices may impact on their blood sugar readings and what would be considered high or low readings for them. Although staff were knowledgeable about their care needs the service had recently employed new members of staff which would make the information within care documentation more pertinent.

People's prescribed creams were not being consistently recorded. Although daily care records identified people were being supported in cream application, MAR were not being completed consistently. This meant it was not clear, where people who required support with more than one cream were having them applied.

The home's kitchen was being prepared for a significant refurbishment at the time of our inspection. In preparation for these works, equipment had been moved outside the kitchen which resulted in blocking full access to a fire exit. However this impact had not been considered or reflected in the provider's fire risk assessment. The provider took steps to rectify the potential impact on the exit and following our inspection provided us with an updated risk assessment from a company specialising in fire safety.

The above shortfalls in records, leadership and governance are a breach in Regulation 17 HSCA (Regulated Activities) Regulations 2014.

A requirement of a provider's registration with the CQC is to have an up-to-date Statement of Purpose (SOP). This is a document produced by the provider which clearly sets out the function and rationale of why the service exists. The providers current SOP did not accurate reflect the services being provided. For example,

the provider's SOP stated they were registered to 'accept clients over 65 years of age'. However there were people living at the service in their fifties.

We recommend the provider reviews and update their SOP in line with the CQC requirements.

Care staff told us they regularly attended staff meetings which were helpful and an effective way of sharing information and raising general points to improve the quality of the service. Meeting minutes demonstrated meetings were well attended and a broad range of operational topics had been discussed. One staff member said, "One week day afternoon is always set aside for meetings, makes it easier to know when they will happen."

All staff told us they enjoyed working at Elizabeth Court Rest Home and felt supported in their roles. One staff member told us, "This is a really unique place with the types of residents and all the pets; makes it really homely." Another said, "communication is very good, the daily handovers are very thorough and you get to know how people have been and what is planned."

We found the registered manager was responsive to our comments and feedback throughout the inspection and actioned multiple areas during the inspection and sent actions plans immediately after our inspection identifying how they intended to address some of the areas of concern we identified.

There was a clear management structure at Elizabeth Court Rest Home. Staff members were aware of the lines of accountability and who to contact in the event of an emergency or support out of normal business hours. The registered manager was visible to people and staff. Staff commented that the registered manager and their deputy were available for advice and felt supported in their roles. People and their relatives commented there was a 'homely feel' to the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g) The registered provider had not ensured people's safety had been protected by adequately mitigating the risk connected with people's food. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured that appropriate processes had been followed once becoming aware of allegations of abuse. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people received. 17(2)(a)(c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had not ensured there was sufficient numbers of suitably qualified, skilled and experienced staff deployed in order to ensure people's safety and welfare.

Regulation 18(1)