Care Quality Commission

Anchor Carehomes Limited

Lightbowne Hall

Inspection report

262 Lightbowne Road
Moston
Manchester
Greater Manchester
M40 5HQ

Website: www.anchor.org.uk

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24 July 2018

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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

This inspection took place on 23 and 24 July 2018. The first day was unannounced, which meant the service did not know we were coming. The second day was by arrangement.

Lightbowne Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lightbowne Hall is a large three storey detached property in Manchester. The home provides residential care for up to 52 people. At the time of the inspection there were 50 people living in the home. The home has large communal areas on each floor with separate dining areas. Each floor also has a quiet lounge. The kitchen and laundry facilities are on the ground floor of the building and there is a hairdresser's salon on the first floor. All floors are accessible by a lift and stairs.

Our last inspection took place on 27 June 2017 when we rated the service requires improvement. At that inspection we found the provider had implemented a number of positive improvements. However, at this inspection we have found the provider has failed to sustain these improvements and we have identified three new breaches of legal requirements in relation to insufficient staffing levels, care planning and activities, and the quality assurance systems. We requested the provider to tell us in an action plan how they were going to put right the concerns in respect of these breaches.

The manager had been at the service for approximately two months at the time of this inspection. On the second day of inspection the manager confirmed he had received confirmation of his registration with the Care Quality Commission (CQC). 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 home is run.

The service was not staffed safely to meet people's needs. The service was also not staffed in line with the stated provider's minimum staffing levels. As a result, people's basic care needs were not being met. Examples of this included, people not always having their skin integrity needs met and people did not always receive social stimulation within the home, due to a lack of staff.

Staff were observed being kind and compassionate to people throughout the inspection, but their ability to have quality time with people was being compromised by all the tasks they needed to complete.

Demands on staff time meant that staff were not reading people's care plans and risk assessments. Care staff relied on the team leaders to tell them informally and verbal information from other staff. Although care plan records have steadily improved over the last two inspections, essential details were still missing from these, which meant the staff team could not be sure they were using up to date information about people's current needs. Care records were not fully completed which meant people's changing needs could be

missed. Monitoring of people's skin integrity repositioning charts were not always completed correctly. This meant people were vulnerable to unsafe and inaccurate care.

People had access to activities, however we received mixed feedback with regards to the activities provided. People were not always protected from social isolation. The range of activities available were not always appropriate or stimulating for people.

We found arrangements in place for the safe management of people's medicines and regular checks were undertaken. People received their medicines as prescribed.

Staff were provided with relevant training to make sure they had the right skills and knowledge for their role. However, staff did not always receive appropriate supervision and regular appraisals in line with the providers policy.

Staff understood what it meant to protect people from abuse. They told us they were confident any concerns they raised would be taken seriously by the manager.

People continued to be supported to maintain good health and we saw that people had access to their GP, district nurses and other specialist services.
The registered provider had effective recruitment procedures in place to make sure staff had the required skills and were of suitable character and background.

Staff understood the requirements of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The registered provider's policies and systems supported this practice.

It was clear to the inspection team the manager demonstrated a commitment and willingness to improving the quality and safety of care provided at Lightbowne Hall. However, we found the quality assurance and audits systems in place to monitor and improve service delivery were not always effective.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were a breach of Regulation 9, Person centred care, Regulation 18, Staffing and Regulation 17, Good governance.

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.

The service was not staffed safely to meet people's needs.

Improvements had been made to ensure a more robust management of medicines. People received their medication as prescribed.

People who were vulnerable were looked after by staff who were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular supervision or an annual appraisal in line with the registered provider's own policy and procedure.

The mealtime experience was not positive or well managed.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always enabled to be in control of their care as there were not enough staff to meet their needs.

Staff did not always have the time to provide caring support.

People and their relatives spoke positively about the staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's records had been improved, but still did not fully represent people's current needs.

Some people were not being supported to remain active.

People's end of live care choices was not always recorded.

Is the service well-led?

Requires Improvement

The service was not well-led.

People were not assured of safe and appropriate care due to a lack of robust quality assurance processes and associated systems of leadership and governance.

Staff felt unsafe to speak out about the service and staff morale was low.

People and their families felt they could approach the manager to make suggestions if needed.

Care Quality Commission

Lightbowne Hall

Detailed findings

Background to this inspection

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

The inspection took place on 23 and 24 July 2018 and the first day was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. This included information from whistle blowers and following a review of our records in line with our intelligence monitoring.

We contacted Manchester local authority, and Healthwatch (Manchester) to obtain their views about the quality of this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

Due to the nature of the service provided at Lightbowne Hall, some people were unable to share their experiences with us, therefore we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we spoke with 19 people who used the service and nine people's relatives. We spoke with the regional support manager, district manager, home manager, two deputy managers and seven members of care staff.

We looked at staff training and supervision records for the staff team, three months of staff rotas and the staff files for four staff including their recruitment records. We looked at nine medicines administration

records in the two medicines treatment rooms. We also looked at records of staff meetings, quality monitoring records, medicines adults, fire safety records and health and safety records relating to legionella, maintenance and servicing of equipment. We read the fire risk assessment for the home.

We also looked at records of activities taken place, the activities programme since the last inspection, menus, food and fluid monitoring charts, five care plans, weight monitoring records, complaints, accidents, incidents and safeguarding records.

Requires Improvement

Is the service safe?

Our findings

People and staff told us that not having enough staff was affecting the quality of care. People we spoke with were aware there were not enough staff to meet their needs and spoke to us about how they reduced their demands on staff instead. For example, one person told us, "They could do with more staff, sometimes there is only one staff at night and if there is emergency, people have to wait long before they get their needs met." Other comments included, "They need more regular staff, agency staff often have no clue who you are and what you need", "Sometimes you struggle to get staff as they are busy with someone else who needs more of an immediate care" and "The staff levels are up and down."

Comments received from people's relatives was also negative about the current staffing levels deployed. Comments received included, "Often there is no staff in the living room and I feel it is an accident waiting to happen", "They could do with more staff, that way they can respond to the needs of residents effectively without us family pitching in" and "They need more staff, sometimes the lady next door will be agitated and shouting, often I go in there to reassure her and it works, staff are always rushed."

There were insufficient staff employed at the service to ensure people's care needs could be met. Rotas confirmed that during the day, nine care staff were on duty and five care staff were on duty at night. However, we found staffing levels did not support the tasks assigned particularly on the first and second floors. Care staff were observed providing or prompting personal care, administering medicines, attempting activities and supervising mealtimes. It was observed that throughout the inspection there was little interaction between staff and the people, particularly in the morning time as care staff were busy supporting people with tasks. This meant that staff were not always readily available to provide people with assistance when needed.

Staff told us that they could not always respond to people's needs in a timely way. Staff told us they were aware that people's safety and dignity could be affected by this. For example, they were worried that people may fall and they could not always support people to go to the toilet in time. Staff also said they did not have time to spend with people and fill in essential paperwork such as monitoring forms that may alert to concerns about people's needs. For example, food hydration records; records of turning/moving people to prevent pressure ulcers and, records of applying prescribed creams. We found essential monitoring forms had not been completed consistently, which could mean people's changing needs could be missed.

It was documented in one person's care plan and repositioning chart that they required two hourly turns throughout the 24-hour period. We have found numerous instances when the required two hourly turns were not taking place. For example, on 21 July 2018 it was recorded at 2:10am staff supported with turn, the next turn was recorded at 5:35am. The lack of turns in the appropriate two hourly time periods continued, with the next turn recorded at 10:50am and then 2:14pm. We found these recordings remained a continuous cycle, which meant the person was not receiving the required two hourly turns. We also noted a similar theme with two other people who were at risk of pressures sores and we found they also did not always receive the agreed two hourly turns. This put the three people at risk of developing pressure ulcers as their guidance was not being followed. We asked the staff on duty whether this was a recording issue, rather than

this not happening as required. One staff member told us, "I am embarrassed to be honest, we don't have the time to do these turns. It's not a recording issue, we just can't get to everybody." This was a further indication the current staffing levels were inadequate. Subsequently the Care Quality Commission (CQC) has made a referral to local authority safeguarding team in respect of these three people.

At the time of this inspection there were 50 people living at the home. Lightbowne Hall is separated into three floors, with a mix of differing needs on each floor. Care staff usually worked in 12-hour shifts from 8am to 8pm during the day, and 8pm and 8am during the night. The manager told us there was usually one team leader and two care workers on each floor. The rotas we looked at confirmed this to be the case and we found additional support could be used during the day in the way of the deputy managers. However, we noted a number of inconsistencies from the rotas in May, June and July 2018 when staff called in sick, shifts were not always covered with agency or bank staff. Although we were told by the management team that attempts were made to get agency staff, we found numerous occasions when these shifts had not been covered. For example, on Monday 28 May we found from the hours of 8am to 8pm three staff did not turn in for work, which meant just six staff were available to support people between the hours of 8am to 8pm. We found this was not a one off situation and found a number of instances within the last three months when vacant shifts had not been covered by bank staff or agency. We found the provider had not been proactive at managing these risks, such as changing the agency they use.

In the month prior to this inspection CQC received two anonymous whistleblowing concerns alleging low staffing levels at Lightbowne Hall and the subsequent negative impact this had on the people living there. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. We asked the manager how they worked out how many care staff were required to safely meet people's care and support needs. They told us the registered provider used a staffing dependency tool to calculate staffing levels based on information they provided every month regarding current occupancy levels and the needs of each person living at the home. This was completed more often if people's needs or occupancy levels changed. However, we found the providers staffing dependency tool was not being utilised to its full potential. We viewed the staffing dependency tool for July 2018 with the home manager, who confessed the home was meant to be providing an additional 41 hours of support to people a week, however these additional hours had not been added to the rota. The manager commented that they will now ensure these hours are added to the rota and will make immediate inquiries for long-term agency staff to pick up these additional hours.

Not having sufficient staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Shortly after the inspection the provider sent us an emergency staff cover plan that detailed a process staff needed to follow if staffing hours could not be covered. This also included the person in charge contacting other care homes owned by Anchor to see if they had staff available. The provider also increased the staffing levels to four staff on the first floor. We were provided with evidence that the provider was attempting to recruit new staff and the manager felt all outstanding vacancies would be fulfilled by September 2018. We will continue to monitor the effectiveness of these changes at our next inspection.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that staff employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate pre-employment checks including references from previous employers and a Disclosure and Barring Service (DBS) check. There were staff disciplinary procedures in place and these were used to ensure staff performed appropriately.

Medicines were stored securely in two locked treatment rooms and access was restricted to authorised staff only. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the home's policy.

People had an assessment which identified their medicine needs. We looked at the medication and medicine records of nine people who used the service and found that their medicine had been stored and administered safely. PRN (as required) protocols were in place for people who only required medications to be administered when needed. This meant people's health was supported by the safe administration of medicine. Senior staff administered and managed people's medicine and they had their competency assessed in medicine management.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for malnutrition, skin integrity, medication, mobility and the risk of falls. Staff told us that risk assessments were reviewed at least every month or following any incidents.

We checked the safeguarding records in place at Lightbowne Hall. We noted that a tracking tool had been developed to provide an overview of safeguarding and care concerns that had been received; we noted these records had been placed in a folder for reference. Examination of individual safeguarding records confirmed the provider had taken appropriate action in response to incidents.

The service had appropriate levels of infection control practices in place in order to support people to remain safe from cross contamination. Staff were provided with appropriate levels of protection using gloves and aprons. Only kitchen staff operated in the kitchen, which was kept clean. Audits were completed to keep practices safe.

We saw the manager kept an electronic record of any accidents and incidents that took place. The cause and effect of each accident or incident was investigated and recorded. A summary of all accidents and incidents for the month was also held on the electronic system and these were analysed each month so any similar incidents could be linked together to identify any trends and common causes.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system, passenger lift and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids. All systems had a certificate to evidence they had been assessed as safe at the time of the inspection. Individual personal emergency evacuation plans (PEEPS) were in place, which provided guidance on the support people would require should they need to evacuate the service in an emergency. However, we found there was still outstanding actions from the providers fire risk assessment. We noted a number of fire doors within the home did not meet the fire regulations, due to gaps between the fire door and frame being visibly present. We asked the manager when this work would be completed, as there were no clear timescales in place. Shortly after the inspection we received an action plan from the provider, which suggested this work would be completed by the end of August 2018. We will continue to monitor this.

Requires Improvement

Is the service effective?

Our findings

We saw the registered provider had a staff supervision policy which required staff to have one-to-one meetings every four to six weeks and an annual appraisal. Supervision is regular, planned, and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. We were provided with the homes supervision tracker and found some inconsistences in terms of the frequency set by the provider. For example, two staff had a supervision in January 2018, and their next supervision took place on the 25 and 27 July 2018. In discussion with the manager they said due to changes in management the supervisions have not always taken place per policy, but this was something they were looking to improve.

Staff we spoke with told us supervision was infrequent. However, staff were also keen to tell us they found the manager and senior staff approachable and supportive. Comments from staff included, "I think my one-to-ones could be better, not had one for a long time. But the deputy managers are doing their best" and "Although supervisions have not been regular, I know the managers are available if I need their support."

People were supported by staff who had the skills and knowledge to meet their needs. New staff completed an induction to ensure they had appropriate skills and were confident to support people effectively. Staff training was linked to the Care Certificate which is a recognised set of national standards. Staff training covered all aspects of care and included; safeguarding vulnerable adults, moving and handling, infection control and medicines. Staff also had further training opportunities.

The building is a large and purpose built for people living with dementia. Rooms are spacious and furniture and fixtures were all in a good condition. We found appropriate signage was available with people having photos, or other distinctive indicators in place that would help people recognise their bedrooms. The service had pictorial signage in place confirming the day, month and season of the year.

However, prior to our inspection we received a whistle-blower concern, that the temperature within the home was too warm and fans had not been purchased to combat the heat. We referred these concerns to the local authority commissioners who carried out an unannounced visit to the home. They found a number of fans had been purchased a few days before their visit and they were satisfied the provider had acted appropriately. During our inspection we found the room temperature in communal areas of the home particularly on the first floor exceed 30 degrees centigrade. We found the introduction of the fans did not reduce the room temperature and on one occasion we observed one staff member saying, "I need to sit down, I feel like I am going to pass out with the heat in this home." We raised these concerns with the management team, who commented that no other action has yet been suggested in respect of the warm temperatures within the home, but acknowledged a further discussion would be held with the provider. The manager and provider commented that staff have been told they must ensure people are offered drinks throughout the day. During the inspection as the weather was very warm, we observed drinks being offered throughout and on one occasion we observed the catering staff handing out ice lollipops to people to keep them cool. Shortly after the inspection the manager contacted us to say the home has identified a supplier

and ordered three portable air conditioning units.

The corridor on the first floor had been decorated in a manner which attempted to represent street scenes including a barbershop, a café and a bus stop. At the last inspection we found a new café called 'Olivia's café' had been created, which was managed by a volunteer two day a week. The café was nicely decorated and provided a menu that people could buy breakfast and lunch items such as paninis. We also found at the last inspection a bus stop had been created along the corridor. We were told this had a positive impact on some people and they had been observed on occasions sitting at the bus stop happily waiting for their bus to arrive. This meant the home had been adapted to meet to current and past needs of the people.

At the last inspection we were told by the previous registered manager the home was looking to install a sensory and cinema room in order to provide a varied range of activities. However, at this inspection we found these plans were still on hold. Speaking to the home manager, they were confident this work would take place, but timescales had not been confirmed.

We observed lunch in all three of the dining rooms on the day of this inspection. We saw people were given options of what they could choose to eat. A member of care staff told us people were asked what they wanted to eat for lunch the evening before, however we were told they can change their mind on the day. We saw this was the case.

The meal experience on the ground floor was relaxed and unrushed, however the meal time experience on the first and second floors were not very well co-ordinated. We found for the most part on particularly the first floor there was only one member of staff, who was also responding to people's demands in their bedrooms, and as a result one person's relative intervened and was helping to serve. This person's relative commented, "This is a common occurrence, they can do with more staff, at the moment two staff are changing some resident in their bedroom, and that leaves only one staff in here, who will often have to respond to buzzers, like it just happened, and then there is nobody in here to continue to serve food, that's why I am helping to serve, because I don't want then waiting and getting cold food." Another person's relative commented "When residents want something to drink and there is no staff about, I stand up and do a cuppa for anybody that wants one, I am not just here for my dad, I feel some residents don't have anybody visiting them and appear lonely, that's why I sit with them and have a small chat, just to keep them company." This was a further indication staffing levels were not sufficient. We provided this feedback to the management team during the inspection.

People were supported with their nutritional needs and were provided with a healthy balanced diet suitable to their needs, likes and dislikes. Both care staff and kitchen staff had knowledge of those people with specific dietary requirements and ensured the diet they received was specific to their needs.

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). Although the service's doors were not locked and people were able to access the community independently the registered manager had identified that some people who lacked capacity in relation to certain decision were the subject of restrictive care plans.

Necessary applications to the local authority for the authorisation of these care plans had been made. Where authorisations had been granted the service had complied with any associated conditions. Consent for care was gained in accordance with the principals of the MCA. Staff understood the importance of gaining consent from people before offering care and support; this was observed during inspection.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). Staff had received training and understood how to support people in line with the principles of the Act. One staff member said, "We are much better informed in relation to the Mental Capacity Act. To be fair the home has trained us well in this area."

People were supported to access health and social care professionals; care records showed evidence of people being supported with routine health appointments where needed. Care staff were proactive in referring people for appropriate support from external health and social care professionals and care records detailed any action required.

Requires Improvement

Is the service caring?

Our findings

This key question was rated as Good on our previous inspection completed on the 27 June 2017.

Following this inspection, we have rated this key question as requires improvement, because, people were not always in control of their care. Some people had choice where others did not. People's choice of care was being compromised by the lack of suitable numbers of staff. People could not be assured they were free to choose how they wanted their care to be delivered. People were aware when talking to us that there were not enough staff so they would reduce their demands on them.

Staff were concerned they were not able to be as caring for people as they wanted to due to not having the time to spend with people. Comments from staff included, "I know we are a caring home, but at times we can't give it our all due to the lack of staff" and "I can't comfortably say we are always caring, due to the lack of time we have with people."

We heard friendly conversations between people and staff. We saw people's relatives and friends were welcomed by staff, and people we spoke with told us their friends and relatives could visit at any time. One person told us, "My son visits all the time, the care staff never have a problem with this."

People were supported by a dedicated staff team who had genuine warmth and affection for people. People's comments included: "Staff are very supportive", "They treat you with respect", "Staff are very polite", "They are brilliant" and "Staff are very caring, couldn't live anywhere else"

Due to the nature of the service provided at Lightbowne Hall, some people were unable to share their experiences with us, therefore we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Through our observations of staff interacting with people, it was clear that they knew the people they provided care for well. They understood people's preferences, likes and dislikes. Staff also had a good understanding of people's past lives, which enabled them to participate in meaningful conversations with people. This was further confirmed by the relative we spoke to who also felt the staff knew their family member well.

People told us and observations confirmed, that staff maintained people's privacy and dignity. Staff were observed knocking on people's doors before entering and ensured that doors remained closed when providing support or discussing private matters. Staff were able to clearly explain the actions they take to ensure that people's dignity and privacy were maintained at all times, especially whilst providing personal care. However, during the inspection one person's family member told us at times they found their family member in an uncompromised position and needed changing. They told us they have brought this to the management teams attention and confirmed a new hygiene plan was in place that was currently working well.

Care plans were person centred and included people's life histories and preferences. They provided staff with guidance about the best way to support people and reflect their identity. Care plans indicated that

where possible people or their relatives were involved in their development and review.

People and most relatives we spoke with were not familiar with a care plan. One person told us, "Staff are always informative, even though I don't know much about care plans or whatever you call it." However, two relatives told us they had been involved in providing information on their relative's life history and was involved in their care plan. However, this approach was not consistent and we found no evidence within people's care plans to confirm these reviews had taken place.

People told us they were supported with their independence. For example, one person told us, "I have always been able to do things, even though I am blind, staff place things within reach for me." Relatives told us they were able to visit people freely. People's independence was respected and relationships with people's families and friends were supported.

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so. We saw that no one was accessing these services during our inspection.

People's equality and diversity was respected. Staff had completed training in equality, diversity and human rights and the provider had an equality and diversity policy. The provider also established a LGBT (lesbian, gay, bisexual and transgender) group, we found LGBT posters displayed around the home to show awareness on inclusion. The aims of the group were to help make Anchor a safe and welcoming environment for LGBT customers and employees. There was also a dedicated contact centre within Anchor to ensure that basic human rights principles are a core of the service delivery.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always meet people's current needs and they were not evaluated to ensure people's needs were met in the most effective way. Care plans did not always include relevant and up to date information in relation to people's needs. For example, one person was receiving palliative care since the beginning of July 2018, however this person's care plan had not been updated to reflect this. This meant aspects of their care plan was no longer relevant. For example, their care plan stated staff needed to prompt this person to use the toilet. However, due to the significant changes in this person care needs this was no longer the case and a number of aspects of their care plan had not been updated. Although the staff team were aware this person was receiving palliative care, there was a risk other staff members, such as agency did not have the most current information available for them to follow.

During the two day inspection we were told by the majority of care staff they did not read the care plans and had no role in their design. When we spoke with staff, most demonstrated relevant knowledge regarding people's routines, preferences, likes and dislikes. However, they also said they had no idea what the written risk assessments said about each person and how they were to manage certain health conditions, falls and mobility, for example. Staff told us they relied on the team leaders to tell them and keep them up to date or through shift handover. Staff said, "I'd love to be able to sit down and read the care plans, but we just don't have the time. The team leaders are doing their best to update the care plans, but they don't have enough time either."

We asked the manager what actions they had taken to meet the accessible information standard. The Accessible Information Standard (AIS) was introduced by the Government to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The manager told us if people required information in large print for example, this could be arranged for them. Whilst we saw care plans were in place for people's communication needs, we did not see how this had been extended to assess what format people would require information in. For example, information such as the complaints procedure and their care plan in order to facilitate their involvement in it.

People had different experiences of whether they were given the right level of stimulation to keep them physically and cognitively stimulated on a day by day basis. The home did not have a specific member of staff designated for the coordination of activities, we were told by the management team that all staff were responsible for ensuring activities were undertaken. In house activities were advertised on the notice boards in the corridors of each floor. However, we noticed the previous week's activities planner was still on the notice boards, the deputy manager told us, "I have this week's planner ready, but I am unable to print it yet as our printer is not working". On the morning of the first day of inspection we saw four people browsing newspapers between two floors and one member of staff having a conversation with two people, and in the afternoon, we observed no structured activities going on, even for those who were confined to bed. However, we did see a small group of people actively participating in the garden, planting flowers. We found this staff member had volunteered on their day off to provide this support.

We viewed the floor management file on each of the three floors. This recorded what activities people had been involved with. These records were sporadic and pre-populated with weekly activities that were planned. We were aware of three people being cared for in their bedrooms had nothing recorded to show whether they were physically and cognitively stimulated.

Activities within the home were minimal and people therefore lacked social stimulation as there was not enough staff available to meet social needs as well as personal care needs. We spoke with people who used the service about the activities they received. Comments received from people included, "There is not much to do, not really, sometimes there is a group who comes to sing, but they are playing some 'youngish tunes' and I don't want to feel young, it's just not for me", "I can't be bothered worrying about what to do anymore, I made peace with staying in here all by myself, sometimes my nephews and nieces come to visit me, it makes a change", "I don't do nothing, can't do nothing really, except watch telly", "I wake up, clean myself, have breakfast and maybe read a newspaper or do some puzzles", "Sometimes we play cards and do some exercises", "I like going to the pub, it does not happen often enough", "I just watch telly, or go to my daughter's house to see my grandkids" and "I listen to my radio, day or night, that's all I do."

We also asked staff for their thoughts on the activities on offer. Comments received included, "As you can see today we are trying to keep the clients entertained, but this is not the norm. We rarely have the staff and we have been told by the managers to make sure people are occupied while CQC are here", "We have no budget for activities. We have the pub on the third floor, but we struggle to replenish the drinks due to the lack of funds. Staff do an awful lot to keep this going" and "The activities have gone downhill over the last six months."

There were no activities specifically designed for people living with dementia. Staff told us there were no trips organised outside the home as there were not enough staff to support these.

During the inspection the district manager informed us the provider had recruited a new district wellness co-ordinator and they will project manage seven Anchor homes across Manchester. Anchor is embarking on a fundamental change to how activities are delivered, moving towards a whole team approach. To facilitate this, the provider confirm six staff will be trained in various aspects of delivering activity, including physical exercise and the use of the iPad. The home will also be involved in the Anchor Inspires programme which involves a number of colleagues being trained as Dementia Champions who will then work on a project to enhance the service for customers living with dementia. Although we can see a plan was in place to improve the activities, the provider had failed to sustain previous improvements which impacted on people's social stimulation.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were end of life plans in place, which included people's preferences with people's preferred funeral arrangements, family members to contact and where would they like to stay during the final stages of their life. The home had the support of healthcare professionals to advise and support when they were caring for a person at the end of life. The home continued to be accredited with the Six Steps end of life care programme. The Six Steps is a nationally recognised programme for supporting people and their families about making advanced decisions about the care they want at the end of their lives and their wishes after death.

However, we viewed the care plan for one person who was in the final stages of their life. We found no end of life care plan or preferred priorities in place for this person. This was disappointing considering the home

was accredited with the Six Steps end of life care programme. Shortly after the inspection the providers action plan confirmed this person's care plan had been updated to reflect their current needs.

The service had appropriate systems in place for the investigation of any complaints received. Information about the complaints policy was readily available to people and visitors in the reception area of the home. Records showed that where complaints had been received these had been fully investigated by the previous registered manager and that the service aimed to use any complaints received as opportunities for learning and to improve the service's performance.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post for approximately two months at the time of this inspection. On the second day of inspection the manager confirmed he had received confirmation of his registration with the Care Quality Commission (CQC). Throughout this inspection people, relatives and staff offered positive feedback about both the manager and the deputy managers supporting the manager.

The number of shortfalls that we found during this inspection indicated quality assurance and auditing processes had not been effective. There was a lack of suitable and effective quality assurance and governance systems operating at the service. The provider had not ensured the quality of service had improved to a level that was acceptable and did not breach the Regulations. Despite some improvements, we continue to find breaches of the regulations and concerns throughout the report.

The provider's assurance systems had not identified that staffing levels needed to improve to ensure better experiences for people using the service. We found the service was not staffed in line with the provider's expected basic number. They had not ensured they deployed enough suitably qualified, competent and experienced staff to meet the regulations. For example, audits in respect of people's dependency levels and call bell response times were not being completed or used to help determine the number of staff required to keep people safe and meet their needs. Staffing was not therefore, constantly reviewed and adapted to respond to changing needs and circumstances of people living at the service. As a result, people's experience of the service was being negatively impacted and people were not able to have control of their care or always assured care was caring, personalised and timely. People's care had to fit around the staff routines.

We viewed the district manager's monthly 'compliance visit record checks', this highlighted the findings found and what action was needed to rectify any issues that had been identified. We looked at the most recent compliance visit, which was in June 2018. The compliance visit check looked at similar key lines of enquiry used by the CQC and when areas were identified an action plan was devised for the registered manager to follow. However, this compliance record failed to pick up on the shortfalls we found in respect of staffing levels, inconsistencies in care planning and the lack of progress in activities.

Although staff stated they felt they could approach the manager, staff also said they did not always feel valued and heard by management and the provider. Staff shared with us concerns about the quality of peoples' care and their ability to ensure changes took place. Staff told us they raised particular concerns with management, only for changes to not take effect or feel they would be treated negatively for speaking up. One member of staff said, "I told the [managers name] we had issues at the home with staffing levels, but they didn't listen and of course nothing has changed" and "I feel this home could be great, but we are constantly not being listened to and I feel the team's morale is very low, many good staff have left."

Over the past three inspections of this service we have found several breaches of the regulations since 2015. We found the same or similar breaches in regulations where the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service

due to the lack of reliable and effective governance systems in place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people, relatives and staff if they were asked for their views on the service and given opportunities to make any suggestions for improvement. For example, this can be done via meetings and questionnaires. People we spoke with told us they had attended a recent relative meeting, but some felt the next meeting needed to be brought forward as three months was too far in advance. We provided this feedback to the manager.

The registered provider continued to ensure the ratings from their last inspection were clearly displayed in the home and on their website.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that appropriate activities for people's age, abilities and interests were organised and provided. There was also a failure to ensure care plans people's care plans met their current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems in place failed to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff employed at the service to ensure people's care needs could be met.