Care Quality Commission

Avery Homes (Nelson) Limited

Elvy Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
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

Overall summary

This inspection was carried out on 15 June 2015. The inspection was unannounced.

Elvy Court is registered to provide Accommodation and nursing care for up to 55 older people, including people living with dementia. Accommodation was provided on two floors, with a passenger lift providing easy access between floors. People had a variety of complex needs including dementia, mental and physical health needs.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated Regulations about how the service is run.

Avery Homes (Nelson) Limited took over the provision of regulated activities at Elvy Court Nursing Home in November 2014. This was our first inspection of the service under the new provider.

Avery Homes (Nelson)

Before our inspection we received information of concern from the local authority safeguarding team, a member of

Summary of findings

the public and a whistle blower. During our inspection most people made complimentary comments about the service they received. People told us they felt safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. There were mixed views from relatives about the service.

Systems to assess, monitor and improve the quality and safety of the service or identify and manage all the risks to people's safety were not effective. Where shortfalls were identified during audits by the manager, action was not taken in a timely manner to improve the quality of the service. Staff understood how to safeguarded people from abuse.

People did not always receive their medicines as prescribed. Medicines were not always stored securely to ensure people's safety.

People's privacy and dignity was not respected because bedroom doors were left open throughout the home when people were in bed or in their rooms. There was no evidence that people were consulted about this practice.

People and their relatives felt there were not enough staff deployed in the service. People were left unsupervised for periods of time in communal areas. The provider did not have a clear system to assess how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times.

People and their relatives were involved in planning their care. Care plans were personalised to make sure staff knew how to care for people's physical, emotional and social needs. People were provided with opportunities to take part in a range of activities. Care plans were reviewed and updated regularly to make sure staff had up to date guidance about how to care for each person.

Staff felt well supported by the management team. New staff received induction training. All staff had essential training and opportunities for additional training. Each member of staff had an annual appraisal to assess their performance and any further training needs. Staff told us they received regular supervision.

People were complimentary about the food and were provided with enough to eat and drink. Choices of menu were offered each day. Some improvement was needed at mealtimes to make sure people were offered choices in ways they could understand and had as much control as possible over the content of their meals and portion sizes. We have made a recommendation about this.

There was a system for managing complaints about the service. People felt they were listened to and knew who to talk to if they were unhappy about any aspect of the service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Guidance in the Mental Capacity Act 2005 was not always followed to make sure people were safe when they made decisions that were not in their best interest.

Staff were kind and caring in their approach and had a good rapport with people. The atmosphere in the home was calm and relaxed and there were lots of smiles and laughter.

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and were complimentary about the care their relatives received. People were consulted through residents and relative's meetings and their views taken into account in the way the service was run.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe

Risks to people's safety and welfare were not always managed to make sure they were protected from harm.

People's medicines were not managed safely.

There were not enough staff deployed in the home to meet people's needs. Staff understood how to safeguard people from abuse.

Safe recruitment procedures were followed to ensure staff were suitable to work with people.

The provider did not provide the information we requested to evidence that recruitment procedures were safe.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Not all staff had received training in the Mental Capacity Act 2015 or Deprivation of Liberty Safeguards to enable them to support people effectively who made decisions that were not in their best interest.

Staff had the essential training and updates as required. Staff had annual appraisals and were supervised and supported to carry out their roles.

People's independence and preferences were not promoted effectively in the way meals were served. People were complimentary about the food and received enough to eat and drink.

Is the service caring?

Requires improvement 

The service was not consistently caring

People's privacy and dignity was not always protected.

People or their representatives were involved in planning their care.

Staff were kind and caring in their approach or supported people in a calm and relaxed manner.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Complaints were managed effectively to make sure they were responded to appropriately.

People's care was planned in a personalised way.

Summary of findings

People were provided with a choice of meaningful activities and supported to maintain their relationships with people who mattered to them.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Quality assurance systems were not always effective in recognising shortfalls or acting to address them in a timely manner.

Records relating to people's care and the management of the service were not well organised.

People were satisfied with the service they received and their views were taken into account in the way the service was run.

Elvy Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 15 June 2015 and was unannounced. This was a comprehensive inspection to look at how the provider was meeting the regulations relating to the fundamental standards of care. This was the services first inspection since they registered with the Commission.

The inspection team included three inspectors and an expert-by-experience who had personal experience of caring for older family members. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information from the local authority and a whistle blower.

During our inspection we observed care in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We examined records including staff rotas; 10 staff files, management records and care records for eleven people. We looked around the premises and spoke with 10 people, nine relatives, three nurses, four care staff, the activities coordinator, the deputy manager, the registered manager and the regional support manager. We also spoke with two health and social care professionals who were visiting people at the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. People said, "I am safe. I've got all I need for peace of mind here" and "I do feel safe". Relatives told us, "He is very safe here, no problem there", "I don't worry so much about her anymore", "He is safe here, of course he is" and "He is very safe here, no problem there".

Each person had individual risk assessments which covered most aspects of their daily lives. Guidance included in the risk assessments was not consistently followed to ensure people were safe.

We observed one person, who was nursed in bed, had moved position so that one of their legs was over the bedrails. We alerted staff to this and they repositioned the person so they were safe. Later we observed the person had both their legs over the bedrail. Although the person's door was wide open this was not noticed by staff who walked past the person's room until we alerted them. This person's mobility risk assessment showed they were at high risk of developing pressure ulcers and instructed staff to check them regularly. Their falls risk assessment showed they were at high risk of falls and should be checked every two hours. This person's position change charts showed gaps of three to four hours and there was no record of any checks between 06:00 and 12:40 on the day of our inspection. This meant that the person was not protected from risk of harm and potential entrapment within the bedrails

We observed one person eating their lunch whilst lying flat on their bed which placed them at risk of choking, they were coughing between mouthfuls. We alerted staff who asked the person if they wanted to sit up but the person preferred to lie flat whilst eating. This person's relative told us, "I know (the family member) eats in this position, it is what she wants". There was no risk assessment in the person's file relating their choice to eat in this position and the person was left unsupervised while they ate their meal. This person was not protected from the risk of choking.

Accidents and incidents were recorded. Records showed that action was taken as a result of accidents and incidents although this was not consistently effective. Where ongoing risks were identified such as the risk of people falling, specialist advice about how to minimise the risk was sought. We spoke to the fall specialist from the local falls clinic who had been asked to advise and assess a person who was identified as at high risk of falls and had fallen. The falls specialist told us that this person needed 15 minute observations as they were at serious risk of falling. The falls specialist told us they had been unable to find any clear records of checks or any review of the person's medication, which could be impacting on their safety. This meant the person was not protected from risk of injury through falls.

The examples above showed the provider was not assessing or mitigating risks to people's safety effectively. This was a breach of Regulation 12 (2) (a) & (b) & (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were well supported with their medicines. One person said, "I get my tablets regularly". People's individual medicine records were generally up to date, although a few gaps were evident. The medicine record for one person, who was at high risk of developing pressure ulcers, showed that their prescribed cream was not being applied to protect their skin. The nurse who was responsible for the medicine round during our inspection told us the cream had not been supplied by the pharmacist when the last order was delivered. The nurse had not contacted the pharmacist to chase this or enquire if it was still prescribed.

Medicines were not stored safely at all times to make sure people were protected from risk of harm. During the lunch time medicines round there were two medicine trolleys in the area outside of the dining area. A nurse was observed dispensing medicines into two individual pots. One pot was taken to the dining room and given to a person whilst the other pot was left on the trolley unattended. The nurse retuned and sat at the nurse's station completing some paperwork. The pot of medication was still left on the trolley and was unattended for over 5 minutes.

The nurse who was dispensing medicines wore a tabard requesting that they should not be disturbed during the medicines round. During the round they were asked by another member of staff to assist them in supporting a person. The nurse went to help, interrupting the preparation of one person's medicines and leaving the medicine trolley unlocked and within reach of people who walked by.

Inadequate

Is the service safe?

The examples above showed the provider was not managing people's medicines safely. This was a breach of Regulation 12 (2) (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When medicines were not in use they were stored securely in a locked trolley in a clinical room Medicines that needed to be kept cool were stored appropriately in a locked refrigerator. There was a chart to record the temperature for the refrigerator and clinical room daily.

Accommodation was arranged over two floors. People with dementia and nursing needs lived on the first floor. People with general nursing needs lived on the ground floor. There are two nurses deployed on the first floor throughout the day and one on the ground floor supported by a team of care staff. At night there was a nurse and two care staff on each floor.

We observed that staff were very busy. They did not spend time with people unless they were helping with a task. There were periods of time when people were left unsupervised in communal areas. Three people in the first floor lounge over the lunch period were left alone for over 30 minutes. Three people were waiting in the lounge to be transferred from their wheelchairs to armchairs. We also observed people calling out for staff from their rooms and having to wait for staff to be free to attend to them.

People commented on the time it took staff to respond to call bells. They said, "Within 10 minutes, there is someone on duty", "There's plenty of help. She says see you in a minute, but it's a long time", "They usually come within five minutes to help" and "It depends on when I press it. Usually more than five minutes, I know they are busy". and "They can't be everywhere at the same time and they can only do their best. When I need help, it is there".

One person told they had called for help which had not arrived, "I needed help, so after 10 minutes I pressed it again. Then I had to call out and eventually, they came. They said I had picked a bad time of day. It was not terrible, but upsetting. It is. A rarity, it is usually only five minutes",

Relatives told us, "If we ring the bell ourselves it takes about 10 minutes", "There are probably not enough of them", "When they have time, they stop and chat, but there are not enough of them", The falls specialist told us that they had let staff know that the person they were assessing needed the toilet during their visit but they were still waiting when the specialist left.

Staff said they did not often have time to sit and talk to people because they only had time to attend to people's immediate physical care needs. Staff told us that the home often used agency staff to supplement the employed staff on duty. There was an active programme to recruit new staff. There was no measuring tool showing the level of care and nursing people needed that was used to determine safe staffing levels. This meant that the provider could not demonstrate that there were sufficient staff deployed to meet people's needs.

The examples above showed the provider was not deploying sufficient numbers of staff or taking a systematic approach to determine the number of staff required to meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people made positive comments about the cleanliness of the service. One person said "It looks like a hotel and they clean it every day". Some relatives commented about stained bedding, having to clean dirty bedrails, furniture not being cleaned and marks on walls. Other relatives told us they had noticed an improvement in the cleanliness of their family members' rooms in the last few months. The falls specialist commented that floors and carpets were 'sticky' which increased the risk of falls.

Most areas of the service were clean and tidy. However there were some areas that were not hygienically clean which meant people were at risk of infection because the provider had not assessed or taken action to mitigate the risks to make sure that people were protected from the risk of infection. The majority of bathrooms and toilets did not meet acceptable standards of cleanliness to ensure people who used them were safe. Walls and floors in these areas were damaged, exposing porous surfaces, which meant they could not be cleaned effectively. Lime scale had built up around some taps and sinks, including the sink in the room where medicines were stored. The undersides of chair lifts in baths were dirty. A mattress and been washed in one of the bathrooms people used and was left standing in the bathroom. Another bathroom did not have a foot operated bin for the disposal of soiled items.

Food was prepared in the main kitchen and taken to the dining areas on heated trolleys. Food temperatures were checked and recorded. The heated trolley on the ground floor was parked in the corridor outside the dining room and food was served there. This area was a main

Inadequate

Is the service safe?

thoroughfare. There was no facility in this area for chilling foods or drinks and some cold foods were left out for more than an hour. The provider had not risk assessed the use of this area for serving food to make sure it was safe and people were protected from risk of infection. Best practice was not being followed in accordance with the Code of Practice for health and adult social care on the prevention of control of infections and related guidance.

The examples above showed that people were not protected from the risk of infection. This was breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider operated safe recruitment procedures to ensure that suitable staff were employed to work with people. Staff told us that they were required to complete an application form and attend an interview as part of the recruitment process at the home. We reviewed the files of three staff who had been recently recruited by the provider. These contained evidence that identity and Disclosure and Barring Service (DBS) checks had been carried out, employment histories had been checked and references had been received.

People were safeguarded from abuse. Staff confirmed they had completed safeguarding training and it was updated regularly. Staff understood the signs of abuse and were able to describe the different types of abuse. There were posters in staff areas giving guidance to staff in how to report a case of suspected abuse. This included contact details for the local safeguarding authority. Staff were familiar with these procedures. They told us they felt confident that the management team would deal with any cases of suspected abuse swiftly and appropriately.

Procedures were in place to ensure people were safe in the event of an emergency. Staff were aware of the procedures and knew what to do and who to report to. Each person had a personal emergency evacuation plan. Fire safety equipment was in place and checked regularly. Regular safety checks were carried out on gas and electrical equipment and installations. The provider had an action plan in place for planned refurbishment and maintenance of the premises.

Requires improvement

Is the service effective?

Our findings

People were complimentary about the staff. They said, "They are all very helpful here" and "They are all right here". Relatives told us, "They are all friendly, helpful, trained staff here" and "They are really good here". One relative said, 'The staff are much better now than 6 months ago, but all the best ones are going. The newer staff have had lots of training".

Where people made decisions that were not in their best interest, such as eating in an unsafe position, there was no mental capacity assessment relating to these decisions and no evidence that relevant health or social care professionals had been consulted to make sure that their best interests were fully considered. Staff did not fully understand the principles associated with the Mental Capacity Act 2005 when supporting people who made decisions that may be to their detriment.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People on the first floor at the service were living with dementia and were not always able to make decisions for themselves. The first floor was locked which meant people could not go outside or to other floors without supervision. We saw evidence in people's care files that applications had been made to the local authority in accordance with DoLS guidance to make sure no one was deprived of their liberty without authorisation from the relevant authority.

The provider had not carried out the planning and delivery of care in accordance with the Mental Capacity Act 2005. Regulation 11 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received essential and additional training. There were two training co-ordinators; one nurse and one carer, who had been specifically trained to deliver training to their colleagues. There was a training schedule that recorded when staff received training and when refresher courses were due. Staff told us that the training they received was good.

Most staff had received dementia awareness training but not in-depth training to help them to effectively support the specialist needs of people who were living with dementia. Some staff told us they had received training in the Mental Capacity Act 2005. Due to their condition some people exhibited behaviours which posed a risk to themselves or other people. Staff told us they had some training in managing challenging behaviour and we observed they managed these behaviours effectively.

New staff underwent an induction programme that included an orientation to the service and essential training such as fire safety, health and safety, moving and handling, and safeguarding. Their knowledge was tested to make sure they were competent to begin working with people. Following their classroom based induction, new staff shadowed experienced staff colleagues before working on shift in the home in a supervised capacity. At the end of their first 12 weeks their competency was assessed before being able to work on their own. New staff were supported to study for the Care Certificate. This is a qualification awarded by Skills for Care to staff who have demonstrated competence to care for people.

Staff received an annual appraisal to assess their performance and identify any additional training or support they need to fulfil their roles. The Activities Coordinator told us about their appraisal and felt that sufficient training had been provided to enable them to offer meaningful activities to people. This included dementia training and also activities in dementia'; palliative care and 'the use of life stories. A further three day course had been booked specific to the activities coordinator role and the activities coordinator had been able to spend time at another service to look and learn from the activities provided for people there. Staff told us that they received regular supervisions of their work and that they felt well supported by senior staff and managers.

People told us they were satisfied with the way their health care needs were met. They told us about doctor's visits from GPs, physiotherapists. Most relatives were satisfied with the health care. They said, "They phone if (the family member) is unwell. Sometimes they can be a bit slow to respond", "When (the family member) is unwell, they tell me", "(The family member) has been quite well here, much better than at home", "Doctors when (the family member) needs them" and "(The family member) had a bad infection, there was always a doctor here to see him if there were any changes and they always let me know".

Nurses at the service monitored people's health and provided treatment, with advice and support from other health care professionals as needed. People were referred

Is the service effective?

to external health professionals when they needed additional support with their healthcare needs. These included the stroke team and the falls team for advice about causes and how to minimise the risk of falling.

People also saw speech and language therapists, dieticians, podiatrists, physiotherapists, opticians and dentists.

A health worker from the stroke team who was visiting people told us they were satisfied with the health care people received. They told us staff followed their advice and worked well with them to make sure people received the care and support they needed.

People made positive comments about the food. They said, "The food is fine", "Pretty good, not

100% but pretty good. I can always have another helping", "There's plenty to eat" and "The food is very, very good indeed". Most people ate independently, one person told us, "There's plenty of water here, and hot drinks", and "We can have drinks in the lounge. Tea and coffee is as and when you want it and there's alcohol to celebrate a birthday" and "They always fill the water when they come in".

People's nutritional needs were assessed using a nationally recognised tool and action was taken where people were identified as at risk of malnutrition and dehydration. Fortified foods were provided to boost people's calorific intake when needed. People were weighed regularly and food and fluid charts were maintained to where necessary to ensure that people who were at risk had enough to eat and drink.

People were supported appropriately when they needed assistance and staff were attentive to their needs during mealtimes. We observed the lunchtime meal in the dining rooms. Food looked well-cooked and appetising. People who were living with advanced dementia were not offered choices of meals in ways they could understand. Although there were no printed menus or pictures of meals to assist people who were living with dementia to choose their meal, staff were quick to respond when one person rejected the meal they had originally ordered and requested an alternative. The alternative meal was quickly supplied by the kitchen. People were offered a choice of cold drinks and these were shown to them before the meal was served so they could choose which they wanted.

Staff knew who required special diets for conditions such as diabetes. However, this was not recorded on the daily food sheet where people's meal choices were written and relied on staff who were serving meals to remember. This put people at some risk of being given the wrong diet if staff serving food were not aware of their special requirements.

The environment and equipment was suitable to meet the people's needs. Corridors were wide, with hand rails for people to hold on to. There are two lifts to enable people to move easily between floors. Signs assisted people to locate toilets, bathrooms and communal areas. Suitable equipment was provided to assist people who needed it. This included mobility and stand aid hoists to assist people who were not able to move independently. There were assisted bathing facilities. We observed that pressure relieving cushions and mattresses were also in use to make sure people were comfortable and protected from risk of injury. Staff told us that pressure relieving equipment was obtained quickly when needed, to protect people who were at risk of developing pressure ulcers.

Requires improvement

Is the service caring?

Our findings

One person told us, “It’s all right. A couple of the girls I like. The rest are foreigners, they talk in their own language if they don’t want you to know anything. I am not always happy with the care.” A relative told us they sometimes found their family member wearing other people’s clothes, “I just say this to them, though, and they take them away. At least they are all clean but I wish it didn’t happen”. Another relative told us how they had found their family member “Dressed in a ripped tee-shirt, which was disappointing”.

People’s bedroom doors were all left open throughout the service which meant that anyone walking along corridors could look into their bedrooms; this did not protect people’s privacy or dignity. A member of staff told us, “Doors are open so we can check them”. There was no record in people’s care plans of discussion about whether people wished to have their doors open or closed. A cleaner, did not knock before entering a person’s room who we were talking with. They left abruptly without apologising for disturbing the person.

The examples above showed the provider was not ensuring the people were treated with dignity or that their privacy was maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they were satisfied with the way staff cared for them. They told us, “They all know me and treat me well”; “Some of the staff are brilliant. I know them now. It helps when you know them” and “Nothing is too much trouble. They are proper darlings here. All sociable and nice” Relatives told us the staff were caring. They said, “The staff are very understanding here”, “Really good here, and helpful”, “The staff are all really nice”, “Both the nurse and the carers are brilliant here” and “The office staff are always so nice here. They are caring, too”.

The atmosphere was calm and relaxed and it was evident that staff knew people well and had formed positive relationships with them. We observed people smiling and laughing during their interactions with staff. Staff were kind and caring and respectful towards people. We observed how a member of care staff supported a person who became agitated. They talked quietly and gently to the person in a calm way until the person was reassured. Staff were attentive, they communicated with people in a pleasant and cheerful way. They checked if people needed any assistance during lunch; if they would like more drinks; if they had enjoyed their meals and if they would like any pudding. One member of staff was assisting a person who was nursed in bed to eat their meal in their room. The staff member ensured the person was well positioned, comfortable and covered with an apron. The member of staff did not rush and talked with the person in a patient and cheerful way throughout the meal ensuring that mealtime for them was a pleasant experience.

People’s rooms were personalised with different décor, photographs and personal possessions to help them feel ‘at home’.

People and/or their relatives were involved in planning their care and treatment. People and their relatives told us their care needs had been discussed with them before they moved to the service. They said they had agreed a care plan when they came to live at Elvy Court. Relatives told us they saw a nurse every couple of months to discuss their family member’s care and go through their care plan.

People were supported to maintain their relationships with people who mattered to them. There were no restrictions on visitors to the service. People were able to spend time with their visitors in private in their own rooms or in communal areas. “My visitors tend to overstay, but it’s nice that they can.” A family told us they came in at all different times and were always made welcome. Other visitors told us, “We were always made welcome here, whatever the time, and even late in the evening”, “No restrictions on when we visit”, “I feel welcome here. I haven’t heard of any restrictions on visiting at all” and “They give you a cup of tea”.

Requires improvement

Is the service responsive?

Our findings

People told us, “They do have activities, but I choose to stay in my room” and “There is always something going on. I play bingo”. One relative told us how their family member liked to wear makeup, “They (staff) help with this. They take her to the lounge too, to encourage her to socialise. The activities lady is excellent with her”. Another relative said, “They (staff) remember when I have asked to talk to someone”.

Although some people told us that response times to call bells was not always as prompt as they would like. People generally felt the service was responsive to their needs. People had their needs assessed before they moved to in to make sure the service is suitable for them and there are resources available to manage their care.

Each person’s care included a number of care plans relating to aspects of their care such as moving and handling, nutrition, skin integrity, elimination and personal hygiene. Care plans were personalised and also provided some guidance for staff about how to meet people’s emotional, social, and spiritual needs. There was information about people’s preferred routines, lifestyle preferences and likes and dislikes. Care staff maintained a record of the personal care they provided each day. People’s care was reviewed each month and where possible, people/and or their relatives were involved in their reviews.

People were offered choices about where they wanted to spend their time. Some people chose to remain in their rooms. Others preferred to spend time in communal areas. Staff described how they offered people choices if they needed help with decision making by showing them a choice of clothes to wear. Staff were responsive to people, taking time to answer questions and provide support as needed.

People who remained in bed and were nursed in their rooms had some one to one time with the activities coordinator and staff for activities. There were no individual activity programmes to ensure people who were less able to take part in organised activities had meaningful activities which took account of their interests or abilities to promote their wellbeing.

The activities coordinator said told us, they hoped that a volunteer would soon apply for an activities support role as assistance was needed to make sure people were all provided with meaningful activities. They told us that staff were helpful but they had their own jobs to do.

Most people had a document in their individual care file which had provided information about their background and social history. Most people had TV’s and radios in their bedrooms. There were also televisions and music available in communal areas.

During our visit some people were doing flower arranging. Other people were looking at newspapers. Another person was playing a game of cards. The activities coordinator told us about the activity programme. The programme was flexible and included current affairs and reminiscence, bingo and regular coffee mornings the weekly ‘pat dog’ visit and a singer who was booked for later in the month. A relative praised the work of the activities coordinator and described recent outings to a fish and chips shop and the pub.

Most people were satisfied with the service and told us they had no complaints. People knew how to make a complaint if they had any concerns about the service. People were clear that they would speak to the manager. The complaints procedure was displayed in the reception area of the service. The manager told us there had been no complaints about the service.

Requires improvement

Is the service well-led?

Our findings

People spoke positively about the service. A relative told us they would be happy to recommend the service to anyone. Another relative said they thought the new organisation was more open and felt their values were more around person centred care. A third relative was disappointed that fees had gone up even though they had been told this would not happen.

The registered manager told us they had a system in place to regularly assess and monitor the quality of the services provided to people. We looked at the medicines audit; there was no improvement plan to address shortfalls identified in the audit. There was an improvement plan developed by the provider which identified some shortfalls in safety standards we found during our inspection. The regional manager confirmed that work was in progress to address these issues.

Systems to manage risks to people's safety were not effective and had not identified areas of risk we found during this inspection. Individual risks to people's safety were not properly assessed such as a people who were at risk through choking or injury because they were not monitored effectively. This meant that staff did not have the information and guidance they needed to mitigate these risks. People were also at risk because medicines were not kept secure and one person did not have the medicine they needed. There was a risk of infection because some areas were not clean. Other areas could not be cleaned effectively because of lack of maintenance or the premises. A senior manager contacted us after our inspection to tell us that work on refurbishing bathrooms and toilets was scheduled to start in July 2015.

The examples above show that people were not protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems. This was a breach of Regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team and staff were in the process of changing and updating records into new formats used by the new provider. This meant that policies and procedures such as the complaints policy were not up to date or accurate because they did not show information about the new provider. Some people's care plans had been updated using new forms. Other people's records had not yet been updated. This meant that staff were working with two different kinds of care records. Staff told us they found this difficult but they had not had time to update everyone's care records.

People who were at risk from pressure ulcers had positional change charts but the frequency of positional changes was not stated on the charts. Charts were not completed in accordance with instructions in people's risk assessments to make sure they were protected from harm.

The provider used resident and relative's meetings to communicate about changes at the service. A relative said, "There's another meeting due soon. I've been to one". There were open letters in the reception area informing people and their relatives about the change in the management team.

Staff had been provided with opportunities to meet the new management team. Staff told us about the induction they had when the new provider took over the service. Staff felt this gave them an understanding of the leadership and management structure and corporate values which were applied to the service.

The provider's statement of purpose set out their values and how they were applied to the service, putting people first was a stated priority. People were asked about their views through surveys and meetings. The latest survey in April 2015 covered topics such as meals, housekeeping and laundry, furnishing and communication. The results showed that 75% of people rated the service as good; very good or excellent and stated they would recommend Elvy Court to a friend or relative. The results of the survey had been evaluated and the provider had drawn up an action plan.

Regular staff meetings were held to make sure staff were kept up to date with changes in the service. Staff told us that managers were approachable and that they were able to talk to managers whenever they wished.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risks to people's safety were not being assessed or mitigated effectively.** **Regulation 12 (2)(a) & (b)** **People's medicines were not managed safely.** **Regulation 12 (2)(f) & (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider was not ensuring the people were treated with dignity or that their privacy was maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People were not protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems.** **Regulation 17(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not carried out the planning and delivery of care in accordance with the Mental Capacity Act 2005.
	The provider was not deploying sufficient numbers of staff or taking a systematic approach to determine the number of staff required to meet people's needs.