Care Quality Commission

Anchor Trust

Orchard Court

Inspection report

East Grinstead Road
Lingfield
Surrey
RH7 6ET

Tel: 01342834444
Website: www.anchor.org.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 March 2018 and was unannounced.

Orchard Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Orchard Court accommodates 63 people in one adapted building. At the time of our inspection there were 52 older people living at the home, some of whom were living with dementia.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager, who had previously been the registered manager at another of Anchor Trust's services, had commenced in January 2018 and had applied to become registered manager. The new manager (manager) assisted us in our inspection.

Medicines management, infection control and safeguarding processes were not suitably robust. We also found at times staff were not always deployed across the service in a way which meant people received consistent attention. At the end of our inspection the manager and provider's senior management told us an increase in staffing levels had been approved. Gaps in some people's care records meant staff may not be using the most up to date information about a person.

People were supported by staff who knew them well and they got along with. Staff displayed kindness, care and empathy towards people and showed people respect. People were given attention by staff and staff adapted their approaches in response to individuals dependent on their need.

People had access to activities both in communal areas and within their individual living areas. Although no one was on palliative care there was evidence that staff discussed people's end of life wishes with them.

People were cared for by staff who had gone through a good recruitment process and in the event of an emergency there was information and equipment in place for safe evacuation. People's risks were identified and action taken in response to these. The manager reviewed accidents and incidents and as such had taken action to help reduce reoccurrence.

People's legal rights were protected because staff were aware of the principals of the Mental Capacity Act (2005). The home environment was adapted for people living with dementia and people's needs were assessed before moving into the home.

People had access to healthcare professionals where required and staff followed national and local guidance to provide effective care. People told us they liked the food that was prepared for them and their

dietary needs were met. We also found that people were being cared for by staff who had access to a range of training to support them in their roles.

The manager had a clear vision for the service and had already started to make a positive impact on the care people received. However, this needed to be sustained and audits being carried out embedded to demonstrate continued improvement.

Staff felt supported by management and took part in staff meetings. There was a good culture within the staff team. People told us they liked the new manager and felt he was visible around the home. This was confirmed by our observations on the day.

People were involved in the running of the home and any complaints or suggestions were listened and acted on. Staff worked alongside other agencies to improve the quality of people's care.

During our inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made a recommendation to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines management, infection control and safeguarding processes were not suitably robust.

Staff were not always deployed in a way which meant people received care and support when they needed it.

Good recruitment processes were carried out and there was information and equipment in place in the event of an emergency.

People's risks were identified and action taken in response to these. The manager reviewed accidents and incidents and as such had taken action to help reduce reoccurrence.

Is the service effective?

Good

The service was effective.

People's legal rights were protected because staff were aware of the principals of the Mental Capacity Act (2005).

The home environment was adapted for people living with dementia and people's needs were assessed before moving into the home.

Staff had access to a range of training courses to support them in their roles.

People liked the food that was prepared for them and their dietary needs were met.

People had access to healthcare professionals where required and staff followed national and local guidance to provide effective care.

Is the service caring?

Good

The service was caring.

People were supported by staff that knew them well and they got along with.

Staff involved people in their care and enabled them to remain independent.

People were treated with respected and dignity and people were provided with empathetic and attentive care.

Is the service responsive?

Good

The service was responsive.

People had access to activities both in communal areas and within their individual living areas.

People's care plans contained information about people's individual needs. However, gaps in record keeping meant staff may not be using the most up to date information about a person. Although no one was on palliative care there was evidence that staff discussed people's end of life wishes with them.

People knew how to raise a complaint.

Is the service well-led?

Requires Improvement

The service needed the continued good leadership from the new manager to ensure it was consistently well-led.

The manager had a clear vision for the service and had already started to make a positive impact on the care people received. However, this needed to be sustained and audits being carried out embedded to demonstrate continued improvement.

Staff felt supported by management and took part in staff meetings. There was a good culture within the staff team.

The manager involved people in the running of the home and listened and acted on people's feedback.

Staff worked alongside other agencies to improve the quality of people's care.

Care Quality Commission

Orchard Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 14 March 2018 and was unannounced. The inspection team consisted of three 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.

We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. 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 PIR prior to our inspection to see if there were any areas in particular we needed to focus on during the day.

As part of our inspection we spoke with nine people and two relatives. We also observed the care that people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not tell us about their experience directly. We spoke with the manager, the activities co-ordinator, chef and 13 care staff. We read care plans for eight people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We also looked at three staff recruitment files and records of staff training. We saw records of quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff, people and relatives.

Our last inspection of Orchard Court was in February 2016 where the service was rated 'Good' overall with no breaches of the legal requirements.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Orchard Court. One person said, "I feel safe because of the staff. We are never really alone here." Likewise a relative told us, "If anyone can keep her out of hospital as much as they have it must be safe." Another said, "This is the ideal place for mum. I know that she's safe and happy here."

Despite comments we received from people we found some issues across the home that related to medicines administration, record keeping, escalating safeguarding concerns and deployment of staff.

Although staff had received training in safeguarding, they were not always able to recognise signs of potential abuse. We read in three people's care plans notes which recorded potential abuse. These related to one person slapping another person's hand, another person grabbing someone by the wrist and a third person reporting money missing. We asked the manager when they would expect to be told about potential safeguarding concerns and they told us, "Immediately." However, although the latter concern had been reported to a team leader in the morning, by the end of our inspection this had not been fed back to the manager and as such they were unaware of it. We had also not received notifications from the service in relation to the first two instances. Furthermore, we asked a staff member what they would do if they found unexplained bruising on someone. They told us, "I think it would need reporting, rather than it being a safeguarding."

One person told us, "I know what my medicines are for as I have been taking them for years." Another said, "(Medicines) yes, and it's on time – very much so." However we found that people's medicines may not always be managed safely. Each person had a Medicine Administration Record (MAR). This displayed a picture of the person although we did note one person's photograph was taken in 2014. It is important to have up to date photographs for identification purposes. We also found gaps in some people's MARs, notations that did not follow the correct MAR coding and some people who did not have protocols in place for their 'as needed' (PRN) medicines. PRN protocols are important, particularly with people living with dementia, as they give guidance to staff on what to look out for in a person to indicate they may be in pain but cannot express this verbally.

We also found that medicine patches did not have a body map to record which areas of the body they were placed. A staff member said that they wrote on the patch when it was applied with their signature. People who are on medicines patches should have had an application record completed (TPAR) which evidences removal as well as administration of patches. The site of administration of patches should be rotated and recorded on the TPAR as putting a patch on the same site can affect someone's skin. In addition, without a TPAR if a patch fell off staff would not know which part of the body a new patch should be placed.

There was a locked medicines room downstairs where medicines waiting to be returned were stored and we saw there was not an excess of medicine awaiting return. The medicine room was clean and well organised. The temperature of the room and refrigerator was checked on a daily basis and records recorded the temperatures were within safe limits. Medicines were also stored in locked trolleys in each unit. The three

trolleys checked were clean and well organised with each person's medicine clearly labelled. However the temperature inside the trolley was not recorded, and the trolleys seen in living areas were all stored next to radiators. One staff member said they had never been asked to record the temperature, although they told us, "Temperature can affect the medicine." The manager told us following the inspection that thermometers had been ordered for each of the trolleys. They also told us they had met with the team leaders to remind them of their responsibility to carry out regular medicines audits. In turn the manager would carry out spot checks on MAR charts.

Although one person told us, "The place is nice and clean" we found that good infection control practices were not always followed in a way that may help avoid the transfer of infections around the service. We noted the sinks in the sluice rooms (rooms for cleaning soiled equipment) were dry and there were no clinical bins in them. We asked staff where they washed their hands after using the sluice and we were told by one staff member, "I wash my hands in the sink here (pointing to the hand sink in the kitchenette area). It's easier, but I may do it quickly in the toilet if I am passing, rather than walking through areas with dirty hands." Likewise a second staff member said, "I use the sink here (in the kitchenette). It's easier." We also observed a staff member carrying a full urinal bottle down the corridor without gloves on. A staff member told us they wore gloves and aprons and there was always plenty of those. However, they told us, "There is always a shortage of red bags (for soiled laundry) and you have to go and find a housekeeper to get more which takes time."

We received a mixed response in relation to staffing from people, relatives and staff. One person said, "They do work hard, but I don't have to wait if I need help." Another told us, "Daytimes there's enough staff, but then there hasn't been an emergency." A third person said, "I think so (enough staff) if I need them I've a bleeper." However another person, whose care plan recorded, 'bath or shower regularly and wet shave' told us they had not been offered a shower and had not been supported to have a shave (due to staff been rushed). Other people commented, "Enough staff on? No. They're always saying that they're short staffed," "I heard the call bell for next door – it rang for ages. They don't respond quickly" and, "I've had a stroke and if I had another and I press the bell and they don't come that'll be it for me." A relative told us, "I was disappointed to see so many agency staff, but I think it has got better now. However, I don't think having agency staff has affected her care." Another relative said, "Mostly I think they are okay, not enough maybe at weekends."

A staff member told us there was an issue with some staff not wanting to do medicines which meant there were times that they were short of trained staff. They told us, "I have to go and give medicines on other units and they have even called me at home and asked me to come in and give medicines as no one was on that could do it." This staff member added, "There is not enough staff here. It's hard to get good people. We have to have someone on the unit at all times but we can't be everywhere at once." A second staff member said they did not feel there was enough staff on duty and as such it, "Stops you having a good day. On [living area] staff have been in tears because they are working on their own. All people want is a conversation and regular baths and we just don't have time to do it." A third staff member said, "It varies. Sometimes there's plenty but other times not which means we have less time for bathing and socialising if we are on our own. It worries staff and we are concerned people are at risk of falls."

At times during the day we found there were not always sufficient numbers of suitably deployed staff at the home. We were told that 10 or 11 staff would be on duty during the day to cover the seven living areas. Staffing varied in each living area with between one and two staff members. A 'floating' staff member helped across the whole service. In addition, two team leaders were on duty each day as well as the deputy manager and manager. However, we found that on one unit where we were told that two staff were on duty that for a period of one and a half hours only one staff member was present. People in this living area had

higher needs and we saw there was at least three occasions when the staff member left the main lounge area which meant people were unsupervised for a period of time. At lunchtime on this living area one person started coughing. There was only one staff member on duty and they were supporting someone else to eat. The person kept trying to clear their throat. Eventually the staff member went to the person's aid, but this demonstrated that one staff member on their own was potentially leaving people at risk. A staff member told us, "I feel anxious if I leave the room when working alone. I always feel it is unsafe. If people attempt to get up they are at risk of falls." During the afternoon we noticed one person sitting in a lounge area dozing. They had a pressure mat in front of them to alert staff if they got up. We were alone in the room with the person when they awoke and started to stand up. The one staff member was in another part of the unit. When the person, who was unsteady on their feet, shuffled forward they set off their alarm mat. We saw the staff member come into the room and look at the alarm display and heard them say, "Number 5, I don't know where that is" and left the room. Although the staff member did quickly return it meant that this person was left at risk of having a fall because there was not a staff member observing people in the lounge. We read in this person's care plan that they had had three falls already this year, one of which was in the lounge.

During lunch time in one living area we saw a staff member sitting close to someone prompting them to eat. However, this staff member was also prompting another person on a separate table which meant they were changing between the two and as such people did not have the staff member's undivided attention. This was because there was only one staff member on duty. After a short while a second member of staff came into the dining area and although they started to support one person, the first staff member left so again two people were being supported by one staff member. One person's care plan stated, 'benefits from activities such as going outside' however staff told us this required additional staff to enable this. At the end of our inspection the Head of Care Services for Anchor told us they had approval of budgets to increase staffing levels by one and this would commence tomorrow. The Head of Care Services and manager confirmed in writing following our inspection that staffing had increased by one staff member from 15 March 2018.

Impact in some of these areas was low for people. However accumulatively the lack of robust processes in relation to medicines, infection control, safeguarding, record keeping and deployment of staff meant that the provider could not assure themselves people would consistently receive safe care. This was therefore a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had accidents and incidents these were recorded and analysed by the manager. We saw that the manager produced a monthly falls record. This showed the time and location of falls and as such helped them to identify potential trends for people. They told us reducing falls in the home was their priority. One person's falls occurred at the same time each day and generally in the same place and as such staff had been instructed to help ensure this person was engaged in an activity at that time in order to prevent further falls.

Risks to people were assessed and guidance was in place for staff to help reduce the risk to people. One person required insulin for their diabetes and there was a risk assessment in place which set out the potential dangers of them not receiving their insulin and how to mitigate this. Another person had suffered some falls and staff in addition to referring them to the falls team, had installed a motion sensor in their room to alert staff should they get out of bed unaided. Their care plan noted, 'I have a magic eye in place as I have had an increase in falls during the night'. Another person had had several falls since moving into the home and there was clear evidence that this had been followed up by staff. There was a referral to physiotherapy and an alarm mat in their room to alert staff when they got out of bed. Staff were aware of potential risks. A staff member told us snacks were put out in the lounge during the day and they needed to remember to move them out of the way if working alone and leaving the lounge as one person was at risk of

choking.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history, relevant references, medical fitness and proof that people had the right to work in the UK.

Environmental risks had been considered and mitigated. People had personal emergency evacuation plans that provided guidance to staff in the event of an emergency situation. These were personalised. For example, staff had noted that the emergency services should be aware that one person's first language was not English and that they needed someone to walk with them. We observed the necessary equipment to aid evacuation was readily available throughout the service.

Good

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority for all the people who lacked capacity and were unable to leave the service freely. As part of this process mental capacity assessments had been completed which considered what decisions people had the capacity to make. One person was on covert medicines (medicines disguised in food) and we found evidence of a mental capacity assessment, best interests discussion, GP comments and consent and pharmacy guidance on how to give the medicine. However, another person had a motion sensor in their room (to alert staff if they got out of bed during the night) and yet staff had not followed the appropriate processes. The manager had told us at the start of our inspection that they were currently reviewing all care plans in relation to the MCA and as such knew that this person required the necessary documentation.

We observed staff asking people for their consent before carrying out care. For example, during the medicines round we heard a staff member say to one person, "Can I give you your medicine?" Only once the person had said yes did the staff member administer the medicine to them. Where people had capacity we noted they signed their consent to care. A staff member told us, "People can always make decisions if you ask them in the right way."

People were supported by staff who were trained to carry out their roles. A new staff member said, "I had two weeks training. I wasn't just thrown in at the deep end." They added, "Training was good, I've had dementia and health and safety and moving and handling covered all areas of keeping people safe." Likewise another staff member told us, "We have physical and e-learning training to make sure you tart up your skills and don't forget things." Training was tailored to the needs of the people that staff supported. For example, the majority of staff had attended training in 'dementia awareness'. A staff member told us, "I did have a competency check as I give medicines. They watched me on five separate occasions to make sure I was doing it right and we can have more observations if we want."

Staff were also encouraged to progress as well as have knowledge of the fundamental standards of care. One staff member said, "I am doing my Care Certificate" (a nationally recognised set of assessments relating to the care industry)." Another staff member told us they wanted to progress within the organisation. Staff had the opportunity to meet with their line manager on a regular basis. One staff member said, "I have supervision mostly monthly with [staff name]. We talk about everything and they feedback if I need to improve in any way."

People told us that they were happy with the food that was prepared for them. People commented, "It's okay. I was a school cook so I am a bit fussy. We do have a survey that we are asked to complete about the food. I like fish and we do have plenty of it," "The food is very nice. If there's something that you need you ask them. Fruit it freely available," "The food is excellent" and, "Good food – I like my grub" A relative said, "She likes the food." People told us they always had access to fluids. One person said, "There's always a jug in my room and staff encourage me to drink." We observed lunch time in various living areas across the home. In one living area we found the atmosphere was happy with people chatting to each other and staff engaging with people. A staff member told us that on sunny days some people liked to eat their lunch outside.

People's dietary needs were met. Where people had specific dietary needs, these were listed in their care plans and staff were able to tell us which people this affected. The chef was very knowledgeable in relation to people's needs and was able to tell us about one person who had only lived at Orchard Court for two days. They told us if people were diabetic they would put less sugar in their pudding or if the pudding was unsuitable would provide them with fruit. People on a fork mashable or puree diet were offered the same choice of meals and those at risk of weight loss were given fortified meals with full cream milk, cream or extra butter. Snacks were available for people during the day and drinks were plentiful. Where people were being monitored for their weight we saw evidence that people had put on weight or those who had not were being weighed more regularly.

Staff worked together and followed national guidance to meet people's needs effectively. We saw that people on a particular medicine had regular blood tests. A recent medical alert directive had raised concerns about misappropriate use of inhalers and as such staff had requested a review of people who were using inhalers from the GP. We saw one person had a pacemaker fitted and there was national health information entitled, 'Living with your Device' in their care plan.

People's healthcare needs were met and staff supported people to access healthcare professionals and followed best practice guidance. We heard a staff member come and talk to one person about visiting the hospital dental department to sort out their tooth. They were telling the person what would happen and keeping them updated. We saw evidence of people seeing the GP, dentist, optician and podiatrist on a regular basis as well as other professionals, such as a district nurse. The GP practice was located next door to the service and as such there was a good working relationship between staff and them. One person told us, "They take us to have our blood tests and everything else." A staff member said following advice from a district nurse they no longer stored opened insulin in the fridge. They said, "It makes it less painful for the person as the medicine will be at room temperature when it goes into the person's body."

People's needs were assessed before moving into the service and the service was adapted to meet people's needs. We read pre-admission assessments in people's care plans. We read people's wishes around daily routines, mealtimes and interests had been transferred into care plans to guide staff in the delivery of personalised care. A person told us, "I go around the home and I like to look at the old clocks and things that are around" making reference to the objects of interest scattered around the home. We noted large analogue clock faces on walls, memorabilia and other artefacts around the home which were appropriate for people who may be living with dementia. Each person's room had their name on and a picture to help with orientation and there were photographs of people displayed around the service showing them enjoying themselves. The décor was varied and homely.

Good

Is the service caring?

Our findings

People told us that the staff that supported them were caring. One person said, "Staff are very nice and friendly. We take the mickey out of each other and have a laugh together." Another person told us, "Staff are caring and we're well looked after." Relatives were equally happy about the care they observed. One relative told us, "I like the service."

We asked people what the best thing was about living in Orchard Court and what could be better. One person told us, "The company, people (staff) are around all the time and there's also lots to do. I don't think there is anything they could do better for me." Likewise a relative told us, "They keep her safe."

People were supported by staff that they got along well with. We observed staff interacting with people warmly. People looked comfortable with staff and were observed smiling and laughing whilst interacting. Throughout the day we heard staff complimenting people which people responded warmly to. Two ladies came out of the hairdressers and we heard a staff member say, "You hair looks lovely, you both look like a couple of princesses." Both ladies smiled at the compliment. We heard another staff member say to one person, "Your hair looks lovely… did you just go to the hairdressers?" A gentleman had also been to the hairdresser and when they returned to their living area a staff member commented, "Look at that, you look great" to them. In one of the living areas during the morning we heard a staff member discuss a range of topics with people. They chatted about the garden and how it would change as spring came and about hobbies and holidays. It was easy going conversation with the staff member ensuring everyone had the opportunity to contribute.

People were cared for by staff who showed patience and attention towards them. We heard one person ask if they could go to the toilet after everyone had sat down to lunch and staff had started to serve people. We saw a staff member stop what they were doing and patiently accompany this person to the toilet as requested. The post arrived and there was a letter for one person. Staff took it to them saying cheerfully, "You have a letter." The staff member asked the person if they wanted them to open it and if they needed help. The person asked staff to open the letter for them and read it to them. This was done straight away. We heard a relative ask staff about arranging a haircut for their family member and we observed the hairdresser come and talk to the person and their relative about the style and length they wanted. People commented, "Staff are excellent," "Staff are really lovely" and, "I'm quite self-sufficient but they (staff) help out with anyone that needs attention."

People were shown empathy by staff. One person who had recently moved in to Orchard Court became upset during the morning and we observed staff showing kindness and concern towards them. They spent time comforting the person and took them to a quieter part of the lounge, settled them into a comfortable chair and brought them a cup of team. To boost the person's mood the staff member asked them if they were local and chatted to them about the area and where they had lived. They turned to the person's relative and said, "If you need anything at all just let us know." Later on we observed this same person upset and bewildered. A staff member talked quietly to the person saying, "I know this must be a little scary for you right now. We are all here to help you settle." Another person became anxious when they could not find their

shoes and had a doctor's appointment. We saw a staff member spent time with them and reassuring them whilst they got ready to accompany them to the surgery. A third person became upset and a staff member showed kindness and caring telling the person how much they and their family wanted them and eventually managing to get the person to laugh at themselves.. A relative told us, "We had a call last week to say she was anxious. This gave us the heads up to come in on an extra visit, which hadn't the staff phoned we wouldn't have done."

Staff involved people in decisions about their care and people were enabled to remain independent. People were asked about their preferences and wishes when they came to live at the home and these were revisited in reviews. Staff had a good knowledge of people and we observed that staff knew how people liked things done. For example, a staff member prepared hot drinks for three people and knew what drinks they all liked and whether they liked sugar or milk in their drinks. One person came into a lounge area in their nightdress and staff encouraged them to get dressed, however they did not want to. Instead staff made sure they were warm and comfortable and had slippers on. A second person needed the toilet. Staff asked if they could manage on their own and they said they could, however we saw staff check on the person after a while without being intrusive to check they were safe. We saw during the afternoon that staff had set up tables for people to do some planting. However people said they wished to do something else and as such staff cleared everything away and set up an activity that people had requested. One person told us, "I can go where I want in the home and I do!" They told us they had free reign to visit friends around the home in other living areas. Another person said, "Staff are very caring and I am able to make my own decisions about my care." A third person commented, "They encourage me to do what I can for myself. They always leave you something to do which is good."

Staff were respectful of people's privacy and dignity when providing care. Staff were observed kneeling down to speak to people, ensuring that they were at their eye level. Staff spoke in a calm tone and repeated themselves gently when necessary, enabling positive communication with people. Staff were observed knocking on people's doors and waiting for permission before entering. When a staff member noticed one person needed to be changed they discreetly asked the person to accompany them back to their room. One person said, "Privacy is maintained. I cannot make comparisons with another home, but it's very good." A staff member told us, "I treat each person individually and try and encourage them, but respect their choices."

People were enabled to maintain relationships close to them as well as visit and spend time friends in other living areas. A relative said, "We can visit whenever we like and take mum out if she is up to it. I have been involved in her care plan and her annual review is imminent." Another relative told us, "The care home is mum's comfort zone." One person commented, "Visiting is unrestricted and you're not prevented from going out. I go out with friends and family."

Good

Is the service responsive?

Our findings

People had access to a range of activities which included those to meet their spiritual needs. One person said, "I like talking and we do lots of it here." Another person said, "I'm probably staying up here today and then going downstairs later to meet the others." This person liked children and dancing and we saw pictures of them involved in dancing activities. We also confirmed from the activities lead that schools visited most weeks which would be meaningful to this person. A third person commented, "I like to go to the chair Zumba on Tuesday. I do as many of the activities as I can." A staff member said, "Every Sunday four of our ladies walk to the local Catholic church with either a relative or member of staff. A Church of England vicar comes in to the home once a month to give Communion."

We observed one person during the morning in the main lounge sitting by the stereo listening to music. They were smiling and singing along to the songs that were playing. A staff member said, "He loves this type of music." It was nice to see that this person was enabled to sit in another area of the home spending their time in an activity that meant something to them. Later in the morning we observed six people sitting together in a companionable way having tea and finger foods. They were passing the time of day together and clearly enjoying each other's company. In the afternoon nine people were sitting in the main lounge area playing a balloon game. There was a lot of laughter and people were having fun.

We saw an extensive list of activities that took place at Orchard Court and scrap books and photos displayed the outings, activities and entertainment that people had enjoyed. A staff member told us, "We are fortunate to have volunteers that support some of our activities. Some people that volunteer are relatives. We have jumble sales to raise funds for our welfare fund and to support charities. We've had outings to Eastbourne, garden centres, shopping, places of interest and public houses. We celebrate special and themed days." Another staff member said, "We have links with local schools who work with us every week. We've had a mother and toddlers day and the residents loved having the young children around them." We also noticed that Orchard Court had animals for people's engagement, such as a cat, budgies and a guinea pig.

We had a mixed review of the activities on offer to people. Most people said they were happy with what was organised for them, however we received comments that some activities were not appropriate for people and as such they did not join in. A relative told us, "No, there are not enough activities. However how can the activities lead be in seven places at one time? It's impossible." A staff member said, "Yes and no (enough activities). They used to go out more and a bit less is happening now." A further staff member told us, "The activities aren't always suitable. People in this living area like chair exercises and more energetic activities and these are not always available. They're not interested in dominoes or jigsaws so although these are set up each day they are not used." The manager had told us they were aware that activities needed to be developed further and during our inspection they confirmed they had recruited a second activities co-ordinator. This would help ensure staffing capacity to offer people more individualised, meaningful activities.

The manager had told us at the start of our inspection, "You are not going to see brilliant care plans" and we

found this to be the case for some people. People's care plans contained information that related to their needs but information was not always completed or fully known by staff. One person had had a stroke and it was recorded that they requiring a spoon for their food. We asked staff if this person needed any specific cutlery and they told us they did not. During lunch time we found the person struggling to eat their meal because they had been given a knife and fork. This resulted in them dropping their knife on the floor. We suggested to the person that they may be better using a spoon which they did and we observed they were then able to eat their meal. Their care plan also recorded their name incorrectly in places and it also stated, '[name] agrees to two-hourly checks during the night', but their night check record form was blank. Another person was recorded in their care plan as having a visual impairment and as such, 'wears glasses. Staff to ensure glasses are clean'. We asked a staff member where this person's glasses were as we noted they were not wearing them. However the staff member did not know and went to search their room. A third person's care plan had written and highlighted on the front, 'weigh every Saturday. However, we noted this had not happened consistently and the last time the person had been weighed was 24 February 2018. A further person had had a recent decline in health and although staff had responded to this and there was evidence the GP and community psychiatric nurse had been involved, their care plan had not been reviewed. We did read a note that stated, 'decline in appetite, no changes at present'. This was written on 8 February 2018, however their emotional and communication care plans had not been reviewed since September 2017.

We recommend the registered provider ensures the hold contemporaneous records for each person.

Care plans contained information about people in relation to communication, personal care, mobility, sleep and nutrition. There was a separate document which gave information on a person's background such as what they had done as a job, what family they had, their likes, dislikes and interests. One person was noted as, 'likes her daily papers' and we saw this person reading a newspaper. Another person had a catheter and there was a clear care plan in place in relation to this. They were also recorded as 'preferring to lay on their bed as they find it more comfortable' and we observed this person laying on their bed snoozing on and off throughout the day.

We observed staff provide response care to people by tailoring their interactions and communication depending on the person and their individual needs. We observed staff speak with one person who had a visual and hearing impairment. They spoke gently into the person's 'good' ear and used touch to communicate and reassure them. We heard them say, "Is that a smile?" and, "That's my hand" as the person was feeling for something. Another staff member spent time with one person helping them to sing their favourite songs within a group setting to make them feel included. When one person became upset and agitated a staff member offered to get their favourite breakfast cereal.

Staff told us they got to know people by reading the care plans. One staff member said, "Obviously we've got the care plans which we read, but we can ask and talk to them – it's the best way." This staff member was able to tell us about one person who got anxious and they explained to us how they would distract them with activities or take them for a walk around the building. This was in line with what the person's care plan said. Staff responded to people's changing needs. We saw information that showed staff had promptly responded to changes in people's weight, mood or general health and sought specialist medical support as needed.

Staff were considerate of people's needs at the end of their life. At the time of inspection, nobody was receiving palliative care but care plans were available for staff to discuss end of life care and document people's advanced wishes. Although in the documentation we looked at people had declined to discuss this. One care plan noted, 'Does not wish to discuss, family know wishes' and in another, '[name] and son not prepared to discuss'.

People and relatives were aware of how to raise a complaint. One person said, "I did complain to the last manager about how a member of night staff spoke with me and she sorted it." Another person told us, "We have carers that we can talk to or we could go to the manager. It would depend what it is." A third person said, "I'd speak to someone at the front desk or be in touch with the management." The manager proactively invited comments from people and relatives. A relative told us, "I was unhappy about something and asked the manager if I could speak to them after the relatives meeting. I was expecting them to ask me to come to them another time, but they offered to speak to me straightaway." We read that five complaints were received by the service in 2017. These were recorded and a formal response made. None of the complaints had been received since the manager had commenced in post.

Requires Improvement

Is the service well-led?

Our findings

We found the manager was open and transparent with us throughout and following our inspection and they took steps where they could to address our concerns. They had told us during our introduction meeting that care plans needed reviewing and that some paperwork may be missing in relation to the MCA. They also said they knew they needed to review staffing levels and recruit another activities co-ordinator which they hoped to do that day. They said their biggest challenge was recruitment and although recording mechanisms were in place for people they needed to ensure staff were being consistent. It was clear from our inspection that the manager had a lot to do, particularly in relation to records but we had confidence in the new manager and were assured that they would work hard to bring the service up to standard.

The positive changes to the leadership and management of the service now need to be embedded and sustained. Although we had no concerns that this would not happen we are unable to give the service a Good rating in Well-Led. This is partially due to the shortfalls identified during our inspection but also in line with our new methodology.

We noted in the most recent medicines audit that it had been identified some issues with staff not signing the MAR sheets or signatures were 'scribbles so not clear' which matched with what we saw during the day. An external pharmacy audit carried out in September 2017 had not raised any major concerns but had made some recommendations. It was also noted that, 'some competency checks to be updated – should be yearly for all staff' and 'as required (PRN) medicines administration should be recorded on back of MAR'. Both of these actions were still on-going at the time of our inspection. We reviewed the records in relation to medicines competencies and found that out of 12 staff five had not had their competency recorded as checked within the last 12 months. However, it was not clear whether or not this was a recording issue. Another recommendation related to covert medicines (medicines disguised in food). We noted this had been actioned. We read an infection control audit completed in December 2017 and saw it had highlighted no concerns despite staff telling us on the day that they did not use the sluice room sinks.

In addition we discussed with the manager some staff lack of understanding in relation to records they were keeping. We had asked staff about fluid charts, the purpose of them and at what point would the records trigger further follow up. One staff member told us, "We do a three-day monitor of fluids and then review. We don't give care staff a target for how much people should be drinking it's the review that we do that picks up if there are any issues. I don't really know if people have enough to drink though as I don't know the targets either. I'd look for signs of dehydration." One person's care plan stated, 'I also need to drink 2 litres of fluid per day'. However a staff member was not able to tell us what this person's fluid target was. Furthermore, a third staff member said, "I would have to ask a superior for [names] target. We just write down what they drink and the team leaders check them." We asked this staff member who was responsible for raising concerns if someone did not drink enough, or drank too much and they told us, "Well everybody really." A further staff member said, "I wouldn't know anyone's fluid target. If it appeared abnormal then I would tell a team leader. We don't tot up the totals we just log and then if we feel it's not right we'd raise it." This meant that although staff were recording people's fluid intake, there was a lack of a robust system in place which ensured staff knew when to raise concerns and team leaders could assure themselves that they were

monitoring the information in a consistent way. We were told during our feedback session that Anchor planned to introduce a new system in relation to fluid charts which would make recording and monitoring more relevant.

The manager had only been in post for eight weeks but had already started their own auditing programme. This included care plans, compliance in relation to the MCA, people's dependency scores, catering audits and monthly safety checks. In addition, the provider's district manager carried out visits to the service. We saw they had last done this in December 2017. The manager had a clear development plan for the service that they were working to and actions from audits were transferred to their main plan for improvement. Each senior member of staff owned the actions in place and were given targets in which to complete them. Actions included listening sessions with staff following the recent change in management, auditing records, reviewing staffing levels, implementing a falls management system and reducing the use of agency staff by recruiting and retaining permanent staff. Some of these actions were underway and as such following the introduction of a more robust falls review process falls in the home had reduced after one month. We read that the manager planned to have most actions completed by end of March 2018.

The manager had a clear vision for the service. They told us, "I want to get an outstanding rating. I want to keep people safe and get the team leaders on board." They said that staffing was a priority and he had discussed with senior management to get an increase to decrease the reliance on agency staff. The manager said they were proud of the care team. Staff were clear on the vision of the service and there was a good culture within the task force. One staff member said, "We are here to meet people's needs on a day to day basis" and they told us Anchor's vision was discussed at staff meetings. Another member of staff said, "It's helping people, keeping them safe and happy." A third staff member spoke highly of the job and said, "The best bit is getting to know the people living here."

Staff felt supported by management and were happy working at the home. Staff member's commented, "I think/hope the new manager is going to make a difference. He pops into the unit all the time which is good, the other manager didn't do that," "He's more hands on and supportive of staff," "[Manager] – a good first impression. More approachable so far" and, "The carers are amazing and [manager] is really on it checking things are done. I feel he cares about us and he's always asking if we're okay." One staff member also praised the team leaders. They told us, "The team leaders are good, especially [name]. They are always popping down and helping out like putting the kettle on and starting to make tea for people if they can see I am busy." In turn the manager told us they felt supported by senior management and Anchor as a whole. They said they were assured that they would be provided with the necessary support and tools they needed to progress any areas of the service they felt needed it.

We could sense a good culture within the staff team and it was clear staff were happy working at the service. We asked them what the best thing was about it. One staff member told us, "The best thing is the residents. I had never met anyone with dementia before and you think they don't have much to talk about but they do, they have so much. It's really interesting." Another said, "I love caring for people (and would not change my job)."

Staff worked in partnership with other agencies to provide the most appropriate care to people and to share practices and information. The manager told us they worked closely with the GP practice, the community psychiatric nurse and the nurse advisors for care homes as well as other agencies. They also said manager's met with the provider's district manager once a month and this was a useful opportunity to meet with their peers and share news and ideas.

Staff were involved in the running of the service and there was a clear recognition of people's individual

responsibilities to ensure the service provided good care. The manager met with each discipline group in turn and as such there was evidence of care staff, housekeeper, team leader and catering staff meetings. A wide range of areas were covered during each meeting. We noted in the care staff meeting the manager reported that staffing levels would increase to 12 each day. They had also reminded staff that food and fluid charts needed to be completed and uniforms must be appropriate with name badges worn. We did note however that at least three staff we spoke with during our inspection did not have their name badge on. Team leaders were reminded of their responsibility to observe staff practice each day by walking around the home and that care plan auditing would start. A staff member told us, "[Manager] is great and wants to make improvements." Another staff member said, "[Name] is looking at staffing and has asked for our ideas."

People had opportunities to give feedback on the home. Anchor ran a 'You Said', 'We Did' programme which displayed people's feedback and the service's response for everyone to read. We noted that the most recent feedback noted that people felt there was a long time between tea time and breakfast the next day. People were reminded that snacks were available and they should ask staff. We also noted people had fed back they wanted more mental and physical exercise. The service had responded to remind people to join in on the weekly Zumba session and that dominoes and jigsaws were available. There was a fish tank in one living area and budgies in another which were at the request of people.

Relatives and residents were able to meet with the manager and staff and we read from the most recent meeting that all aspects of the service was discussed. This included food, activities, the welfare fund and how to spend it, maintenance and staffing. A relative told us they had attended the meeting for the first time and had found it very informative. Another relative said, "I know that they have residents and relatives meetings. The last one was a couple of months ago where we got to meet the new manager. They are a good way of communicating what's going on and what the plans are for the future."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider could not assure themselves that people would consistently receive safe care. This was due to the lack of robust processes in relation to medicines, infection control, safeguarding, record keeping and deployment of staff.