Anchor Trust

Greenacres

Inspection report

The Horseshoe
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 May 2018 and was unannounced.

Greenacres is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Greenacres provides care and accommodation for up to 62 older people some who have physical needs and some people who are living with dementia. People have varied communication needs and abilities. The service is set over two floors, and is divided into different living units; each unit has their own lounge and dining area. On the day of our inspection there were 53 people living in the home.

At the time of the inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Instead we were supported by the new manager who was applying to become the registered manager.

At the last inspection in December 2016, we asked the provider to take action to make improvements in relation to the safety of people and the requirements of the Mental Capacity Act (MCA). In relation to safe, we found at this inspection that people were not always safe due to risks that had not been resolved. There were continued concerns around people's capacity not being assessed, non-decision specific MCAs being completed and limitations being placed on people who had capacity.

People did not always receive safe care. The provider was not always proactive in identifying risks and staff were not clear on how to manage individual risks to people. We also identified that important information was missing from medicines records and safe medicines management practices were not always followed.

At our inspection in December 2016, staff were not always raising safeguarding incidents/accidents with management. At this inspection we found that incidents were being reported to management.

Care sometimes lacked personalisation and was not always provided in a way that reflected people's needs and preferences. We saw instances where staff failed to promote people's dignity and independence when providing care. People's dietary needs were met and we received positive comments about the food. People's end of life care was not always planned and recorded in their care plans.

Auditing systems were not robust enough to identify the concerns that we found on the day of inspection. Where improvements had been identified through audits, these had not always been actioned.

People did not have access to a range of activities that were meaningful or stimulating. Where a complaint had been made about this, an appropriate response had been sent by the manager. People had been

provided with a complaints procedure and were confident that any complaints would be handled appropriately.

Auditing systems were not robust enough to identify the concerns that we found on the day of inspection. Where improvements had been identified through audits, these had not always been actioned. The provider had also failed to notify CQC of important incidents and events. There had been a lack of overall improvement at the service since the last inspection.

There were enough staff at the home to safely meet people's needs. Recruitment checks were carried out consistently across staff. There was regular supervision occurring with management throughout the year to support the staff. There was a clear and up to date staff training matrix which showed that staff were receiving relevant and necessary training for their work.

Although the risks around care was not always identified there were care plans that were detailed to inform staff about people's previous lives and other identified needs. We observed some positive and friendly interactions between staff and people in the lounges where staff used activities to engage people. Staff were usually respectful towards people.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider was not always proactive in identifying risks and staff were not clear on how to manage individual risks to people.

Medicines were not always managed in safe way.

There were enough staff to safely meet the needs of people.

There was a detailed fire safety plan in place for each person.

The service was clean and had good infection control in place.

The recruitment process was detailed and ensured staff were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal rights were not protected as staff did not follow the guidance of the Mental Capacity Act (2005).

People's dietary needs were met and we received positive comments about the food. However, people were not always given choices of meals.

Staff were given consistent and relevant training and supervision by management.

People were seen regularly by healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and independence was not always promoted by staff.

We observed some practice that was caring but we had mixed responses from people regarding their interactions with staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not always delivered in a personalised way.

People did not have access to a range of stimulating activities which were person centred.

People's end of life care was not always planned and recorded in their care plans.

Care plans were detailed and person centred.

Complaints were recorded and responded to.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a lack of governance at the home.

The provider's audits were not robust enough to identify or implement changes to the concerns found. We did see instances of improved care as a result of quality assurance.

The provider did not always submit notifications to CQC when they were required to do so.

The systems in place to involve staff and relatives in the running of the home were not viewed as effective by people.

Staff and people spoke positively about management.

Greenacres

Detailed findings

Background to this inspection

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

The inspection took place on 8 May 2018 and was unannounced. The inspection team consisted of four inspectors.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We reviewed the information the provider sent us in their Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with twelve people and two relatives. We also observed the care that people received and how staff interacted with people. We spoke with the manager, the deputy manager and nine members of staff. We read care plans for ten 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 looked at three staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records of menus, activities and minutes of meetings of staff and residents.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person told us "I do feel safe here, I've no complaints." Another said, "I feel quite safe, nobody can come into my room." One relative told us, "My mum is safe there. As safe as she can be anywhere." Despite this we found that there were aspects of care that were not always safe.

At our previous inspection in December 2016 we found that incidents and accidents were not always reviewed on an individual basis and actions were not always taken to reduce risks to people. Following the last inspection an action plan was sent in by the provider to that this had been addressed. At this inspection we found improvements were still required.

There was an inconsistent approach to how the information from accidents and incidents was used to keep people safe. The local incidents and accidents were considered and monitored at a local and regional level every month by this service. We found two instances where no changes or improvements had been made following incidents/accidents. For example, one person had fallen and hit their head. Following this accident their falls risk assessment had not been updated to try and mitigate further falls.

Risks in the home were not always adequately managed to ensure people stayed safe. When we checked two people's bedrooms we found that the large furniture had not been fixed to the walls. This was despite it being identified in a safety audit at the service that furniture could be at risk of falling on top of people if it was not fixed to the wall. This meant that people were still at risk in their own bedrooms. Since the inspection the manager has now confirmed that all furniture has been fixed to the walls in all of the bedrooms. We will check this on our next inspection. Another person's care plan stated that they would, "Lose their temper" if they were sat next to a specific person at lunch. We observed at lunch that they were sat next to that person by staff. We observed that person becoming irritated and angry with that person. The member of staff present had not picked up on this and told us that they were not aware of this risk.

Developing risks were not always noticed or reacted to in people's care plans. One person's care plan stated, "Staff to weigh (the person) weekly and support (the person) to stay at the table during mealtimes." We observed that the person did not have support with their meal during lunch. The only support they received was when another person who was sat at the same table alerted staff to the fact that they were pouring their drink onto their food. The person had not been weighed weekly since January 2018 and the person had lost four kilograms in five months. There was no additional information in their care plan to guide staff on what actions should be taken to address the weight loss. We saw in another person's care plan that they had lost nearly ten kilograms in under six weeks and their care plan had not been updated to reflect any action in relation to this. Weight loss is an important indication of people's general health and safety. If a person has lost weight then this needs to be monitored and their support needs should be reviewed and updated.

People's medicines were not always managed and administered safely. Medicines administration records (MARs) contained gaps and did not always state the reasons why medicines were not administered. This meant that it would not then be possible for the service to demonstrate that people had received their medicines as prescribed. The inconsistent approach of staff to the administration and recording of when

and how PRN medicines were used put people's safety at risk. Where PRN (as required) medicines were given, staff did not always record the reason why. Some PRN medicines did not have any protocols in place to inform staff of when to administer them. This meant that there was no guidance for staff on how to use PRN medicines as prescribed by healthcare professionals. For example, maximum dosage allowed in a 24 hour period, and minimum time between doses. This could result in people being given more medicine than was safe. We also found gaps in three people's cream charts. These should have been filled out to confirm that the medicinal creams had been applied to people.

We found that some medicines had no expiry or opened date on them. We also found that some medicines had expired but were still being administered to people. This meant that the effectiveness of medicines may have diminished. Since the inspection the provider has sent us an action plan to address the concerns found with medicines. We will follow up on this at the next inspection.

The failure to respond appropriately to risks, the lack of consideration of health and safety in people's rooms and the shortfalls in medicines management was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found examples where the service identified patterns and trends. For instance, in one person's care plan we identified that the person had fallen three times in the same month. Staff had completed a review of medicines and the person had their feet checked. The falls risk assessment had also been updated as a result of the falls. Following this no further falls were seen to be recorded after all the action had been taken.

Residents were kept safe from abuse because staff understood safeguarding processes and their roles in protecting residents from abuse. All staff had been trained in safeguarding and demonstrated a good understanding of the signs of abuse, as well as the procedures for escalating any concerns that they might have. One staff member said, "If I ever saw abuse I would inform seniors and call telephone numbers. I could call CQC, police or social services."

There were mixed responses from people about staff levels at the service. One person told us, "They are so short staffed at times." Another said, "Very often I need some help and there is no one around." A third told us, "There's enough staff here." A fourth said, "I rarely use it (call bell) but when I do they respond quickly." The manager told us that there had been occasions where staff levels had decreased at times at weekends but that this had been addressed. We saw that there were sufficient numbers of staff present to safely meet people's needs. We observed that when call bells were used, staff responded within three minutes. Throughout the day we observed staff being present in the lounges and visiting people who remained in their rooms. The service rota ensured that a minimum of eleven care staff were present each day. We saw from the rotas that in one week the quota for staff was being met or exceeded except for two days where staff called in sick. Staff told us that there were enough staff to meet people's needs. One told us, "There are enough staff, We get done what we need to get done." This was reflected in what we observed on the day.

People were protected against the risk of the spread of infection. The home environment was clean with no malodours. The provider conducted regular audits of infection control which resulted in appropriate action plans. People's clothing was regularly cleaned and systems were followed that reduced the risk of cross-contamination. Staff were observed consistently washing their hands before and after supporting people. Staff were also observed using personal protective equipment (PPE), such as gloves, before providing care to people. Hand sanitizer was also available throughout the home and we observed staff making use of it.

There were areas where people were protected against the risk of harm. For example, one person's care plan had a risk assessment in place to ensure staff could monitor him for falls when he got out of bed at night. A

sensor mat had been put into place to alert staff as to when they got out of bed so that they could check if they needed assistance. We also saw that each person had a personal emergency evacuation plan to be used in the event of a fire. The manager sent us their business continuity plan which clearly set out processes for staff to follow in the event of an emergency. The manager stated that all staff communicate updates about service user risks at handovers, meetings and reviews.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff members confirmed they had to provide two references and had a DBS check done before starting work.

Requires Improvement

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).

At our inspection in December 2016, we found that staff did not always follow the guidance of the MCA. This was because the inspection found that relatives and a general practitioner (GP) had made decisions about people's care without holding the correct legal powers. At this inspection, we found that the provider had not made all the required improvements in this area.

People's legal rights were not protected because staff did not always follow the guidance of the MCA. We found examples where restrictions and limitations had been placed on people without any DoLS or best interest decision meetings being held. For example, one person had restricted access to specific drinks. Their care record noted that they were unhappy about this restriction. Although this was based on their health and wellbeing, the restrictions were in contravention to the MCA principle that people have the right to make unwise decisions. When we asked the Manager about this person they told us the person's capacity fluctuates but no MCA assessment had been completed in relation to this particular decision. In another care plan, a 'Do not resuscitate' form (DNR) had been completed by a GP and a relative when the person themselves had been deemed to have capacity. It had not been picked up by staff at the service that despite the person having capacity the decision to not resuscitate had not been discussed with them.

Although staff had knowledge around MCA, the concerns we found showed that staff were not putting this into practice. We found that MCAs that had been applied for were not always decision specific. One MCA created by a GP found that the person lacked capacity but did not specify what the relevant decision was. There was no evidence that this had been questioned by staff. In another care plan a person had a sensor mat and a sensor alarm to alert staff as to when they got out of bed. There were no MCA assessments in relation to whether they person had capacity in relation to this equipment being used. Since the inspection the service has created an action plan to confirm that a decision specific process in now in place. However, the action plan has not addressed the further issues found at inspection in relation to MCAs.

The lack of MCA assessments and not adhering to the principals and code of practice of the MCA was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014).

We did observe instances where staff asked people's consent before providing care. This showed consideration to people's right to consent to day to day decisions.

Adaptations had been made in the premises to support people's mobility. The corridors were wide with hand rails on both sides. The service had also given thought towards making adaptations for people with dementia. However, we saw a dementia activity board on one of the walls for people to interact with was blocked by a chair. There was also a cabinet full of games which was also blocked by a hoist. When we mentioned these issues to the manager the furniture was removed immediately.

People were very positive about the food they were served. One person told us, "The agency chef is brilliant, I have never had scrambled egg like it, and the meat they cook is so tender...we get the menus for lunch and dinner, there are always two choices, but you can go to the kitchen and order whatever you want." We observed lunch time and noted the dining room was welcoming with napkins and clean tables. There were two choices for lunch and staff told us how they generally knew people's preferences.

We saw a detailed staff training matrix which set out a long list of relevant training that staff had completed. Staff were positive about training and could describe multiple relevant courses they had completed this year. One staff member told us, "I have done a lot of e-learning including fire safety, manual handling and safeguarding since last September." We also saw records of regular supervision being completed by management.

Staff and teams worked well together across the service and people had access to a range of healthcare professionals. People's records contained evidence of ongoing involvement of healthcare professionals such as physiotherapists, opticians and dentists. Where concerns were identified, staff regularly contacted the GP.

Requires Improvement

Is the service caring?

Our findings

People gave positive and negative comments about the caring attitudes of staff. One person told us, "Staff are pleasant, they refer to me as '(preferred name)'…. the staff, on the whole, are nice." Another person told us, "Some staff are very good, but the new ones don't really know a lot and are not interested, it's just a job to them." Another person said, "I am happy here." One relative said, "Everyone there is very smiley, staff are very happy. They care for my mum impeccably."

We found people were not always treated with dignity and respect. For example, one person was shouting for assistance to go to the toilet and we observed a staff member react slowly and without a sense of urgency. Another person was receiving one to one care with a staff member in their room. The manager told us that the purpose of the one to one care was to talk to the person and support them. This was to support the person who was cared for permanently in bed and unable to communicate effectively. Yet we observed that a senior member of staff gave the staff member a laptop whilst they were in room and told them they could complete their online training whilst doing the one to one care. This showed that the intended support and stimulation of the one to one care was not being encouraged or focussed on. Another person was inside a toilet blowing their nose. A member of staff entered the toilet and squeezed around the person to get a pair of rubber gloves. The staff member didn't say 'excuse me' or take into consideration that the person may have wanted privacy in the toilet.

Peoples possessions were not always treated with kindness and respect. In the laundry we observed that colours and whites were not separated which had led to clothes being turned grey. A member of staff told us that they routinely washed people's dark and light clothes together. We checked the resident's meetings minutes and in these meetings this issue had been raised six months ago by a person directly to the manager. This meant that people's clothes were still being ruined even after the complaint had been brought to the manager of the home.

People did not always have the opportunity to be independent when they wished. Staff were risk averse when considering activities which meant that people faced limitations in their everyday lives. For example, people were not allowed to make cups of tea because of the risk that they might burn themselves. One person told us, "I have been independent all my life, so it annoys me here where I can't do things for myself. It would be nice to be able to make myself a cup of tea for myself. I get the feeling they (staff) would feel I was interfering. I am sometimes fed up beyond words because of this." When we asked staff about this limitation we were told that it would be too dangerous for people to make tea for themselves. This means that people's independence is being reduced due to a risk averse attitude and culture.

We recommend that people are always treated with dignity and respect at all times and their independence is always encouraged.

We did see occasions of caring and positive interactions between staff and people throughout the day. We observed staff sitting with people throughout the day in the lounges and chatting with them. We observed staff being patient and answering repetitive questions or statements from people in a friendly manner. One

person repeatedly asked a staff member, "Have you seen my husband?", the staff member replied, "No I haven't darling, not today." The person asked this several times but the member of staff did not get impatient and answered them every time. Another person brought in their knitting into the lounge and a carer said to them, "Why don't you knit a scarf, have you done all that (person's name)? That's really good." The person smiled and you could see that the person appreciated this interaction.

Relatives and friends were encouraged to visit and maintain relationships with people. We saw that people had had visitors that week.

We saw examples where staff respected people's privacy. Where people needed support with personal care tasks staff were discreet in how they supported people. Staff were considerate of where they discussed people's personal information. The provider stored personal information safely and had systems in place to ensure that it was secure. When one person began to shout across a room about their personal medical information a member of staff crossed the room to speak to them quietly about the matter.

Requires Improvement

Is the service responsive?

Our findings

People did not have positive comments to make about the activities at this service. One person told us, "We have the odd occasion when I go out, but mostly I just sit here." We asked another person what they were going to do today and her response was, "Bugger all. It's not bad here, but I get so bored, there is often nothing to do." A third person said, "We don't really join in the activities, they are nearly all in the conservatory and it gets crowded and hot. I don't like being in crowds." A member of staff told us, "Some days it can be difficult for people to go out on activities. Lately they haven't been able to get out as much."

People told us they were isolated and felt as though they were lacking stimulation. One person said, "I'm not able to talk to others here because of their condition." These two people were in separate parts of the service. There was a lack of integration at this service in that the people living there could have been more involved socially with other people at the same service. In this same person's care plan it was noted that they liked meaningful conversations and socialising. From their comments to us it was apparent that their known likes and interests were not being catered for. We found that people shared the same interests but staff had not acted upon this information.

People did not always receive activities that were responsive to their needs. We found that there were few activities each day for people to take part in. Each person had a folder which detailed their activities for each day. In one person's folder, their activity for the day stated, "Had a chat with (person) about the weather." Many other days throughout the month were blank. In another person's folder, their 'Life going forward' section had been filled in by staff stating "[person's name] wants a quiet and peaceful life and to die peacefully." There was nothing about their hobbies or interests.

There was a lack of activities tailored to people's interests. People told us that they were bored and were not being creatively included in their care. Where people's care plans described hobbies and interests, staff had not taken action to encourage them to participate in them. We spoke to two people who wanted to play scrabble or dominoes. A staff member replied that they used to have these games but they didn't know where they were now. Another person mentioned that she loved to knit but nothing had been done to enable them to do this or be involved in something like it. This showed there was not a proactive approach to encouraging people to take part in activities that interested them. In one activities survey, people had said that they wanted to go swimming. When we asked an activities coordinator about this they responded that there were too many risks associated with swimming for it to be considered.

The manager told us that one activities co-ordinator had recently left the service and they were in the process of recruiting two new co-ordinators.

Staff were not always aware of specific people's needs. We asked staff why one person's bed was lowered to the floor. They responded that they did not know why despite the fact that were providing one to one carer to that person for the day. Another member of staff we spoke with had just returned from leave and had not been given up to date information about people's needs. They had not had an opportunity to review care plans.

The service was not currently supporting anyone at the end of their lives. However, there were not always plans in place to ensure people had the care they wished for at the end of their lives. One end of life plan simply stated, "No hymns, cremation". We saw three other care plans with no end of life plan at all. The provider told us that they only 'only introduce this paper work when a person has been deemed at the end of their life by a clinical practitioner.' However, if people were not offered the opportunity to discuss what they wanted to happen at the end of their lives before they reached this stage there was a risk that their wishes would not be known.

We recommend that the provider reviews the activities available to people to ensure that they are meaningful and stimulating and to ensure that staff are aware of people's up to date needs.

Despite this feedback from people about activities, on the day of the inspection we observed occasions of positive interactions between staff and people with activities at the home. In the morning people were sat around a table with staff painting. The people involved could be heard talking about their paintings and staff were making an effort to ask people questions and prompt them with the activity. There was also a music activity in the conservatory which staff took people to from different parts of the home. In the morning up to six residents went out with staff for a day centre trip not far away from the home. There is an Age Concern Garden at the home for people to use whenever they want to. We were told by the manager that one person loved horses and the service had arranged for them to have rides in a buggy each week. Another person gets taken to Chelsea football matches to support their team. The manager sent us a survey which found that 94% of people were satisfied with the service overall.

Aside from the issues we found in safe in relation to risks, peoples care plans were detailed and person centred. For example, mobility, health and dietary needs. Care plans were generally updated and reviewed regularly with care records to ensure that staff had up to date information. For example, one person had diabetes, Type 1 which was insulin controlled. They had a care plan that stated staff were to check blood sugar levels daily and administer injections using an insulin pen. The medicine record clearly stated this should be done by senior staff that had been trained in how to use the pen. We saw records of daily blood sugar check and staff signatures to show the insulin had been administered. In another person's care plan there was a detailed record of their younger life. This included their profession, family and interests. We asked staff about this person and they were knowledgeable of these details. We also observed staff speaking to this person about topics they were noted as being interested in. Staff had also put pictures of this person's interests up on the wall next to their bed.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. We looked at three complaints and their responses. People's concerns and complaints were responded to quickly and in detail. The process for complaints was well communicated to relatives and people in the service as it was on the board at reception. People said they would feel comfortable complaining to management and they knew how to.

Requires Improvement

Is the service well-led?

Our findings

After the previous inspection in 2016 we asked the provider to send an action plan to show they were meeting the shortfalls that we had identified. The action plan stated they had met the shortfalls we had identified with MCA consent, medication errors, notifications being sent to CQC, audits not being actioned and enabling people to carry out daily living tasks such as making cups of tea. On this inspection it was clear that concerns were ongoing. This meant that management has failed to implement or sustain the action plan created following on from the last inspection.

Although there were multiple quality assurances in place, these were not being used effectively to ensure the best delivery of care. We saw from a service audit in December 2017 that they had identified unfixed furniture as a risk in people's bedrooms and flooring in need of repair six months ago. Neither of these necessary improvements had been made as we found unfixed wardrobes in two peoples rooms and the floor in one toilet still needed repairing. An observational audit from the previous month had found that there needed to be 'engaged' signs for communal toilets. This had also not been actioned. Care plan audits had not always picked up on concerning developments in people's care. For example, two people had been losing weight consistently in the past months. Neither of their care plan audits had identified this issue.

Improvements were not always sustained. We saw one complaint from a person's relative, one month ago, which stated their father was not being stimulated by activities. There was an appropriate response from the service which apologised and set out plans to improve activities to stimulate their father. However, there was no oversight by management to ensure that good practice was maintained. In the weeks since this complaint this person's daily activity record had multiple blank days with no activities and the days with activities included examples such as '(person) was given various objects from the past' and 'visit from daughter'.

The provider stated in information sent to the CQC in December 2017 that it would "Ensure activities and outings are person centred, stimulating, and chosen by customers where possible." This plan had not been successfully implemented by the provider or management.

People said they were happy with the management at this service. One person told us, "The managers are all very nice." However, where feedback from people and their relatives was sought action was not always taken to address the concerns raised. One person told us, "They have lots of meetings but we don't go because nothing changes, so it is a waste of time. Things just seem to go on the same old way." This was supported by the fact that the manager had been informed of grey clothes coming from the laundry six months ago at a residents meeting. The manager responded to the complaint during the meeting with a plan of action to resolve the problem. We observed the same grey clothes being created through a lack of separation of colours during our inspection of the laundry room.

We saw from the minutes of a resident's meeting in February 2018, people were told that Anchor didn't have a budget for activities and so the service had to rely on donations and fund raising. People responded that Anchor should have a budget given the costs people are paying. This issue had not been resolved given the

lack of stimulating activities recorded and complained of. The manager confirmed after the inspection that there is a budget for activities.

Management were aware of the problems with activities and yet this had still not been addressed. We saw from a staff meeting in January 2018, the manager stated that "Activities need to greatly improve." At that time there was only one activities co-ordinator and it was announced that management was recruiting for more. After five months, we found at our inspection that there was still only one co-ordinator and improvements were still required.

As systems and processes were not robust and operated effectively this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to were positive about management. One staff member said, "I feel supported by the manager. She will pull us up on things if we are doing them wrong." One staff member had stated in a staff survey, "Better communication before changes are made, more information about changes so we know what to do." The response to this comment was that changes would be discussed at meetings with staff and a board would be put up to identify actions/changes resulting from the meetings and we saw that this was now taking place.

There were occasions where quality assurance was effective. In one person's care audit, it was identified that there was no body map for creams and a lack of an MCA. We saw that this had been rectified and the appropriate work was completed following the audit. There was an up to date and regular first aid audit record and there had also been a recent observational practise audit completed. The infection control audit had been completed recently and was effective in ensuring the home was safe.

Reportable incidents were not always notified to the commission. There had been three safeguarding incidents that had occurred which had been raised with management of the service and discussed with the local authority. There had also been an injury to a person that required medical treatment. Whilst appropriate action had been taken by the service to address this they had not been reported to CQC in line with the regulations. This meant that CQC may not be aware of important events and could not effectively monitor the safety and quality of the service.

The failure to notify CQC of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found four incidents that should have been sent to CQC as notifications of incidents/accidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks identified from accidents and incidents/safeguarding were not always reported. Improvements were not made in line with the managers action plan since the last inspection. Actions from the providers own audits were not always implemented.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's legal rights were not protected because staff did not always follow the guidance of the MCA. We found examples where restrictions and limitations had been placed on people without any DoLS or best interest decision meetings being held.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always proactive in identifying risks and staff were not clear on how to manage individual risks to people. Medicines were not always managed in safe way.

The enforcement action we took:

Warning Notice