Runwood Homes Limited

Elizabeth House

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service responsive?	Good

Overall summary

This inspection took place at 6.15am on 17 July 2015 and was unannounced.

The service provides care and support for up to 108 people some of whom may be living with dementia. There were 106 people living in the service on the day of our inspection.

At our previous inspection in November 2014 we had concerns about the way communal space had been used. People had been crowded into one lounge when another lounge was empty. The lounge was noisy and people had found it difficult to hold a conversation because of this. At this inspection we found that improvements had been made and people used all of the available communal space.

There was a 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.

There were insufficient staff on duty to meet people's needs. Staffing levels had not been appropriately assessed to take into account people's individual needs and staff and time required to support people safely and ensure their wellbeing.

People were not being treated with dignity and respect. Staff used unacceptable and unsafe practices due to the lack of appropriate body washing materials This also posed an infection control risk.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe

There was not enough staff to provide the support people needed.

Staff used unacceptable and unsafe practices due to the lack of appropriate body washing materials; therefore people were not always treated with dignity.

Requires improvement

Is the service responsive?
This service was responsive.

At our previous inspection in November 2014 we had concerns about the way communal space had been used. At this inspection we found that all of the communal space had been used.

Good

Elizabeth House

Detailed findings

Background to this inspection

We carried out this early morning inspection because we had received concerns about the level of staffing and the impact it was having on people who used the service and the staff. We were also told that there was a shortage of towels, flannels, crockery and cutlery.

This inspection took place on 17 July 2015 and started at 6.15am, was unannounced and carried out by three inspectors.

Before the inspection we reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We spoke with the nine people who lived at the service and six visiting relatives. We also spoke with the operations director, the registered manager, the deputy manager and seventeen staff. We spent time with people in the communal areas observing daily life including the care and support being delivered.

We looked at 12 people's care records, staff duty rotas and the system used for calculating staffing requirements.

Requires improvement

Is the service safe?

Our findings

There was not always sufficient staff on duty to meet people's assessed needs. People told us they were often kept waiting for staff to support them. One person said, "I have had to wait up to 20 minutes because they are so short staffed." Another said, "The staff are always so very busy, rushing around and trying to do everything so I don't think there are enough of them."

On our arrival at 6.15am we saw that some people were washed and dressed and sitting in chairs fast asleep and snoring. People told us that the staff were very busy helping others and that they had not had a drink since waking. There were jugs of orange juice in the room but they were out of people's reach and no cups or beakers were available. Staff told us that people were offered drinks but that sometimes they were so busy in the mornings supporting other people that they had not given them until later. One person told us that the staff with the tea trolley often forget to come back when they had asked for a second cup of tea.

There were two night care assistants and one care team manager working on Poppy unit to support 55 people. Staff told us that 26 of the people on this unit required support from two members of staff. We heard call bells sounding continuously on Poppy unit and saw from the control panels that staff took a long time to respond. On this unit we saw that five people were out of bed, washed and dressed by night staff and were either lying fully dressed on their bed or sitting in their room. Another person was half dressed and told us they were waiting for staff to help them with the other half. Another person told us they felt unwell and wanted to go back to bed. Their bed had been made and there was dirty laundry on their chair so they were unable to sit down or get back into their bed themselves.

Staff on all units were very busy until the morning shift arrived. A visitor told us, "There rarely seems enough staff to meet people's needs because you ask staff to do things and they never seem to have the time to do them as several days later the job has still not been done. I have waited more than seven minutes for the call bell to be answered and they are often ringing throughout my visits." On one unit there were nine people washed, dressed and asleep in their chairs until lunchtime. The operations director and manager told us that people chose to get up early. Some people confirmed this, however, others were not able to and their care plans did not reflect it. Therefore we were unable to determine if this was people's choice in all instances and if their wishes had been adhered to.

On Bluebell unit there were three staff working at night to support 51 people. One staff member said, "There are a lot of people who need two staff to assist them. There is not enough staff, we are always rushed and never have time to sit and talk with people as there is always something to do." Another said, "It takes longer to complete people's personal care and breakfast because there is not enough staff. If we had more staff we could take our time with people and be less rushed."

The care team managers were responsible for allocating staff to each unit throughout the night according to people's needs at the time. On the day of our visit the care team manager told us that Poppy unit had been one member of staff short because of the late notification of staff sickness. They said that this late reporting of staff sickness had meant that they were not able to obtain bank or agency staff to cover the night shift. This meant that on the night in question the service had six staff on duty to meet the needs of 106 people of whom 52 needed to be assisted by two members of staff. Staff told us that there were many times they had been short staffed because of staff sickness and the staff duty rotas confirmed this. The manager told us that shifts were sometimes covered by the deputy manager but it was not always shown on the staff duty rota. The inaccuracy of the rota meant that we could not be assured of what we had been told and people were often left in unsafe situations because of a lack of staff being available to meet their needs.

The dependency tool used by the provider was not effective or accurate in reflecting the level of people's needs and the time and input needed for staff to support them safely. The manager told us that they used a dependency level tool to determine the overall number of staff required for the service. They said they regularly re-assessed the levels to ensure that they continued to meet people's changing needs. They told us that care team managers deployed staff on each shift. The dependency level records showed that five of the 106 people's needs had been assessed as high level dependency. The remaining people had been assessed as having either a low or a medium level dependency.

Requires improvement

Is the service safe?

Staff were telling us that they felt more people were of a higher dependency than that assessed. They said that it took considerably more time to support a person who needed two staff to assist them with their personal care and toileting needs. One staff member said, "Dependency levels do not accurately reflect the needs of people, we have regular meetings with the manager to discuss this."

On the day of our inspection we saw some people eating their breakfast late morning and other people were being washed and dressed just before the lunchtime period. One person said, "We sometimes have to wait for breakfast because there are not enough staff." Another person was seen sitting outside the office in their dressing gown with a full catheter bag that had been leaking as they walked and they were very distressed and uncomfortable. This showed that there were insufficient staffing levels to meet people's assessed needs in an appropriate timeframe and ensure their safety and welfare.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being treated with dignity and respect. Staff told us that they were always short of flannels and wash wipes. On the day of our visit they said there were wash wipes available but they 'often run out' of them.

There were no flannels in the laundry store. Three different staff members told us they had used towels to wash and wipe people because there were no flannels or wash wipes available. They said they had no choice and used different ends of the towels for washing and wiping people. Improvements needed to ensure people received safe care as it also posed an infection control risk.

The person who became distressed about their overfull and leaking catheter bag due to staff shortages was another example of people not being treated as individuals and without due care and dignity.

This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that there was a lack of appropriate crockery and beakers. On the day of our visit there were plenty of cups, plates, cutlery and beakers on all four units. One staff member said, "There may be plenty today but often there are not enough for breakfast and as we are so short staffed it takes time for us to run to the kitchen to collect them." A discussion took place with the manager about ways of ensuring that crockery and beakers were available at all times. The manager assured us that kitchen staff would make sure they were returned to each unit after use.

Good

Is the service responsive?

Our findings

At our previous inspection in November 2014 we had concerns about the way communal space had been used. People had been crowded into one lounge when another lounge was empty. The lounge was noisy and people had found it difficult to hold a conversation because of this. At this inspection we found that improvements had been made and people used all of the available communal space. There were now spaces available for people to use if they preferred some time in quieter areas and for them to meet with friends and family.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect. Regulation (10) (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was insufficient staff deployed to meet people's assessed needs. Regulation 18 (1).**