

Peaceform Limited

Eliza House

Inspection report

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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?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This comprehensive inspection took place on 30 November, 4 and 5 December 2017 and was unannounced. At our last inspection on 15, 16, 23 June 2017 we found that the provider was not meeting all the regulations that we inspected.

At the last inspection we identified breaches of regulations 9, 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of activities provision for people. Medicines were not always managed and stored safely. Accidents and incidents were not analysed for trends and patterns. The provider did not ensure that all areas of the home used by the service were clean, suitable for the purpose for which they were to be used and properly maintained. Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues around the home. Poor recording and analysis of complaints, safeguarding, accident/incident and customer satisfaction surveys meant that the provider had no management oversight on the quality of care. There was a lack of evidence that staff were supported through regular supervision.

Following the last inspection in June 2017, we asked the provider to complete an action plan to show what they would do and by when to improve each of the key questions to at least good. In addition we also took enforcement action against the provider and issued a warning notice in relation to good governance and the breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The warning notice required the provider to address the concerns related to the breach and become compliant within one month. We checked the provider's compliance of the warning notice as part of this inspection.

Eliza House 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. Eliza House accommodates up to a maximum of 26 people in one adapted building. However, following our last inspection and findings, the local authority placed an embargo on Eliza House accepting any new referrals. This means that the service was not allowed to admit any new residents. At the time of this inspection there were 20 people using the service.

The home did not have a registered manager in post. The previous manager present at the last inspection in June 2017 was no longer employed by the provider. A new manager had been appointed in October 2017 and was in the process of applying for registered manager status with the Care Quality Commission (CQC). 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.

The provider, manager and a commissioned consultant continued to complete a number of audits and checks to monitor the quality of the service. However, we found that these audits continued to be

inadequate and failed to identify any of the issues that we identified as part of this inspection. Where issues were found, there was no record or action plan in place stating how the issues were to be addressed or resolved and by when.

Relatives and external visiting professionals had completed satisfaction surveys, giving feedback on the quality of service provided to people. Where emerging concerns had been raised around activities and the condition of the home, no action plan had been developed on how these issues were to be addressed and no further feedback had been provided to relatives and professionals on the results of the survey and the actions they proposed to take.

At the last inspection we found significant concerns around the health and safety of people in relation to the fabric and condition of the home. Although these concerns had been addressed at the time of the previous inspection, we found significant new concerns as part of this inspection. This placed people at the risk of significant harm.

At the last inspection we found that although care plans identified and detailed risk associated with people's health and support needs, information contained within the care plans was not always consistent with the associated risk assessments.

However, at this inspection we found that this issue had not been addressed. Risk assessments were not always in place for people with significant health conditions. Where risk assessments had been devised specific guidance or direction on how to manage specific risks had not been incorporated into the risk assessment.

At the last inspection we found that medicines were not managed safely. There were a number of concerns around the storage of controlled drugs, room temperature checks for the storage of medicines and incomplete paperwork confirming the safe and appropriate administration of covert medicines. At this inspection we found that these concerns had been addressed and that people were receiving their medicines safely.

At the inspection in June 2017 the manager was unable to provide us with records in relation to staff supervision, appraisals, medicine competency assessments, safeguarding investigations, complaints, accidents and incidents and the results of previously completed satisfaction surveys as they were not available within the home. At this inspection we found that these records were readily available in a more organised format for us to be able to review.

At the last inspection we found that scheduled activities did not always take place. People and relatives all told us that there was very little provision of activities taking place within the home and that activities listed on the activity timetable did not always take place. During this inspection we found that improvements had been made in the provision of activities.

In June 2017 we found that care plans did not always contain information about the person's likes and dislikes, choices and preferences. At this inspection we found that the provider had made significant improvements in this area. However, we found that care plans were inconsistent with a variety of care plan templates in use, which had all been reviewed as current, and so it was difficult to ascertain which version was the most recent and up to date document to be followed.

People and relatives told us that they knew who to speak with if they had any concerns or issues to raise.

All staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS). At the last inspection we found that care plans did not always evidence that people or where appropriate their relatives had consented to the care and support they received. At this inspection we found that this had been addressed.

Care staff demonstrated a good understanding of the terms safeguarding and whistleblowing and were able to describe the actions they would take if abuse was suspected. However, where people had presented with unexplained bruising or marks on their body, the manager had not taken any action to investigate these.

The provider demonstrated safe recruitment processes were in place to ensure that each person employed at the service was safe to work with vulnerable adults.

Care plans contained records of all visits and appointments made by a variety of healthcare professionals such as GPs, dentists, chiropodists and district nurses. Details of the visit and any actions to be taken had been recorded.

Throughout the inspection we observed positive and caring interactions between people and staff. People were observed to be treated with dignity and respect. Care staff knew people well and demonstrated a sound awareness of supporting people from different backgrounds.

People and relatives knew the new manager and felt confident in approaching them. Staff were equally positive about the new manager and found him to be supportive in the short time that he been present at the home.

At this inspection we found continued breaches of Regulation 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to lack of detailed risk assessment, concerns related to health and safety, infection control and the condition of the fabric of the home and ineffective quality audit systems.

The overall rating for this service is 'Requires improvement'. This is the second and consecutive time the service has been rated Requires Improvement and therefore we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe. We found a number of significant concerns around the health and safety of people in relation to the fabric and environment of the home that placed people at risk of harm.

People's individual risks related to their health and support needs were not always assessed appropriately. Information for staff on how to reduce or mitigate those risks was not provided or lacked sufficient detail in order to keep people safe.

Care staff understood how to keep people safe and where concerns were noted the actions they would take to report their concerns.

The provider followed appropriate systems and processes to ensure the recruitment of staff assessed as safe to work with vulnerable adults.

People received their medicines safely and on time. Appropriate processes were in place to manage medicines safely.

Requires Improvement 

Is the service effective?

The service was effective. Pre-admission assessments and review of care plans had been completed to ensure people's needs and choices were considered and reviewed to ensure the provision of appropriate care and support.

Care staff received regular training and support which included regular supervisions and annual appraisals.

People were supported with their nutrition and hydration which took into account their needs and preferences in these areas.

Care staff understood the principles of the Mental Capacity Act 2005 (MCA) and how these were to be put into practice when supporting people. However, care plans did not always confirm that consent to care had been obtained or reviewed with people or where appropriate, with their relatives.

Good 

Is the service caring?

Good 

The service was caring. We observed care staff supporting people with dignity and respect. Care staff knew people well and demonstrated a good understanding of how people were to be supported.

We observed care staff involving people in day to day decisions about their care and support needs where appropriate.

People and relatives confirmed that care staff were kind and caring and where possible supported them and their relative to maintain their independence as far as practicably possible.

Is the service responsive?

The service was not always responsive. Most care plans were person centred and contained detailed information about the person. However, documents contained within the care plans were inconsistent.

The manager and relatives confirmed that care plans had been recently reviewed, however, due to the inconsistency of documents available, we were not assured that the manager's review had been effective.

Although we observed an improvement in the provision of scheduled activities, feedback from people and relatives was that activities continued to be an issue.

People and relatives knew who to complain to if they had any concerns or issues.

Requires Improvement 

Is the service well-led?

The service was not well-led. The new manager had been in post since October 2017 and was in the process of applying to become the registered manager.

The provider completed a number of audits and checks to monitor the quality of the service. However, we found that these audits continued to be inadequate and failed to identify any of the issues that we identified as part of this inspection.

Feedback from completed satisfaction surveys identified emerging concerns around activities and the condition of the home. However, the provider and manager had not recognised these.

People and relatives were aware of the recent changes in management and gave positive feedback about the new

Inadequate 

manager and improvements that he planned to implement.

Care staff told us they felt supported by the new manager through regular supervisions and staff meetings and were positive about the improvements that he planned to implement.

Eliza House

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.

This inspection took place on 30 November, 4 and 5 December 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience who spoke with people and relatives. An expert by experience is a person who has personal experience of using or caring for someone who has used or uses this type of care service.

Before the inspection we looked at action plans that we had received from the provider following the last inspection about how they were going to address the issues we had identified. We also looked at notifications that we had received about incidents affecting the safety and wellbeing of people using the service.

Due to the issues identified at the last inspection, the service had been placed under the local authority provider concern process. As part of this process we obtained feedback from local authority and visiting healthcare professionals about the service and any improvements that had been made.

During the inspection we observed how staff interacted and supported people who used the service. During the visit we spoke with six people using the service, seven relatives, the provider and seven staff members which included the manager, a commissioned consultant, senior support workers, support workers and the chef.

We looked at the care records of five people who used the service and medicines administration record (MAR) charts and medicines supplies for ten people. We also looked at the personnel and training files of six care staff. Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Is the service safe?

Our findings

People and relatives told us that they and their relative felt safe living at Eliza House and with the care and support that they received from care staff. Comments from people included, "They keep an eye on you, make sure you are alright in your room" and "I feel safe here." Relatives confirmed people's safety by stating, "Oh yes definitely", "Safe? Yes! The carers are very good" and "I think she is safe." However, despite this positive feedback, there were certain aspects of the service that were not safe.

At the last inspection in June 2017 we found significant issues related to health and safety, and infection control. Although these issues had been addressed at the time of the last inspection, at this inspection we identified new and serious concerns in the same area.

On the first day of the inspection we found that hot water taps around the home were running at very high temperatures, above the recommended 44°C in nine bedrooms out of the 26 bedrooms. The highest temperature reading measured was 55°C. Health and safety legislation states that 'Controls should be provided to ensure that water hotter than 44°C is not discharged from outlets that may be accessible to vulnerable people.' One person who was leaving their bedroom whilst we were walking around the home, offered to show us their room. We asked them if they found the water running from their bathroom tap too hot, which we recorded as running at 46°C. The person replied, "Yes, it is. I have to run the cold as well."

We also found three bedrooms that had radiators in the en-suite bathrooms that were too hot to touch. These radiators were exposed and did not have a radiator cover in order to protect people from sustaining burns. All of the above placed people at significant risk of harm where they could be scalded or burnt.

We also found that window restrictors in place in two bedrooms on the first floor were not in use as outlined by legislation. Health and safety legislation requires providers to ensure the following, 'Window restrictors should: restrict the window opening to 100 mm or less.' In three bedrooms we found that although window restrictor chains were in place, chains had either been removed or the windows opened up to approximately 457 millimetres. This meant it was possible for a person to fit through and exit through the window.

In addition to the above we also found in one person's bathroom, the toilet cistern ceramic lid was broken and we were able to pick up the large broken piece with sharp edges. In a second bedroom we found the cover of a wall mounted lamp above a bed was broken and the bulb was exposed. This was in easy reach for the person who, if attempted to touch would be placed at risk of sustaining a burn, cut or electrocution. In the hairdresser salon, which was unlocked and accessible to any person, we found five bottles of chemicals which included shampoo, shaving foam and hairspray. All these items were in easy reach to people especially those living with dementia who may not have understood what they were and mistaken them as something to drink or eat.

On day one of the inspection, we went through the issues with the rooms we had found with the management team. Following the feedback we saw that the provider had begun to take steps to address the

issues with the hot water temperatures and hot radiators. A plumber was visible around the home attending to the issues. We then informed the provider that all of the issues identified must be addressed immediately and that we would check this on day two of the inspection.

On day two of the inspection we checked the improvements that the provider had made. Hot water was found to be at an acceptable temperature. The provider did state that there continued to be issues with the homes heating system which they were trying to address. The three hot radiators had been covered with a radiator cover. Appropriate window restrictors had been fitted to the two windows where issues had been identified and the exposed light fitting in one bedroom had been replaced by a dementia friendly touch light fitting. However, we found that the hairdresser's salon remained unlocked with chemicals still accessible. We also found in the main lounge three large loose pump containers of hand sanitiser easily accessible to people. These were removed immediately once we highlighted this to the manager.

At the last inspection in June 2017 we found that risk assessments were not always consistent in line with the information available within people's care plans. During this inspection we found that this issue had not been addressed. We found that risk assessments for people with diabetes or epilepsy were not detailed. Most staff were able to tell us what the associated risks were with such health conditions and the steps they would take to keep people safe, however, the risk assessments did not give sufficient guidance to staff to ensure that they would be able to mitigate or reduce the risks associated with these health conditions.

Three people had risk assessments in place for behaviour that challenged. However, none of these risk assessments identified the risks associated with their behaviours, the triggers for their behaviour and any de-escalation techniques to be used to manage and support the person with their behaviour. Two people's care plans identified them as being at risk of having recurrent urinary tract infections, however, no risk assessments were available giving staff the knowledge and guidance on how to manage this condition.

One person had a completed Waterlow assessment in their care plan. Waterlow assessments assess people's skin integrity to determine risk of developing pressure ulcers. The person had been assessed as being at high risk, however, there was no further risk assessment or guidance in place for staff on how the person was to be supported to maintain their skin integrity and prevent any skin breakdown. Another person's care plan contained a bed/mattress risk assessment which stated that they had a pressure relieving mattress in place. However, there was no information available as to why the person required a pressure relieving mattress and what the appropriate setting of the mattress should be based on the person's weight.

Falls risk assessments had been completed for all people living at the home. In addition to this a further falls risk assessment tool had also been completed. However, neither of these sets of assessments linked with each other and it was unclear the purpose of completing both documents and what the outcome of these assessments meant for the people receiving care.

All of the above was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we did see one example of a detailed risk assessment for the use of catheters. The risk assessment described the hazard/risk, the control measures in place and the control measures required to reduce or mitigate the risk. Following the inspection the provider sent us updated risk assessments for diabetes and epilepsy which gave clear guidance and information to staff about people's risk and how to support them appropriately.

At the last inspection we found concerns with the environment and the condition of the home. The concerns

found were addressed at the time of the inspection. However, during this inspection we identified further issues relating to disrepair and overall maintenance of the home. We found clinical waste foot operated bins were not working in one toilet and one communal bathroom. The door to the electrical system and boiler room was unlocked with the padlock hanging off the door which meant any person could access the room and harm themselves.

There was a steep flight of stairs leading up to the first floor where the light was not working. On the first floor the door leading to the steep stairs had a slide bolt to keep the door locked at all times. We found the door to be unlocked and the door did not have a slow closure mechanism which meant that people could open the door and potentially either fall down the stairs due to their being no lighting or be knocked and pushed down the stairs by the unlocked heavy door closing very quickly behind them.

A fire door on the first floor, which should be kept closed at all times, had been wedged open with a foot stool causing an obstruction. Several walls and doors were scuffed or dated and required decorating. We found door handles in four bedrooms either loose or hanging off the door. In one bedroom the plug socket was broken and in another two bedrooms, the taps in the en-suite bathrooms had the same coloured caps making it difficult for people to identify which was the hot water tap and which was the cold water tap.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the provider and the manager about these concerns and saw that some of the issues we had identified had been addressed by day two of the inspection. The provider confirmed that a refurbishment plan had been devised in November 2017 and a plan of scheduled works was in place but that this would be updated to incorporate the issues we had identified as part of this inspection. Throughout the inspection we found that the home was generally clean and free from any mal-odours. Staff had access to personal protective equipment (PPE).

At the last inspection we found a number of issues with the way in which medicines were managed and administered. Body maps had not been completed correctly to identify where creams or ointments needed to be applied, the Controlled Drugs (CD) cabinet had not been secured to the wall, appropriate records had not been kept for the safe administration of covert medicines, appropriate temperature checks for the medicines room and the medicines fridge had not been maintained, competency assessments were not available for care staff assessing them as competent to administer medicines.

During this inspection we found that these issues had been addressed and that medicines were being safely administered and managed. People received their medicines as prescribed. Medicine storage areas were noted to be clean and secure. However, we found three months of medicines that needed to be disposed of had been securely locked in a vacant bedroom. The service had not ensured that these had been returned to the pharmacy in a timely manner. We brought this to the attention of the manager and found that by day two of the inspection the medicines had been returned to the pharmacy.

We looked Medicine Administration Records (MAR) for 10 people who used the service. Records were clear and fully completed and showed people were receiving their medicines when they needed them. There were no gaps on the MAR's and any reasons for not giving people their medicines were recorded. Temperatures of the medicine storage area and the medicine fridge were being monitored and recorded appropriately.

Controlled drugs (CD) were stored and managed appropriately. The CD cupboard had been securely attached to the wall. A number of people received medicines which were disguised in food or crushed. When

medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, there were protocols in place which were tailored to the individual and provided guidance to staff on how and when these medicines were to be administered. Records showed that all staff had completed medicines management training. Medicines competency assessments had been completed for those staff who administered medicines.

Care staff demonstrated a good understanding of safeguarding and whistleblowing and were able to describe the actions they would take if abuse was suspected and the professionals they could contact to report their concerns. Comments from staff included, "Safeguarding is about protecting people from harm. You can call various organisations to report any issues with the home" and "Safeguarding the residents from hurting themselves, abuse and harm and I would report to the manager."

Policies and procedures were in place for safeguarding people which gave information about the different types of abuse as well as the procedures that were to be followed if abuse was suspected. However, we found recent records that for one person, there had been no follow up or investigation where care staff had reported unexplained bruising to the person's wrist and hand. The day after the bruising had been noted, the manager had documented that he had reviewed the bruising and recorded as 'skin intact' with no detail of any investigation completed as to the how the bruising had appeared and any follow up action taken such as informing the GP or raising any concerns as a safeguarding alert. We spoke with the manager about the importance of investigating such incidents and his response included, "Staff said [person] gets them [bruises]. On this occasion I took the history of the bruises and I was quite okay that there was no problem." The manager confirmed that he had taken no further action. Following the inspection we received confirmation that the GP had been called to review the person's health care and their care plan had been updated accordingly.

We looked at six staff files and saw that the service had safe systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK.

At the last inspection we found inconsistent and disorganised recording in relation to accidents and incidents. At this inspection we found that this issue had been addressed. The provider recorded all accidents and incidents with details of the person, details of the incident or accident that had taken place, the actions taken and any investigative action taken where required. The manager and care staff confirmed that they would undertake an investigation to ensure that incidents or accidents were prevented and were appropriate lessons were learnt.

Throughout the inspection, we observed there to be sufficient numbers of care staff available around the home. Care staff did not seem rushed and were able to attend to people's needs in a timely manner. Dependency assessments had been completed which gave directive on the level of staff required to meet people's needs. Rotas seen for the days of the inspection, confirmed that the stated number of care staff were present in the home. Relatives confirmed that when visiting their relative they always observed there to be a staff member available and supporting people. Comments from relatives included, "Yeah I think there is enough staff", "There seems to be more staff on some days compared to others. Possibly less at weekends" and "Staffing varies a little bit."

Records confirmed that all care staff had received food hygiene training. We saw that all food preparation

and storage areas were clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures. Issues identified as part of the Environmental Health Agency food hygiene inspection in June 2016 had been addressed. However, during this inspection we learnt that a further food hygiene inspection had taken place in May 2017, where the service had been downgraded in their rating from a three star rating to a two star rating. This has been reported on under 'Well-led'.

Personal Emergency Evacuation Plans (PEEPs) were in place in case of fire. The provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency. However, these had been kept at the front door of the home, which meant that people's confidential information could be accessed by anyone visiting the home.

Is the service effective?

Our findings

People were unable to tell us about whether they felt staff were adequately trained and skilled to deliver effective care and support. This was because most people living at Eliza House were living with dementia and were unable to understand the question that was being asked. Relatives that we spoke with were satisfied with the quality of care and support that was delivered. Comments made when asked if relatives felt staff were appropriately trained included, "Yes I do, they know [person] well", "The ones that I have seen seem to be skilled and trained" and "I don't know how skilled they are but most of the time they look like they know what they are doing."

Records confirmed and care staff told us that they all received an induction when they began their employment at the service followed by regular training and refresher training in topics such as moving and handling, medicines administration, safeguarding, dementia, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Most care staff had also completed all relevant training modules to achieve the care certificate. The care certificate is a training course that covers the minimum expected standards that care staff should maintain in relation to the delivery of care and support.

Records confirmed staff had completed competency assessments following each completed training module. This included assessed competencies for each of the modules of the care certificate. However, we noted that the provider did not have a system in place to review whether care staff had passed the competency assessment at the required standard to ensure care staff could be deemed as competent in each assessed area. We highlighted this to the provider who confirmed that they would look into this with a view to making the necessary improvements.

We spoke with care staff about the training that they received and whether sufficient training was provided by the provider to support them in their role. Comments from staff included, "They [provider] do provide regular training and they would organise additional training if we asked" and, "We are able to suggest topics for training but if something has to be paid for, I am not sure the home would cater for that."

At the inspection in June 2017, records kept for supervisions and appraisals were disorganised and we could not confirm that staff had actually received regular supervision. At this inspection we found that this issue had now been addressed. Records confirmed and care staff told us that they received regular supervision and felt appropriately supported through the supervision and appraisal process. Comments from care staff included, "Yes, I have had supervision. We talked about the job, how I feel and what I want from the future" and "Yes, I have. We spoke about my long term and short term goals and changes in the home."

The adaptation and decoration of Eliza House was very basic and did not always support people living with dementia. Feedback we received from relatives about the condition and environment of the home was not always positive. Comments from relatives included, "Condition of the home is not very good. Could do with decorating", "The inside of the home could do with a freshen up including individual bedrooms" and "The environment is not what it should be. Due care and consideration is not given to laundry or bedding." Our observations throughout the inspection was that the home was in need of modernising. The environment

was not always dementia friendly. Some signage for toilets and bathrooms were seen, however, there was no signage or orientation aids for people to recognise the location of their bedrooms. We saw some people's bedrooms were very person-centred especially where family were involved with the person's care and support. However, some bedrooms were very basic and in need of attention such as appropriate bedding and curtains. We told the provider and the manager of our observations. They told us that they would look at this as part of their refurbishment plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards.

We saw records confirming that the service had appropriately submitted authorisation requests for people who lacked capacity and who were possibly being deprived of their liberty. Where authorisations had been granted this had been documented within the care plan including details of any conditions that had been set. Where authorisations were due to expire a re-authorisation application had been submitted in a timely manner.

Care plans showed that the service had assessed people's capacity. Where people had been assessed as lacking capacity and decisions had been made in their best interests, a multi-disciplinary approach had been taken in order to reach the decision. We saw documentation for decisions that had been made for people such as a 'do not attempt cardiopulmonary resuscitation' (DNACPR) directive, leaving the building, administering medicines or where a person required support with their personal care. At the last inspection the home had not given appropriate consideration for people who were administered their medicines covertly and the appropriate decisions and authorisations were not in place to support this practice. At this inspection we found that the service had addressed this issue.

At the last inspection care plans did not always evidence that people or where appropriate their relatives had consented to the care and support people received. At this inspection we found that this had been addressed. Care plans had been signed by the person or their relative where appropriate.

Care staff understood the key principles of the MCA and DoLS and how this impacted on the care and support that they provided to people including the need to always seek consent from the person. One care staff told us, "Residents don't always have the mental capacity to decide what they want. We make decisions depending on what decisions they can't make." A second care staff explained, "We still have to seek consent even though they don't have the capacity. You will be surprised as to the decisions they can make."

Pre-admission assessments had been completed prior to the person being admitted to home. This ensured that the service would be able to meet the needs of the person and provide them with the appropriate care and support. The pre-admission assessment obtained information about the person, their medical history,

mental capacity, social history and any religious and cultural needs and wishes. Based on the information obtained, care plans had been developed to reflect this information including people's choices, wishes and preferences as to how they wished to be supported. Assessments had been completed in partnership with involved relatives and health care professionals. Where people required specific equipment to support their health and care needs this was provided. The provider and manager confirmed that out of the 20 care plans, 15 had been reviewed recently with the involvement of people and relatives to ensure that they contained the most current information about the person to ensure the service was meeting the needs of people appropriately.

At the last inspection we recorded a mixture of positive and negative observations of the lunch time meal experience where little consideration had been given to the setting and preparation of the dining room to promote a positive mealtime experience. At this inspection we found improvements had been made to people's mealtime experiences.

A seven day menu was in place, outlining the meals that had been planned for the week. Two choices were offered for lunch and the evening meal. Where people did not want to have what they had chosen, we were told that arrangements would be made for them to have an alternative of their choice. People's preferences were obtained every morning for the day. People's likes and dislikes in relation to food were also recorded in their care plan.

We observed people were served in a timely manner and where support was required this was offered and provided in a respectful manner. Food looked and smelt appetising. Care staff knew the people they were supporting and knew about their likes and dislikes in relation to food and drink. People were served their meal depending on where they wished to be sat. People were seen to be able to sit in the dining room or the lounge area if they wished. Care staff were always present in each area checking on people's progress, while focusing their attention on people who required support. Throughout the day we observed people had access to a variety of fruit and a choice of drinks were available throughout the day which people could access independently where possible.

People were complimentary of the food and comments we received included, "Oh, I liked my breakfast, it was lovely", "It is like my mother used to make, homely" and "They give you tea and snacks." Relatives told us that they believed meals were of an acceptable standard and that they felt their relatives were eating well and no concerns had been raised about their weight. Comments from relatives included, "She looks healthy. She is eating it", "She enjoys the food", "The home is trying to improve and they are trying to offer a choice" and "The food must be fine. [Person] has put on weight since she has been there."

People's weights were checked and monitored on a monthly basis. Where weight loss or excessive weight gain was noted we saw records confirming that the appropriate referrals had been made to help ensure that people's nutritional needs were met.

Where people required professional input in relation to their health and medical records, care staff and the manager were aware of how to access the additional resource where required. Eliza House also worked in partnership with the local Care Home Assessment Team (CHAT), which consisted of nurses, occupational therapists and geriatric consultants, who supported the home with acute illnesses so as to prevent any unnecessary hospital admission. Each person's care plan contained records of all visits and appointments made by a variety of healthcare professionals such as GP's, dentists, chiropodists and district nurses. Details of the visit and any actions to be taken had been recorded.

Daily handovers between the care staff team took place at the change of each shift so that information

about each person could be communicated to the new team to ensure continuity of care. In addition where significant changes, observations or incidents had been noted about a specific person this was also passed on so that the appropriate steps or actions could be followed through to ensure that people received the appropriate care and support that they required.

Is the service caring?

Our findings

People and relatives told us that care staff were caring and that care staff had got to know them and their relatives really well and as a result were supported according to their needs and wishes. Throughout the inspection we observed positive and caring interactions between people and care staff which promoted respect, dignity and compassion.

We observed staff being respectful with people. Care staff demonstrated that they had an understanding of each of the people living at Eliza House. Care staff were cheerful and were seen to encourage people with daily living and promoting their independence. Care staff were also seen to be observant as people tried to be as independent as possible. During mealtimes we observed care staff to be patient and gentle. Where people were non-verbal we saw care staff read people's non-verbal signals and respond in a way which was reassuring and encouraging through touch and voice.

People we spoke with were positive about how care staff interacted with them and undertook personal care tasks. Comments from people included, "They are lovely, always helpful", "They know me, know what I like, they are kind" and "If I have to be somewhere that is not home, then this is best place, I been a number of times before, I am here now."

Relative's feedback about the care staff and the care that their relatives received was also positive and included comments such as, "I haven't got a problem with the care. I can't fault the carers. They love my [relative]" and "Staff are caring. I have to admit it is hard work for them but they are caring."

Care staff understood the need to ensure people were treated with dignity and respect at all times. We discussed this with the care staff that we spoke with who gave a number of examples of how they did this on a daily basis. One care staff said, "When giving personal care I make sure the doors and curtains are closed and I always ask people what they want before I do anything" and "I always make sure their door is closed to give them their dignity. When we get a chance it also helps to learn about the person by reading the care plan and speaking with their family."

At the last inspection care plans did not always evidence that people had been involved in the planning or decision making process of how they wished for their care and support to be delivered. Relatives we spoke with confirmed that they had been involved with reviews and updates. Care plans detailed people's individual choices and preferences in areas such as when they wished to get up and go to sleep, what they liked to eat, how they wished to be supported with their personal care and their strengths and abilities. Throughout the inspection staff were observed asking people about what they wanted and how they wished to be supported. This included asking people if they wanted support with their meal or if they required assistance when wanting to visit the toilet.

Care staff demonstrated a good awareness of supporting people from different backgrounds, varying religious and cultural backgrounds and supporting people who may identify as being lesbian, gay, bi-sexual or transgender. One care staff told us, "It makes no difference to me. You support the person in the way that

they want."

Is the service responsive?

Our findings

At the last inspection in June 2017 we observed and were given feedback from people and relatives that there was very little organised in terms of activities. We observed that people were always seen to be taken to the lounge and positioned to watch television or listen to music throughout the day. We saw very little interaction, activity or stimulation that was initiated by care staff that were on duty. At the last inspection the manager at that time explained that they were in the process of recruiting an activity co-ordinator but in the meantime one staff member per shift had been allocated the responsibility of delivering some form of activity in the morning and the afternoon. We did not observe this to be taking place.

At this inspection we observed that although an activity co-ordinator had not yet been recruited, the service had endeavoured to implement improvements in this area. People were observed to be participating in scheduled activities as well as interacting with care staff throughout the day. Relatives that we spoke with also confirmed that the management was trying to improve the provision of activities and stimulation.

During the inspection we saw people participating in a scheduled art and craft session, playing ball games, being pampered on a one to one basis and singing and dancing along with an entertainer who had been booked to perform for them. Other people were seen putting up and decorating the Christmas tree. People who took part stated they enjoyed this activity. A number of people spoke of liking the art activities including colouring in and painting. There were pictures people had drawn or painted on display as well as photographs of people undertaking activities. There was music playing in the sitting areas, which people seemed to enjoy as well as the television switched on in the second lounge for those who chose to watch. People also spoke of enjoying sitting outside in the garden when the weather was warmer.

An activity timetable was displayed on a notice board in the main lounge which listed activities such as keep fit, art, bingo, sing along, musical reminiscence, ball game and puzzle time. However, although there was positive feedback about improvements made in relation to activities, relatives continued to feel that activities provision seemed to revolve around the same activities every week which included arts and craft, ball games and chair exercises. Activity records that we looked at also confirmed this.

In order to improve the provision of activities especially for people living with dementia, the provider had implemented a Pool Activity Level (PAL) tool for each person living at the home. The PAL is a tool used as the framework for providing activity-based care for people with cognitive impairments, including dementia. The assessment tool helps staff to understand the types of activities that might benefit a person with dementia. However, eight PAL assessment tools that we looked at had not been completed appropriately and did not provide any person centred and individual direction for care staff on the types of activities that might benefit a person based on their abilities. Each of the forms we looked at were generic and were not specific and individual to the person. We brought this to the attention to the provider who said they would ensure the assessments were completed appropriately.

At the last inspection we found that care plans were not person centred and did not identify people's likes, dislikes, preferences and wishes. We also could not confirm that care plans had been reviewed in

partnership with people and their relatives. At the time the provider was in breach of Regulation 9 of the Health and Social Care Act 2008. At this inspection we found that care plans were person centred and contained detailed information about the person and their past history. Likes, dislikes, choices and preference had been documented. Care plans had been reviewed and relatives confirmed that they had been involved in this process.

However, we found that care plans were disorganised and contained a number of care plan templates with inconsistent information contained within them. We were unable to confirm which document within the care plan was current and most appropriate to follow as each document had been signed as reviewed and current by the manager. Consent to care forms, although available, were difficult to find. A best interest form for one person had been completed with a different person's name listed throughout the document. The issues identified suggested that care plans had not been reviewed appropriately and therefore people may not have received care and support that was responsive to their needs, choices and wishes.

Staff understood what person centred care was and were able to explain what this meant for the people that they supported. One staff member told us, "It's all about the individual, their needs. We respect their dignity. You have to know that person." A second member of care staff explained, "It's about them. What might be okay for one person may not suit the other person. Care should be to suit each person."

A complaints procedure was displayed at the entrance of the home and detailed the steps that should be taken if and when people, relatives or visitors had any issues or concerns to raise. A comments and suggestions box at the entrance of the home gave people and visitors an opportunity to make any comments or suggestions. People we spoke with felt able to raise any concerns they had and would speak to the care staff or the manager. People felt they would be listened to and that their concerns would be addressed. Comments from people included, "I did have a problem with someone coming into my room and I told the staff and they sorted it out for me" and "I like the manager, and I would be happy to talk to him."

Relatives also confirmed they knew who to speak to if they had any concerns or issues to raise. However, not all relatives felt that concerns that had been raised in the past about, activities, decoration, laundry and maintenance of the home had been adequately acted upon. Comments from relatives included, "I know who to speak with if I have a complaint" and "Improvements are not always made when you complain."

We looked at the folder that the service held for any complaints that had been received since the last inspection. We found that the service had a complaints register in place which detailed each complaint received, the actions taken and the date by which the complaint had been dealt with. Complaints centred around activities, maintenance and how people were supported with personal care.

People's end of life preferences and wishes had been noted in the advanced care planning section of the care plan. Where people had a 'do not resuscitate' authorisation on file this had been recorded appropriately with their advance care plan. Two care plans that we looked at had incorporated significant detail about how they wished to be cared for and supported at the end of their life including detail of their proposed funeral arrangements. However, for another two care plans we looked at, very little detail was available in terms of people's choices and wishes.

Is the service well-led?

Our findings

The service did not have a registered manager in post during this inspection. The provider had appointed a new manager in October 2017 and was in the process of submitting an application to the CQC to become the registered manager. The provider was present throughout the inspection process along with a consultant who they had commissioned to support the running of the service.

At the last inspection we found that although the manager completed a number of audits and checks to monitor the quality of the service these were inadequate and ineffective and did not identify the issues that we had found as part of the inspection process. The management had made some immediate improvements to some of the issues we found. However, due to the high level of concerns we found, we issued the provider with a warning notice for a breach of Regulation 17 of the Health and Social Care (Regulated Activities) Regulations 2014 telling them to be compliant within one month.

At this inspection we found that overall management oversight of the home had not improved. The provider had not met some of the requirements of the warning notice. This inspection found significant new concerns around health and safety, the environment and the condition of the home. Management continued to complete a number of audits that were superficial and mostly consisted of tick boxes which did not identify any of the new issues we identified during the inspection. Where issues were identified, there was no evidence that steps had been taken by the manager or the provider to resolve the issues. Systems and processes available to oversee the running of the home and quality of care provision were inadequate and failed to identify any of the issues that we identified as part of this inspection.

We were shown a number of completed audits for medicines, care plans, fire checks, room checks, maintenance of the home and infection control. Audits were completed by the provider, the consultant, the manager and a number of senior care staff and care staff.

Room audits had been completed on 13, 27, 28, 29 November 2017 in addition to daily room audits which had been completed for the month of November 2017 by a variety of senior care staff and care staff. The audits were a tick box exercise and did not identify any of the issues that we found around poor bedding, broken light fixtures, broken door handles and broken toilet cistern. Where issues were noted such as missing call bell, requires painting and lampshades dirty there was no action plan or detail available on how these issues were to be addressed and by when.

Health and safety audits and temperature checks had been completed for the home. Hot water temperatures, exceeding 44°C, had been recorded in certain rooms since June 2017 but no action had been taken to address this. Weekly and daily room audits had been completed in the month of November 2017 but again none of these audits identified any of the issues we found during this inspection.

Room checks carried out on 6 August 2017 and 8 October 2017 identified issues such as 'window restrictors needs attention', 'light in the toilet not working', 'call bell removed', 'call bell chord faulty' 'curtain require extra hooks' and 'radiator has a low output'. Both audits had detailed the same issues which suggested that

the issues found on the 6 August 2017 audit had not been addressed at the time of second audit completed on 8 October 2017.

Registered person and compliance visits had been completed by the provider and the consultant between 25 June 2017 and 25 October 2017 which identified issues with the provision of activities, decoration and maintenance of the home and audits not being completed. Where issues were identified and action points noted there was no evidence on when the issues had been addressed and resolved by.

Where action plans were in place these had been developed in response to the last CQC inspection and enforcement action that had been taken. One audit action plan dated 31 October 2017 did not detail any of the issues that the provider had found through numerous audits that they had completed. A sustainability plan in place dated 1 November 2017 identified specific areas that needed to be assessed and reviewed on an on-going basis including, medicine management, care plans, health and safety and refurbishments but did not identify any of the specific issues that the provider had identified through their audit systems and did not include any of the issues we found during this inspection.

Where audits had been completed by staff members including senior care workers and care workers we were unable to confirm whether these staff had been appropriately trained and assessed as competent to undertake this task. The manager confirmed that they had been shown how to audit specific areas, however, where this was the case, the manager had not overseen or checked the audit to ensure that it had been completed appropriately. Where certain issues had been identified, no further detail was available of how and when the issue had been addressed.

At the last inspection issues identified by the environmental health department as part of a food hygiene inspection in June 2016 had not been acted upon. During this inspection we learnt that a further food hygiene inspection had taken place in May 2017, where the service had been downgraded in their rating from a three star rating to a two star rating. The notice for the most recent inspection was not on display and the provider was unable to locate the report from this inspection. After the inspection the provider sent us evidence of the actions they had taken in response to the requirements that had been placed.

At the last inspection in June 2017 we found the providers recording systems in relation to accidents, incidents, safeguarding, complaints, satisfaction surveys, supervisions, appraisals, management audits and medicine competency assessments could not be located or were very disorganised. We were unable to confirm whether the provider had the appropriate systems and processes in place to confirm that staff were being supported appropriately. In addition we could also not confirm that the provision of care and support was monitored so that learning, development and improvements to service provision could take place. At this inspection we found that the provider had addressed these concerns and that records were readily available and organised.

However, we found fresh concerns around the organisation of care plans. We found that care plans were disorganised and contained a number of care plan templates with inconsistent information contained within them. We were unable to confirm which document within the care plan was current and most appropriate to follow as each document had been signed as reviewed and current by the manager. The manager told us that he had signed all care plans and risk assessments as having been reviewed and current. However, this was incorrect and we confirmed that risk assessments especially had not been appropriately reviewed. Consent to care forms were difficult to find with older signed forms in place at the start of the care plan and most recently signed forms at the back of the care plan.

Records confirmed and relatives told us that they had completed satisfaction surveys recently and felt able

to give their opinions and suggestions on improvements that could be made within the home so that the service could make the necessary improvements to ensure people received high quality care. However, we found that the provider did not analyse the results appropriately in order to drive through the required improvements. The provider also did not feedback the outcome of the survey to relatives giving them an overview of the results and any improvements that they planned to implement as a result.

Feedback from relatives as part of the August and October 2017 completed survey included, 'Requires more activities', '[person] room needs decorating, more activities', 'I think there should be a lot more stimulation and with a few small changes the home could be made to look more homely' and 'The inside [home] could do with some improvement.' No action plan had been compiled as a result of the comments made from the survey.

The above was in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People and relatives had met the new manager and felt confident in approaching them. One relative told us, "The new manager is catching up on things." A second relative stated, "The manager is approachable and we can discuss our concerns with him." A third relative said, "I'd like to think things are going to be okay. Since the new manager has been here I am happy."

People were also encouraged to participate in resident meetings where possible to give their views on how they wished to receive their care and support. We observed a residents meeting taking place during the inspection. Topics discussed included the Christmas party and food choices. We observed staff encouraging people to join in and to be vocal. We also observed one person who understood English, but could not respond in English. Care staff knew the person and tried to ensure that the person understood what was going on and was supported to communicate their views.

Care staff were equally positive about the new manager and found him to be supportive and were positive about the future of the home and implementing changes to improve the home. Comments from care staff included, "I feel like he is going to be a good manager. We feel supported and he is always there when you need him" and "The management listens to us. Hopefully things are going to get better."

Records confirmed that care staff were supported in their role through a number of processes including supervision, appraisal and staff meetings. We saw records of regular staff meetings where topics discussed included management changes, detailed recording, care plans and key working. Care staff told us that they felt able to give suggestions and ideas on improvements that needed to be implemented and the support they required and that management did take note of this. One member of care staff said, "We have meetings all the time and we talk about development and how to improve. We are able to give ideas and they [management] listen." A second care staff stated, "We just had one last week. They are good. We talk about how the job is going. Everyone contributes and we are listened to."

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including the Care Home Assessment Team (CHAT). The CHAT visited people regularly who had complex health needs or who were at risk of deteriorating and also liaised with the wider multidisciplinary team and supported care staff to coordinate care. Visiting professionals had also been asked to complete satisfaction surveys. Most recent feedback included, 'Staff have always been approachable and helpful' and 'Staff are always very friendly and willing to assist.'

The provider had a vision, mission and values statement on how they wished for people to receive care and support which focused on people and their needs and the provision of an 'enhanced, meaningful and purposeful lifestyle.' We spoke with care staff about whether they knew of the providers values. Responses were reflective of the provider's values and included, "We give good care to residents and support staff to do a good job" and "Excellence in care. To give our best which we are doing."

Relatives generally felt that the home communicated with them where required and overall there was an open and transparent culture at the service. Relatives told us that the service communicated with them about their relatives especially where incidents or accidents had occurred or where their relative had taken ill. They also found care staff were always approachable and gave them the desired information about their relative.

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 Risk assessments failed to provide staff with guidance on how to mitigate people's known individual risks.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that all areas of the home used by the service were suitable for the purpose for which they were to be used and properly maintained.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that the premises and environment used by people were suitable and safe to do so.

The enforcement action we took:

We issued a Warning Notice on 03/01/2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management oversight of the service was inadequate. Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues around the home that were identified as part of this inspection. Where issues were identified there were no action plans in place on how these issues were to be addressed and resolved.

The enforcement action we took:

We issued a Warning Notice on 03/01/2018.