Community Homes of Intensive Care and Education Limited

Elliott House

Inspection report

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Date of inspection visit:
01 April 2021
14 April 2021

Date of publication:
07 June 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Elliott House is a residential care home providing personal care to up to nine people who live with a learning disability, autism and/or associated health needs, who may experience behaviours that challenge staff. At the time of inspection, there were eight people living in the home.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• The environment was suitable for people to live a life like any other citizen. The service is located in a residential area with access to local facilities.

Right care:
• There were some daily practices which were applied to every person, which meant their care and support was not always person-centred.

Right culture:
• Risks were not always in accordance with best interest and least restrictive principles. Restrictive practices were not challenged and it was not clear how people's skills were being built upon to further improve their choice, control and independence.

The provider had policies and procedures in place designed to protect people from the risk of harm and abuse, however, the procedures had not been followed correctly. The home had restrictive practices in place and care was not always person-centred.

Systems were in place which ensured safety checks and maintenance were completed on water, gas and electric installations. However, action had not been taken to reduce the temperature of the hot water and a waste bin placed under a fire extinguisher was replaced in the same position after we had advised the

registered manager and it had been removed.

The provider had systems in place to monitor the quality of the service but these systems did not identify the concerns we found during the inspection.

The provider followed a recruitment procedure which ensured pre-employment checks were in place before new staff started work at the home and there was a staff training programme in place.

People were supported with their specific dietary requirements, for example, pureed food was provided for those who needed it. People received their medicines as prescribed. People were supported to access healthcare services, for example, seeing the GP and having annual healthcare checks.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 8 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elliott House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches of three regulations in relation to keeping people safe, restrictive and blanket practices and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan and meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Elliott House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by one inspector and one assistant inspector.

Service and service type
Elliott House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We reviewed care records for three people, recruitment records for three staff, people's behaviour observation charts, medicines records and a range of other records such as audits and risk assessments. We observed how staff interacted with people and spoke with people and staff as part of these observations. We spoke with the registered manager.

After the inspection
We continued to seek clarification from the registered manager and provider to validate evidence found. We received verbal feedback from six relatives and written feedback from three health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- The provider had policies and procedures in place designed to protect people from the risk of harm and abuse. Staff had completed safeguarding training; they were aware of the different types of abuse and told us they knew what they should do if they suspected abuse or had any concerns.
- The registered manager had notified us regarding two serious safeguarding allegations.
- The registered manager contacted the local authority safeguarding team and the police as soon as they were made aware of the allegations and took appropriate action with regard to staffing.
- However, staff had not reported their concerns to the registered manager until two days after the events and this meant one person had not been protected from abuse.
- We found evidence of restrictive practices within the service which were not the least restrictive alternative and in the person's best interests. This at times led to increased behaviours which challenged and sometimes resulted in physical intervention by staff. Restrictive practices can be in place to make someone do something they don't want to do or stopping someone doing something they want to do. Restrictive practices can arise, for example, because of habit or blanket rules.
- For example, one person was restricted regarding what they could drink and when. This was based on information received by the provider which was out of date. The provider had not sought an up to date assessment of their current needs when the person moved into Elliott House. The restrictions on the person's wishes were not the least restrictive alternative and were not based on a current, up to date, professional assessment. We were not assured they were in the person's best interests.
- Another person had restrictions around food and their care plan identified strategies which again were not the least restrictive. We were not assured they were in the person's best interests. They did not recognise the person's wishes, and promote their well-being.

The failure to protect people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Systems were in place which ensured safety checks and maintenance were completed on water, gas and electric installations.
- However, although the hot water temperatures were monitored daily, the thermostatic mixing valves which ensure a safe water temperature, fluctuated on a daily basis. Over a period of weeks some were noted as being higher than 44 degrees Celsius. If water exceeds this temperature there is an increased risk of serious injury. Robust action had not been taken to address the reasons as to why the water temperature was too hot at some outlets or to reduce the risk. The provider acknowledged temperatures were too hot

but told us people did not use taps independently.
● There was a self-contained single storey building in the garden which people accessed. On our first visit we advised the registered manager a wastepaper basket was placed by the front door and was directly underneath the fire extinguisher and they later removed it. However, during our second visit the bin was in the same place and we advised the registered manager who removed it again.

Staffing and recruitment
● The registered manager told us there were usually five staff on the rota, plus an activities co-ordinator during the week and the registered manager. However, the rota sometimes showed four staff on shift, without the activities co-ordinator and the registered manager told us this was the minimum staff number required.
● Staffing levels were agreed according to the number of hours agreed by commissioners.
● Staff were responsible for every aspect of the day to day running of the home. This meant cooking a range of meals, cleaning the home and laundry tasks.
● Staff views on staffing levels were mixed. Comments included, "It varies, sometimes on shift there can be four or five staff members, or six. It can be difficult", "There is [enough staff] but also it can be weak team, quite a few of us are new so we're not quite as experienced as the other ones are that have been here longer", "It's a challenge at the minute with only three seniors which is trying obviously, it's long hours and lots of hard work. Staffing levels are getting better because we're getting new starters but [we are] training them all up and getting them all to a level they're confident. People's needs are always met though, any time we have shortages on the rota we try and get it covered".
● Other staff felt the staffing levels were adequate. Comments included, "I think that [staffing levels] are the best that they could be. If [anything is missed], it's only little jobs, like taking the bin out, it's then done on the later shift", "I do [think there's enough staff], there's always adequate staff if someone is on one to one [staff support]. There's always someone, on average during the day there's about seven staff, seven in the morning and seven in the afternoon, nine including activities [staff]" and "Yeah [there's enough staff]. I guess if there was a behaviour and other service users were getting a bit agitated then I mean, everyone would be a bit busier obviously."
● Relatives had generally been unable to visit in the last year due to COVID-19 restrictions but one relative told us, "There seem to be plenty [of staff], they are always happy to talk on the phone."
● Where the provider filled gaps in the rota using agency staff, they followed government guidance which states that agency staff should only work in one care setting.
● The provider followed a recruitment procedure which ensured pre-employment checks were in place before new staff started work at the home.

Using medicines safely
● People received their medicines as prescribed.
● Medicines were stored safely, and staff completed medicines administration records (MAR) after giving people their medicines. MARs were an accurate record of the medicines given.
● There were care plans in place for medicines which were prescribed, "as required" which meant people were supported in a consistent way with their medicines.
● People were supported with their medicines by staff who were trained and had their competency assessed. Training had been provided on-line during the COVID-19 restrictions, but was previously face-to-face.
● The registered manager ensured the use of prescribed medicines were reviewed by healthcare professionals. This meant people were only prescribed medicines when they were necessary and for the time they were needed.

Preventing and controlling infection

● We were somewhat assured that the provider was accessing testing for people using the service and staff. Staff undertook three COVID-19 tests a week. Staff had created 'social stories' about COVID-19 testing but people had remained anxious about the process. A healthcare professional had been involved and advised staff should observe for symptoms rather than test. Risk assessments identified the risks of attempting to test and best interests decisions had been recorded.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. People living at Elliott House were very tactile and often communicated using touch. We heard staff reminding people about social distancing and staff wore face shields when supporting people.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using personal protective equipment effectively and safely.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● The registered manager understood the importance of identifying where things could have been done differently, when things went wrong. For example, where a person had missed a dose of their medicine, the registered manager would consider whether anything could have been in place which could have prevented the incident happening. They also took action to prevent the risk of the incident happening again, through additional training.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- During the inspection we found evidence of blanket practices, which meant the care provided was the same for each person and therefore not person-centred.
- On the first day of inspection one person was told it was not their "turn" to go to lunch. On the second day of inspection a different person was asked to stay in the lounge as it was not their "turn" and they had "not been called." The person vocalised in a way which sounded as if they were distressed. They walked out of the lounge towards the dining room but staff persuaded them back into the lounge to look at something. Staff confirmed all the other people were in the dining room eating lunch. We asked staff and the registered manager why this person could not go to lunch. The reasons given were not consistent and we were told both, "Social distancing" and "Behaviours in the dining room". Alternative dining arrangements had not been considered so that people could eat their meal in a way which met their individual needs or without needing to "wait their turn".
- We heard one person ask for a cup of tea but was told that everyone had a drink at 3pm and the person was not supported to get a drink until the allocated time. However, we did observe another person being supported to make a drink in the kitchen at a different time. The provider told us people could have drinks at different times but there were set times to ensure everyone was offered a drink. However, people should be offered and provided with drinks in accordance with their individual needs and preferences. Any risk of

dehydration should be recognised for each person individually.
● Staff undertook half hourly checks of people's whereabouts . We asked staff why everyone needed these checks and were told, "It's always been done that way."
● People with learning disabilities are at greater risk of unmanaged constipation. Each person had a bowel chart in place. We looked at two charts and one was completed appropriately but one was not, which raised a concern that they might be constipated. We raised this with the registered manager who advised that this person was independent with using the toilet and was not at risk. They were independent using the toilet and staff were therefore unable to make a record of their bowel movements, but recorded only if they saw any evidence. We were told everyone had a bowel chart in place because it had always been the case.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider complied with the Deprivation of Liberty Safeguards when people were at risk of being deprived of their liberty and applied to the Local Authority for the relevant authority.
● Where mental capacity assessments were needed for specific decisions, these were completed in line with the MCA and its code of practice. Where people were assessed as not being able to make a specific decision, records showed decisions had included the relevant people and had been made in the person's best interests. However, as noted above, some restrictions were in place without consent or best interests decisions being in place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had an assessment team in place to assess people's needs before they moved into the home.
● The registered manager told us they met people as part of the process, so they could learn about them and consider whether they would be a "good fit".

Staff support: induction, training, skills and experience
● The provider had a training programme in place which included autism awareness, fluids and nutrition and oral health.
● Agency staff undertook some of the provider's training programme, for example, induction training and specialist training for supporting people with learning disabilities.
● Completion of induction training resulted in staff achieving the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
● Staff were supported through the use of supervision, where they were able to discuss their work with a member of the management team.

Supporting people to eat and drink enough to maintain a balanced diet
● The home had a daily menu in place which consisted of two meal choices. However, people could choose something different and some people would make their own meals with support.
● People were supported with specific dietary requirements, for example, pureed food was provided for those who needed it.

Staff working with other agencies to provide consistent, effective, timely care
● The registered manager and staff had developed effective partnerships with relevant professionals, for example GPs, community nurses, community learning disability team, psychiatrists and chiropodists.
● One health and social care professional told us "My experience is [that of] a committed and open working relationship" and another said, "Effective communication channels with our service have been established."

Adapting service, design, decoration to meet people's needs

● The home is a domestic property and people have their own rooms. There is a sitting room, dining room and a central hallway where people can sit if they wish.

● There is a garden and people can undertake gardening activities or sit outside.

● There is a self-contained single storey building, (the "bungalow") in the back garden which gives added flexibility to the way space is used.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to access healthcare services, for example, seeing the GP and having annual healthcare checks.

● One relative told us their relative seemed "healthier" since they had moved the home. Another confirmed when their relative was unwell, "[Staff] go straight to the doctor" to seek advice.

● Healthcare professionals were involved in the care planning process with regard to specific health needs.

● A healthcare professional told us, "My recent dealings have been with the home manager who has been able to provide information and answer my queries knowledgably."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of robust accountability and oversight of the service.
- There was a management structure within the home which included a senior support team. However, we were told there were not enough senior staff to lead the staff team and as a result the deputy manager and assistant deputy manager were unable to undertake management tasks.
- Restrictive practices and the provision of care and support which was not always person-centred, were not identified or challenged within the service. Staff were not clear as to why certain practices were in place and there was an acceptance that "it's always been done that way."
- Whilst there was a system of monitoring the quality of care provided, this had not identified the concerns we found during the inspection.
- Safeguarding procedures had not been followed.

We found evidence that the governance systems in the home had not always been effective. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The registered manager told us they felt supported by the regional management structure.
- Notifications to the Commission had been received as required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager told us they ensured they were visible in the home and available for staff to talk to. They were also involved with staff supervisions and appraisals, and encouraged additional training and qualifications to support staff to evolve in their role.
- One relative said, "[The registered manager] has been great, there has been good contact. The deputy has been good as well. [My relative] likes both of them and is happy." Another relative said, "The current manager cares so much and is extremely empathetic to parents. Communication is very good, they phone you if there is an incident."
- Comments from staff included, "[The registered manager] is approachable, I feel like I can talk to her about anything", "[The registered manager] does listen to staff and she does know people who live here" and "I can't fault [the registered manager] and [deputy manager] at all."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood the process they needed to follow if something went wrong, which included an apology.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were supported to attend monthly "service user" meetings. The meetings were used to discuss ideas for activities, for example, themed days at home, as well as informing people about COVID-19 and how to stay safe.

● The registered manager told us people were included in decision making in the home. For example, if a new decorating scheme or new furniture was being considered, people would be involved in choosing paint colours or buying cushions. People could choose their bedroom furniture and a feature wall colour. One person brought their own furniture with them when they moved in.

● People were involved in discussing ideas and planning in-house activities, such as themed days. For example, one themed day was based on America and included decorating the house and an American based menu.

● Monthly staff meetings were held.

Continuous learning and improving care

● The provider had a system of audits to monitor the quality of the care provided. For example, there was an annual audit of health and safety. Action was taken to improve areas of concern within the home, for example, the fire doors needed some work to make them safe.

● An annual survey was sent out to people, their relatives, staff and professionals who work with the home. The results were analysed and a development plan put in place where areas for improvement were noted.

● The provider undertook an internal inspection based on CQC's inspection model. The last internal inspection was conducted in July 2020. Action was taken to improve the areas identified as needing improvement at that time.

Working in partnership with others

● Staff and the registered manager worked in partnership with other health and social care providers.

● One healthcare professional told us, "I feel the staff do well at working in partnership with the [healthcare provider]. I regularly speak to the manager and senior carers and it is clear they communicate well with each other and pass on messages; I am never passed from person to person or met with an unknowing response when discussing residents. They seem to work well as a team."

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 17 HSCA RA Regulations 2014 Good governance Governance systems in the home had not always been effective.

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 9 HSCA RA Regulations 2014 Person-centred care People were not always supported in a person-centred way which met their needs and promoted their well-being.

The enforcement action we took:

A warning notice was issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse or improper treatment.

The enforcement action we took:

A warning notice was issued to the provider.