Elliott Care Home Ltd

Elliott Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Elliott Residential Care Home is residential care home providing personal care to 17 people at the time of the inspection. The service can support up to 17 people, so the service was full when we inspected.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support: People were not always supported safely with their medicines. Risks to people had not always been identified and addressed. Environmental risks had not always been resolved to limit unnecessary risk to people. Oversight of the service was lacking, for example audits were not always in place where needed.

People were not supported to have maximum choice and control of their lives as staff did not always support them in the least restrictive way possible and in their best interests.

Right Care: The service needed more staff skilled to meet people's medicines needs available at night. Staff had not always been recruited safely. Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture: People led inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff. Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing. Staff respected people's rights. This included making reasonable adjustments for example for an autistic person to manage their sensory sensitivities.

Staff supported people to achieve their aspirations and goals, for example 1 person was supported to meet other family members abroad. People had a choice about their living environment and were able to personalise their rooms.

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 16 November 2018).

Why we inspected
We received concerns in relation to staffing and communication of staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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 Residential Care Home 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 and will take further action if needed.

We have identified breaches in relation to safe care and treatment and governance and oversight at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. The appeals period has now ended for this, and we have sent the provider 2 warning notices. These give a specified time period to make expected improvements.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Elliott Residential Care Home

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 Health and Social Care Act 2008.

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
One inspector visited the service and an Expert by Experience made calls to service users and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Elliott Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Elliott Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage

the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The first day of this inspection was unannounced. The second day was announced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We sought feedback from the local authority. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 8 people who use the service and 1 relative about the experiences of the care provided. We spoke with 6 members of staff, which included a registered manager, deputy manager, domestic cleaner and 3 care workers.

We reviewed a range of records. This included 6 care plans and multiple medicine records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including staff training records, policies and procedures were reviewed.

After the inspection we continued to seek clarification from the registered manager to validate evidence found.

Requires Improvement

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Medicines disposal did not follow safe processes. Medicines which were no longer in use were stored in an unlocked cupboard in an unlocked room. This meant people potentially had access to the medicines putting them at risk of taking medicines inappropriately.

● People did not always receive 'as required' medicines in a timely way at night because some nights there was no staff on shift trained to give medicines on site. One person told us, "There is no-one to give me pain relief in the night. Sometimes, I don't sleep because of the pain."

● Staff lacked guidance to direct them when 'as required' medicines should be given. Where people were prescribed 'as required' medicines for agitation or pain relief, there was a lack of guidance for staff to direct them when to give the medicines or strategies to try as an alternative to medicines. This meant people may have received medicines inappropriately.

● Staff had not regularly received checks on their competency to give medicines. This meant the provider may not have identified staff who needed additional training with medicines administration.

● People who were prescribed creams did not always have clear directions to guide staff where to apply these medicines. This meant staff may have applied these medicines to the incorrect part of the body without realising.

● The disposal of sharp material such as needles was not always safe. The pot to contain the sharps was too full and there was no date recorded on the container to guide staff to know when the container needed emptying. This put people and staff at risk of sharp materials not being managed safely which put them at risk of injury.

Assessing risk, safety monitoring and management

● People's risks had not always been adequately addressed. For 1 person at risk of falls, the provider failed to mention on the risk assessment they were on a blood thinning medication. This meant the person was at additional risk of bleeding, which might go undetected by staff as the risk assessment did not detail the full risks for the person.

● People who were at risk of falls were not appropriately supported by staff. We heard from 2 staff members

they had been directed to support people off the floor if they were to fall and could not get up on their own by lifting under the person's arms. This placed the people and staff at risk of injury.
● Environmental risks were not always addressed. Wardrobes were not all attached to walls. This meant people were at risk of the wardrobe toppling on them.
● Chemicals were not always stored safely. The cupboard where cleaning products were stored was not always locked. This meant people might have been able to access cleaning products putting them at risk of accidental spillage or ingestion.
● Documentation was not always updated in a timely way when people moved rooms. This meant details about people's needs for evacuation in the event of a fire were incorrectly listed. This placed people at risk of an unsafe evacuation if there was a fire.

Care and treatment of people and medicines management was not always safe. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff assessed people's sensory needs and did their best to meet them.
● Staff had received training on abuse and knew how to recognise and report it.

The provider responded immediately during and after the inspection. They confirmed medicines practices had been improved, falls risks had been reviewed and addressed and chemicals were now being stored safely.

Systems and processes to safeguard people from the risk of abuse
● Staff had training on how to recognise and report abuse and they knew how to apply it.
● People and those who matter to them had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern.
● Most people told us they felt safe at Elliott residential care home. One person told us, "I do [feel safe], the staff have learned to protect people from bad behaviour [from other residents]." One person who told us they were unsure if they felt safe or not were unable to expand on this comment.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not always working within the principles of the MCA. Appropriate legal authorisations were not always in place to deprive a person of their liberty. For example, 2 people had no mental capacity assessments for sensor mats which alert staff to people's movements. However, these were put in place by the registered manager straight away.

Staffing and recruitment
● There were gaps in some recruitment and induction records. There was not always a full employment history recorded, application forms and interview records for all staff who worked at the service. Where there were gaps in employment history or recruitment records there was no written explanations to show these

had been explored and recorded.

Recruitment was not always completed safety. This placed people at risk of receiving care from staff that were not suitable to provide care. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff working at the service at the time of the inspection to fully cover the rota. One person told us, "Some staff work very hard. Most of the staff do well. It can get a bit hectic, but they cope." However, one staff member reported feeling under pressure from the registered manager to take on additional shifts and working excessive numbers of hours. When we reviewed the rotas some staff were working in excess of 50 hours a week, however they had opted out of the Working Time Regulations (WTR), which is an initiative to prevent employers from requiring their workforce to work excessively long hours.
● Weekly training had been introduced by the manager for all staff for example to discuss safeguarding or how staff behave with residents.
● Disclosure and Barring Service (DBS) checks had been completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Supervision was completed with all staff every 2-3 months. Staff told us supervisions were helpful.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. One person told us, "It's spotless. Clean and spotless."
● 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, however the monthly infection prevention and control audit lacked in detail.

● People were supported to have visitors in line with current government guidance.

Learning lessons when things go wrong
● Incidents and near misses were recorded, however the registered manager had not reviewed them, or shared lessons learned.
● The registered manager was quick to take action when concerns were identified to them. For example, body maps were introduced by the start of the second day of inspection, to guide staff where to apply prescribed creams for all people who receive them. However, lessons had not always been learnt by the registered manager without the inspector identifying the concerns to them, as systems and processes were not always in place. This will be addressed in the well-led section of the report.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager failed to review incidents. This meant opportunities to drive positive change might have been missed, which could have resulted in improvement in the outcomes for people and reduce incidents.

● Accurate and up to date records had not been kept. For example, one person who was with the service for a few years, had a sentence in their care plan which stated, 'To discover what events/activities [name] enjoys and encourage [name] to engage in those activities.' This meant staff may not have enough information to guide staff to person-centred activities and the registered manager's own processes had failed to identify this.

● Systems and processes were not always in place to monitor where improvements were needed at Elliott Residential Care Home. For example, a lack of care plan auditing meant discrepancies and gaps within care plans had not always been identified. One person who was diabetic did not have symptoms listed in the care plan for staff to look out for if blood sugars were raised. Staff did have good knowledge when asked, but the lack of records could have put the person at risk of unsafe care if agency or new staff were needed to cover.

● A lack of systems and processes to review medicines practices meant the concerns outlined in the safe section of this report had not been identified by the provider. Additionally, medicines incident oversight was lacking as we identified 5 incident forms, some of which were 5 months old, which had not been reviewed by the registered manager or their deputy. This put people at risk of care that was not safe, going undetected.

● Where systems were in place to monitor equipment, they were not always effective, and this had not been identified by the registered manager. For example, medicines fridge temperatures were consistently warmer than the temperatures set out for the fridge by the provider. This has been identified over several months however, action had not been taken to address this concern with any lasting effect. This put people at risk of

consistently receiving temperature sensitive medicines that had been stored incorrectly.

A lack of effective systems and processes placed people at risk of repeatedly receiving care which was not always safe or appropriate for them. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff knew people's sensory and communication needs well. For example we were directed about the sensory needs of one person at the service who was autistic and the registered manager was able to tell the inspector appropriate topics of conversation to hold with another person to put them at ease before commencing a discussion about what they thought of the service.
● People were supported to live culturally diverse lives. For example, a range of religious celebrations were celebrated, and culturally diverse diets were provided.
● People spoke positively about the manager. One person said, "[They] answer your questions. [They] listen to people with problems. [They] won't allow bad behaviour. I always talk to [them] if I've got something on my mind."
● The registered manager has a duty to inform CQC about incidents which involve the police. They had not done this is a timely way on one occasion. However this was put in place as soon as the inspector highlighted this to the registered manager.

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 was able to describe their understanding of the duty of candour. However, as no incidents had required this to be put in place, they were unable to provide evidence of it in practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Resident's meetings were held every month. Topics such as safeguarding and mutual respect were discussed. People were reminded about ways to reduce the risks to themselves and others of infection. People were given the opportunity to raise suggestions and comments. People gave us mixed feedback about the changes implemented as a result of suggestions made.
● People whose first language was not English were supported by signs around the home in their own language. As well as this, people were supported by staff who spoke a range of languages and had access to multi-lingual resources to aid communication for those who required this. The resident's meeting was always completed in 2 languages to make it more accessible.
● People were supported to explore their equality characteristics such as sexuality and gender.
● Staff meetings are held once a month. We were told by one staff member the registered manager, "Always listens to me and helps me. [They are] friendly with everyone."

Continuous learning and improving care; Working in partnership with others
● People and their relatives were asked for feedback on care from the service on a regular basis. People felt they were listened to. One person told us, "I can express my views."
● People had been referred to health professionals in a timely way. For example, one person's GP was contacted when the person was believed to have the early signs of dementia. This prompted onward referral to a memory clinic and the person has now commenced medication to support them.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always recruited safely. This placed people at risk of receiving care from staff which were not suitable to provide care.

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 People were not always cared for in a safe way and medicines management was not always safe.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were lacking, which meant oversight was not always in place from the registered manager.

The enforcement action we took:

Issued a warning notice