Albany Care (Portchester) Ltd

Ellerslie House

Inspection report

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Date of inspection visit:
29 June 2022
01 July 2022
05 July 2022

Date of publication:
19 October 2023

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
Ellerslie House is a residential care home providing accommodation and personal care to people with a learning disability and/or autism. The service can support up to six people. At the time of the inspection five people were being supported. Ellerslie House has four bedrooms and two adjoining flats.

People's experience of using this service and what we found
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.

Based on our review of the safe, effective and well-led key questions the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

The model of care and setting did not fully maximise people's choice, control and independence. For example, people lived in an environment which was not always clean and communal areas were not always homely. We made a recommendation about this.

The manager did remove some of the clutter prior to our second day of inspection. People had privacy for themselves and their visitors. The service was located so people could participate in the local community following a short car journey.

Ethos, values, attitudes and behaviours of leaders and care staff did not fully ensure people using services led confident, inclusive and empowered lives. People were not always supported to have maximum choice and control of their lives and staff did not always 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 have made a recommendation about this.

Care was not fully person-centred. For example, while regular staff knew people well, people were not always treated with kindness and respect and care plans were not always person centred. We observed one person who consistently had two staff, one either side of them, the staff members continually had hands on this person's arms and were preventing them from going in the direction they wanted to go. The staff were constantly redirecting this person even when they were the only ones in the large enclosed garden. This meant the person's freedom was constantly restricted. The manager told us they would speak to the staff to ensure people had as much freedom as possible, they also told us they were reviewing care plans and would update them to include relevant detail and to be more person centred.

People were at risk of harm because staff did not always have the information, they needed to support people safely.

People did not always receive a service that provided them with safe, effective, compassionate and high-quality care.

The service was not maximising people's choices, control or independence. There was a lack of person-centred care.

Leadership was poor, and the service was not always well-led. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements.

The provider did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified all the concerns in the service and where they had, enough improvement had not taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. This meant people did not always receive high-quality care.

Medicines management had improved since our last inspection although medicines audits had not identified gaps in medication administration records. We made a recommendation about this.

Staff had not always received the training and support they required to carry out their roles safely and effectively. We made a recommendation about this.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 January 2022) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the safety of people and a lack of effective leadership at Ellerslie House. As a result, we undertook a focussed inspection to review the key questions, safe, effective and well-led only. 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.

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.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective 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 Ellerslie 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to equipment being checked and maintained, risks not being identified and mitigated, notifications, mental capacity assessments and good governance.

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

Follow up
We will 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.

Ellerslie 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 carried out by two inspectors and supported by a third inspector who made telephone calls to staff.

Service and service type
Ellerslie 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.

There was also an acting manager who planned to register with CQC as the registered manager for Ellerslie House. We refer to this person as the manager throughout this report.
The registered manager was on leave during the inspection.

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. We sought feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method, and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff and the person themselves. In this report, we used this communication tool with one person to tell us their experience.

We spoke with one person who used the service and three relatives about their experience of the care provided. We spoke with three members of staff including the area manager, the manager and the deputy manager.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three staff members on the telephone. We received email feedback from four professionals who visited the service regularly.

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 requires improvement. At this inspection this key question has remained the same. 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.

Assessing risk, safety monitoring and management
At the last inspection the provider failed to ensure equipment used by the provider for providing care to people was regularly checked and maintained, this was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had not been made and the provider remained in breach of regulation.

● At the last inspection we found checks to ensure people's safety were not consistently completed. We found the same concerns at this inspection. For example, we found gaps in water and room temperature monitoring, fire panel and fire call points daily checks and sharps daily checks all of which had not been consistently completed.
● At the last inspection we found one person who had lived at Ellerslie House for two months did not have a personal emergency evacuation plan (PEEP) detailing the support they needed should they need to leave the service due to fire. At this inspection we found all people had a PEEP in place however, not all PEEPs contained enough detail to guide staff on how to support people in the event of a fire. For example, for one person their PEEP stated, 'Verbal method of assistance with the evacuation procedure being, 'to evacuate the building near the nearest fire exit with support staff.' There was no detail about where to evacuate to, for example, a meeting point outside to check everyone had evacuated the premises safely. Another person's evacuation procedure stated, 'Verbal support and direction to a safe place.
● At the last inspection we found risks to individuals from activities or the environment had not always been considered. At this inspection we found the same concerns. Although there were more risk assessments in place, they did not contain the detail staff would require, to support people safely. For example, one person had a risk assessment for cooking in the kitchen which stated, 'Staff should ensure that all risks are reduced when in the kitchen.' However, there was no additional detail about what risks there were or how they were to be reduced. This person also had a swimming risk assessment however, it did not detail how confident the person was in the water, if they were able to swim, if a staff member was needed to be directly supporting at all times or if they had to remain in the shallow end of the pool. There was a risk new or unfamiliar staff would not know how to support the person safely.
● Other care plans and risk assessments lacked enough detail to ensure people were supported safely. For example, one person had a speech and language therapy (SALT) team assessment in place to support them with their choking risk. Their paper eating and drinking care plan did not detail this person was recommended to have thickener in their fluids. The paper risk assessment guided staff to read the SALT assessment and the eating and drinking care plan but did not contain specific detail about how to prepare their food and drink. The risk assessment did not contain detail about what to do should this person choke other than, 'The management on call can provide advice or attend the service in case of an emergency.' This

meant there was a risk there could be a delay in accessing the appropriate care or medical treatment when required.
● One person's care plan for health and skin conditions specified they had no level of need, however, went on to say they required PRN cream because they tend to get dry skin on their face.
● One person had diabetes however, there was no diabetes care plan in place. This meant new or unfamiliar agency staff would not know how to support this person to manage their diabetes and could put this person at risk of harm. There was information relating to diabetes contained in several other care plans however, this meant staff would have to search through several care plans to find the information they required about diabetes which could result in a delay in care or treatment for this person.
● One person's care plan identified they suffered from high anxiety when they can see food however, we observed this person in the kitchen on multiple occasions helping to prepare food. If the statement about suffering from high anxiety when they can see food is accurate this meant the person was at risk of being continually anxious. In their personal care, psychological and emotional care plan it stated, 'Staff to know techniques of distraction to use and how to gauge [person's] mood.' However, it did not describe distraction techniques or details of how to gauge the person's mood. This meant at times of heightened anxiety staff may not be aware of how to support and manage this.
● One person had been living at Ellerslie House for almost a year however, all the information in their health records and appointments was from their previous placement except one appointment record with their GP for an annual health check.
● In the same person's care plan under; 'My community links and social inclusion.' It stated, 'I am new to this area, so I don't go to any groups yet.' This was completed in September 2021 and there was no date entered for 'Last reviewed'.
● Care plans and risk assessments were available in paper form and in electronic form. Staff used both when carrying out their duties. There was a risk when either the paper or the electronic version was updated the other one wouldn't be. This meant staff may not always be following the latest guidance for providing safe care and support to people.
● Physical interventions were used for some people who were experiencing heightened anxiety and were putting themselves and/or others at risk of harm. Care plans and risk assessments did not always contain the level of detail required to support people in these situations.

The failure to ensure equipment used by the provider for providing care to people was regularly checked and to assess and do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke with the manager about our concerns. The manager told us they would review all the care plans to ensure the information was accurate and care plans would be updated to include more detailed information.

Learning lessons when things go wrong
At the last inspection we recommended a system for learning from accidents and incidents was immediately implemented to minimise reoccurrences of potentially harmful incidents. At this inspection we found the recommendation had not been followed.

● The provider did not have a robust system in place to monitor accidents and incidents, or to identify any patterns or trends. Although we saw evidence incidents and accidents were recorded there was insufficient evidence following incidents and accidents that investigations had taken place. There was no effective analysis of why these incidents may have occurred or measures had been implemented to reduce the likelihood of this happening again.

● Records of incidents where physical interventions were used, did not always detail how long they were used for or the position of staff during these interventions. For example, one incident detailed three members of staff were required to support one person. There was no detail about which physical interventions were used, how long for or which side staff were supporting from.
● We spoke to the manager about this. They told us they did talk to staff following incidents however, no formal debriefs took place. This meant it was difficult to evaluate the incident and to identify where lessons could be learned.

The failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user and the failure to evaluate and improve their practise was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At the last inspection we recommended a review of medicines records to ensure that all documents were securely stored and maintained according to current best practice guidance.

At this inspection we found medicines and records were stored securely and were maintained according to current best practise. However, we found further improvement was required when reviewing and auditing medicines. We have made a recommendation about this.

● Medicines overall, were managed safely. Care plans and 'as required' (PRN) medicines protocols were in place.
● Information to support the safe administration of medicines was not always present or clear in medicines administration records (MARs). For example, we identified two gaps on the medication administration record for one person. On further checking these medicines appeared to have been administered which meant this was a records issue. The gaps had not been picked up on the daily audits and there was no evidence to suggest this had been managed in line with the provider's medicine policy.
● The staff carried out regular medicines' audits. However, the audits had not identified the concerns we had identified during the inspection.

We recommend the provider reviews medicine audits to make them more robust in line with current guidance and best practice and update their practice accordingly.

● All staff had received relevant training to enable them to administer medicines safely.
● The manager was responsive to our concerns and took action to investigate the medicine gaps and told us they would review their medicines audits.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems and processes in place to safeguard people from the risk of abuse.
● Safeguarding incidents did not appear to have always been reported to the local authority. However, there had been some confusion about who in each department the local authority was sharing information with and a lack of detail for the provider about who required the information.
● The local authority has supported the provider to ensure they are aware of who is who and where information needs to be shared.
● Most family members thought their relative was safe from the risk of abuse at Ellerslie House however, one relative told us there had been, 'several safety issues raised around medication errors and bruising/injuries.' The manager told us they will continue to report these injuries when they occur.
● There was a robust safeguarding policy in place which was up to date.

Preventing and controlling infection
At the last inspection the provider failed to have appropriate systems to ensure infection prevention and control was safely managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some improvement had been made and the provider was no longer in breach of this part of the regulation.

● Some areas of the home were not always clean, for example we observed carpets which required hoovering and areas of the home which required dusting. There was a cleaning rota in place however, these were not consistently completed. For example, there were no records completed on 16 and 17 June 2022.
● Staff had completed infection control training. This ensured people were protected from risks associated with the spread of infection.
● Staff told us they had access to personal protective equipment (PPE), and waste was disposed of correctly. We observed stocks of PPE available for staff.

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

● We were assured that the provider was meeting shielding and social distancing rules.

● 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 accessing testing for people using the service and staff.

● 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.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● The provider had tried to ensure there were enough competent and skilled staff available to support people safely. Agency staff were being heavily relied on at Ellerslie House. The manager told us it was difficult to ensure the right level of experience and skill mix on each shift. They said, "We try and split them [staff] fairly, all staff are trained in positive behaviour support, epilepsy and first aid. We try to make sure there are drivers every shift. Not everyone is medicine trained, there are two or three medicine trained staff on each shift and at nights there is at least one."
● Feedback from a recent quality outcomes meeting stated, 'Ellerslie are in the process of moving rota around to have management on every weekend to ensure activities are happening.' The manager told us they have enough drivers on to support activities. Where appropriate, people were also able to use public transport.
● Relatives told us there were not enough staff, their comments via email included, 'My relative's funded hours are still used to support another resident and I am not happy about this and this issue is ongoing and unresolved,' and, 'No, [not enough staff] but this isn't a reflection on Ellerslie, more on the fact that the care

industry just hasn't got the numbers they had before COVID.' The provider told us any hours not provided as planned were provided retrospectively.

● The manager spent a significant percentage of their working hours hands on, this was due to not always having enough staff, role modelling and supporting the team however, this meant they had less hours to focus on the management of the service. A professional who visited the service regularly told us in their report, 'There are concerns that management are often used to backfill the floor, and this may compromise other management oversight.'

● Staff comments included, "They would struggle to get people out, but whoever is two to one has that support," "She [manager] is snowed under as she is on the floor sometimes, feels like they could do with more managers." and, "No. [not enough staff] Gradually people have left because of how they were treated by management."

● We spoke to the manager about staffing, they told us they were continuing to recruit and there currently seemed to be more people applying for the job vacancies. The manager told us they were working towards spending less time working hands on."

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 requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment 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.

At the last inspection the provider had failed to ensure systems were in place to demonstrate compliance with the MCA and DoLS. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection although some improvement had been made, the provider was still in breach of this regulation.

- At this inspection we found the provider had more mental capacity assessments in place relating to specific decisions for people however, we were not assured the provider was always working in line with the principles of the MCA. Where people lacked capacity to consent, mental capacity assessments and best interest decisions did not contain enough detail. For example, for one person under the heading 'Details of the assessment of capacity in relation to the above decision (Date carried out/ assessor/ where a copy of the assessment can be found)' the only comment recorded referred to an email from the next of kin giving their approval. There was no evidence any attempt was made to consult with the person.
- The decision maker was not always recorded on mental capacity assessments and there was a lack of detail. For example, how the information was communicated to the person and how understanding was checked did not include any detail.

The failure to ensure systems were in place to demonstrate compliance with the MCA is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● Where required, DoLs had been applied for and authorised. Where conditions were in place these had been met.

Staff support: induction, training, skills and experience
● Staff did not receive regular supervision or appraisal. We spoke to the manager about this who told us, "Supervisions should be done but haven't been taking place, another manager was supposed to have been doing them, I can't find them. Hopefully they will start up in the next month, they were done in June by [Area Care Manager]." It was clear there was no process in place to check if they had been taking place.
● Staff had completed a variety of training including, Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS), fire safety and safeguarding. They had also received training specific to some people's individual needs, for example, diabetes and epilepsy. However, one person had a medical condition which meant they needed very specific support around food. Nine staff members had not yet undertaken this training. This meant staff may not always understand this person's condition or the most appropriate way to support them. Although regular staff were able to describe this person's needs, the service relied heavily on agency staff members who were not always familiar with the people being supported. There was a risk this could impact on this person's health and wellbeing.
● Relatives told us they thought staff did their best and were caring however, relatives comments also included, "I do not feel that they [staff] are listened to or valued and are often blamed for mistakes that would not happen if more robust systems, staffing levels, and monitoring of standards were in place," "Over all the staff do a good job, some better than others," and, "I have witnessed on many occasions some of the agency staff playing on their mobile phones and they do not appear to engage in any way with residents or visitors."

We recommend the provider considers current guidance on training and support standards for care workers and updates their practice accordingly.

● Staff had completed an induction which included the completion of the Care Certificate where required. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working in the care sector.

Adapting service, design, decoration to meet people's needs
● Peoples bedrooms were personalised to their own taste and contained items chosen by them however, the rest of the house did not appear homely or welcoming. On the first day of inspection there was a lot of clutter. Items were being kept stored in piles around the home. We saw three rucksacks under the table. We spoke to the manager about this and on the second day of the inspection we saw efforts had been made to rectify this.
● Medication was kept in a small office off the lounge. The office had a window looking onto the lounge. This window had been used to place service user information which faced into the lounge, however there were staff notices about the service core values and a sign to say, "Please keep me locked at all times," on the door which meant people living in the service had staff notices in their lounge which made it feel less homely.
● There were a couple of photographs on the mantel piece, an artificial plant and a music speaker. The room was very sparsely decorated although we did see some remnants of Jubilee decorations which were still up.
● Although the lounge was a large wide area, attempts had been made to arrange the furniture to encourage better social interaction with people.

● There was a large garden to the rear of the property which was enclosed. We observed people being supported to use the garden. The garden contained a large trampoline with a safety net, cycles and other activities for people to use.
● On the steps outside the conservatory in the garden we observed several cigarette butts. None of the people living at Ellerslie House smoked.

We recommend the provider seeks current guidance and best practice recommendations to ensure the service is adapted, designed and decorated to meet people's needs and update their practice accordingly.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they moved into the home. Once this information was gathered, it was used to develop people's support plans and risk assessments with the support of people and their relatives. However, we found for one person who had moved into the service some months prior to the inspection, they still had records from their previous home. The old documentation was mixed in with updated information completed by the manager at Ellerslie House. This was confusing and there was a risk staff may follow outdated information and people may not receive care in line with their current assessed needs.
● Because the manager used paper records and an online care planning system, care plans and risk assessments were not always regularly reviewed and updated when people's needs changed. For example; one person's paper care plan stated, 'I don't like people invading my personal space i.e. my bedroom, let me tell you to come in rather than just coming straight in.' However, only the first part of the sentence was in the electronic care plan, there was no information about waiting for the person to tell staff to come in rather than just going straight into their bedroom.
● People had accessed GPs, dentists and opticians and this was recorded in their care plan.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to plan a balanced diet however; one person had gained a significant amount of weight between 23 January 2022 and 25 May 2022. Care plans stated, 'Weight monitoring is a mandatory area for recording at Ellerslie House.' However, there was no detail about how often people should be weighed and what action staff should take if there was weight gain or weight loss that was of concern.
● Care plans also specified, 'Food Intake monitoring is a mandatory area for recording at Ellerslie House.' However, food intake was not consistently recorded. Fluid charts for people did not identify how much fluid people should drink during a day. We saw records were either not completed regularly or people's fluid intake was consistently below current recommended guidance for adults. For example, one-person's fluid records show they received less than 900 millilitres of fluid on 24 days in May 2022. There were risks people could become dehydrated which could impact on their health and wellbeing.

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 requires improvement. At this inspection this key question has remained the same. 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; Continuous learning and improving care

At the last inspection the provider failed to assess, monitor and improve the quality and safety of the services provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of this regulation.

- Leadership arrangements did not ensure the safety and quality of the service. The provider had failed to ensure there was adequate oversight of the service. Quality assurance systems and processes did not identify, or address issues found at inspection.
- Systems and processes were not always operated effectively to ensure the service was safe and people were receiving high-quality care. This led to breaches of regulation and placed people at risk of harm as outlined in the safe and effective domains of this report.
- There was a lack of robust governance systems and processes in place to help ensure the safe running of the service. Without these robust systems, the provider and management team could not be proactive in identifying issues and concerns in a timely way and acting on these. The concerns found at the inspection included but were not limited to, care records, risk management, consent and the mental capacity act.
- The provider failed to follow their own governance policy to ensure quality and safety. Several audits were carried out, but these were not done in line with their policy because they were not completed effectively and did not always drive improvement.

The failure to operate effective systems to assess, monitor and improve the service was a repeat breach of Regulation 17 of the Health and Social Care Act. 2008 (Regulated Activities) Regulations 2014.

- The provider notified CQC of significant events that happened in the service as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were not always engaged and involved. Care plans did not identify, where people lacked capacity, how people had been involved in decisions about their care.
● Staff and relatives told us they, and the people living at Ellerslie House, did not receive feedback surveys. We spoke to the manager about this who told us, "I have an open-door policy and an anonymous suggestion box. Carers do come and tell me everything. Supervisions and appraisals. I am always here." However, we were also told by the manager that supervisions were not taking place and the last team meeting was a year ago. This meant there were limited opportunities for staff to share feedback. People and their relatives also had reduced opportunity to give feedback which could impact the service they received.
● There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.
● Peoples care plans stated, 'I identify as' followed by male or female however, this had been completed for all people, including those who lacked capacity. The manager told us this had not been talked about with those people because they wouldn't understand. This meant people were not being engaged in decisions being made about them by staff.

The provider failed to seek and act on feedback from relevant persons and other persons on the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did have a new area manager who had been in post for a few weeks. They showed us some feedback they had sought from staff and were looking at ways of gathering more information. They talked about how the feedback will be used, improvements made, and outcomes shared with people, relatives and staff.
● The service worked in partnership with GPs, dentists and opticians. We received positive feedback from two professionals who worked with the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture of the service did not fully reflect the principles and values of our Right support, Right care, Right culture guidance. People did not live in a homely communal environment. There was a lack of evidence to demonstrate how people had been empowered to have as much control over their lives as possible.
● Systems did not evidence how people were supported to express and review how they wanted their care to be provided or how the home was run. People were not involved in developing their care plans; however, their individual needs and circumstances were considered when they were developed by staff. Family members had been involved.
● Care plans did not always include people's goals or longer-term aspirations.
● Some staff told us they felt supported by the management team when asked, however, one staff member told us they did not feel fully supported by the manager who could be a "bit moody at times, but does care and does try her best."
● Some people had behaviours that challenged themselves and/or others. All people were being monitored every half hour and a chart was colour coded red, amber or green (RAG rated). We spoke with the manager about this who told us they put everyone on a RAG rating chart. We asked why and were told it had always been in place and seemed like a good tool so was introduced for all people regardless of their need. This tool was not monitored and evaluated. The manager could not tell us what behaviours constituted a red, amber or green behaviour.

We recommend the provider seeks current guidance on providing person centred care and update their practice accordingly.

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

● At the last inspection we identified not all the records reviewed held all the information required, such as updating records and noting any learning from incidents. At this inspection we found the same concerns. For example, incident forms lacked detail, one person had an incident/accident in March 2022 however, the form does not detail how the injury occurred.

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. We found, the provider had reported incidents, accidents and safeguarding concerns to the local authority and had notified CQC when required.

● The manager had informed relatives when incidents had occurred.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure systems were in place to demonstrate they were compliant with the MCA. Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a repeat breach of regulation 11 of the Health and Social Care Act 2008.

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 failure to ensure equipment used by the provider for providing care to people was regularly checked and maintained was a repeat breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to assess and do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user and the failure to evaluate and improve their practice was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to seek and act on feedback from relevant persons and other persons on the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to operate effective systems to assess, monitor and improve the service was a repeat breach of Regulation 17 of the Health and Social

Care Act. 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice