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Elizabeth House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Elizabeth House Residential Care Home is a care home which can provide personal care for up to 16 people. Accommodation is provided over two floors. The service supports people who have needs associated with ageing or are living with a dementia related illness. At the time of this inspection five people were using the service.

People's experience of using this service and what we found
The service was not safe. The provider and registered manager failed to ensure risks to people were assessed and managed. Risks to people were not always assessed, reduced and monitored. The provider had not ensured they followed safe recruitment practices. Medicines were not managed safely.

The service was not clean. Equipment used as part of people's care was not clean. Food was not consistently stored safely. Similar issues from our last inspection had not been acted on. Lessons were not learnt when things went wrong. There was no evidence of learning from accident or incidents. Staff told us they knew how to report concerns about abuse. However, we observed care practices that put people at risk which staff had not reported.

People continued to be put at risk because the provider and registered manager failed to ensure suitable quality assurance checks identified issues with care and support. Audit systems were not comprehensive or robust. Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements.

People were put at risk of harm as the registered manager did not demonstrate they had the required skills and competency to manage the service effectively and safely. The provider and registered manager had failed to act on the issues identified on our last two inspections.

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 Inadequate (published 11 March 2020) and there were multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns from the local authority in relation to risks associated with people's health conditions, management of medicines, unsafe recruitment practices, and unsafe food storage. As a result, we undertook a focused inspection to review the key questions of Safe 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.

The overall rating for the service has not changed. 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 Elizabeth House Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to Regulations 7, 12, 17, and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Please see the action we have taken at the end of this report.

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. We will work with the local authority to monitor progress. If we receive any concerning information we may inspect sooner.

Special Measures:

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Elizabeth House 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors on the first day, and one inspector on the second day.

Service and service type
Elizabeth House Residential Care Home 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. The registered manager is also one of the partners for the provider.

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 about 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

During the inspection visit we spoke with two people who used the service. We spoke with four care staff (including agency staff). We spoke with the registered manager. We also spoke with two health and social care professionals. We looked at a range of records related to how the service was managed. These included five people's care records and how medicines were managed for five people. We also looked at seven staff recruitment and training files, and the provider's quality auditing system. During the inspection visit we asked the registered manager to send us additional evidence about how the service was managed, but they did not do this.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. 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 not enough improvement had been made and the provider was still in breach of regulation 12

● The service was not safe. The provider and registered manager failed to ensure risks to people were assessed and managed. Risks to people were not always assessed, reduced and monitored.
● People's care plans did not have sufficient information to enable staff to support people with behaviour which indicated distress or anxiety.
● For example, staff should record when people displayed anxiety or distress behaviours, clearly documenting what the person was doing, and how staff responded. These records can then be used to look for patterns in behaviour and develop a care plan to help staff use appropriate strategies to support people. Staff confirmed they did not record this behaviour as it was not needed. However, one person's records showed they had regular agitated behaviour, with no clear plan for staff to support the person effectively. This put the person at risk of undue distress and risk of sedating medicine being used inappropriately.
● Another person had bedrails that were not secured adequately to the bed. This put the person at risk of falling from bed, or entrapment in the bed rails. An external health professional confirmed the bed rails were unsuitable and put the person at risk of harm.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure safe recruitment practices were in place. This was a breach of regulation 19 (Fit and proper persons employed) 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 regulation 19.

● The provider had not ensured they followed safe recruitment practices. For example, staff were doing "shadowing" shifts as part of their induction without the provider doing DBS (disclosure and barring service) checks or undertaking an assessment to ensure staff were suitable to work in the service.
● There was no evidence the registered manager had addressed any of the issues relating to staff suitability to work or performance since our last inspection.

This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to a shortage of staff, the registered manager was undertaking a significant number of care shifts. This meant they did not have time free to manage staff or manage other aspects of the service. However, during our inspection, we saw there were enough staff on each shift to provide care and support to people when they needed it.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. 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 not enough improvement had been made and the provider was still in breach of regulation 12.

● Medicines were not managed safely.
Guidance for PRN (as and when required) medicines did not contain sufficient information to guide staff on when PRN medicines were needed by people. Two people did not have PRN protocols in place. This meant there was no information to guide staff on when to give the medicines and put people at risk of being given medicines unnecessarily, or not receiving medicines when needed.
● Staff did not record why PRN medicines were used, which is best practice. For example, one person was given a PRN sedating medicine on 18 out of 28 days with no clear rationale for the use of this. This lack of information meant there was no way of analysing whether PRN medicines were being used appropriately.
● We found prescribed creams in people's bedrooms that were out of date. Staff confirmed these creams were still being used on people.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure the service was clean, or that infection control measures reduced the risk of cross contamination and spread of infection. 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 not enough improvement had been made and the provider was still in breach of regulation 12.

● The service was not clean. For example, medicine pots were dirty and not stored hygienically. We identified this as an issue at our last inspection, but the registered manager had not taken action to ensure medicine pots were clean. This continued to place people at risk of infection.
● We identified furniture and fixtures where the surface was scratched or chipped, including in toilets. These were issues on our last inspection. The registered manager said the provider had plan to improve the fixtures and furniture, but no action had been taken since our last inspection. This meant there were areas of the building unable to be cleaned effectively.
● Equipment used as part of people's care was not clean. We examined one person's specialist pressure relieving chair. The waterproof fabric on the padded areas of the chair was torn in places, meaning it could not be cleaned effectively. Other parts of the chair were dirty and stained. Another person's denture bath was unclean with visible debris in the liquid.

● The provider had not followed their own policy regarding an outbreak of an infectious condition. Only one person had been treated for the condition, and the provider's policy was clear that everyone living and working at the home should also be treated to reduce the risk of re-infection. The registered manager confirmed only one person was treated. Following this inspection, the registered manager took appropriate action to ensure the risk of re-infection was minimised.
● Food was not consistently stored safely. For example, we found food requiring refrigeration stored in cupboards. Food was not marked with the date of opening so staff knew when to dispose of it in accordance with the manufacturer's guidance. Fresh meat had been frozen without staff recording the date of freezing or expiry date. This meant it was unclear whether the meat was safe to be cooked and eaten. We found milk was defrosted to room temperature then put back in the fridge. These unsafe food hygiene practices put people at risk of food poisoning.
● The registered manager's monthly audit identified areas needing cleaning but did not ensure action was taken to address this. This was an outstanding action point from our last inspection. We spoke with the registered manager about our concerns and they said they would be addressed. However, we noted that similar issues from the last inspection had not been acted on. The lack of attention to cleanliness and good food hygiene practices put people at risk from acquiring infections.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection the provider had failed to assess, monitor and improve the service, putting people at risk of harm. 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 regulation 17.

● Lessons were not learnt when things went wrong.
● Accident and incident analysis had not been completed since May 2019. There was no evidence of learning from accident or incidents. The registered manager said they were not sure when the last analysis was done and could not give an explanation for this. They agreed to send inspectors a copy of the latest analysis after the inspection visit but did not do this.
● One person had recently had a fall requiring hospital treatment. Staff and records confirmed the person had a similar fall three days previously. Despite this, staff had not reviewed the risk assessment or care plan for risk of falls or put any additional protective measures in place. The person's care plan said a motion sensor should be used in their bedroom to alert staff when they got up. Staff confirmed this was not in use at the time of the recent falls. The registered manager confirmed they had not reviewed the person's falls risk, and no opportunity was taken to learn from this or put additional measure in place to reduce the likelihood of a fall. This placed the person at continued risk of injury from falls.
● When the person was ready to leave hospital, CQC did not let the person return to Elizabeth House Residential Care Home. This was because we had concerns about the service's ability to keep the person safe. CQC has restrictions on admissions to the service; this was action we took following our inspection in June 2019, when the service was rated Inadequate.

This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff had received safeguarding training and were able to describe the signs of abuse they needed to look out for. Staff told us they knew how to report concerns about abuse. However, we observed care practices that put people at risk which staff had not reported. The provider was unable to demonstrate that staff put their learning into practice.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 our last inspection systems in place to assess, monitor and improve the quality and safety of the service were not effective. This was a continued 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 regulation 17.

● People continued to be put at risk because the provider and registered manager failed to ensure suitable quality assurance checks identified issues with care and support. Audit systems were not comprehensive or robust. For example, the last medication audit was October 2019, and the provider had not taken any action since our last inspection to ensure medicines were managed safely. The provider's policy on managing medicines stated, "Regular, weekly audits will be carried out and the results will be recorded."
● The registered manager could not tell us why audits were not carried out regularly. The registered manager told us they had carried out audits since our last inspection. For example, in relation to medicines and infection prevention and control. We requested copies of these but were not provided with them. This meant people were placed at risk because issues with the quality of care were not identified quickly through an auditing process, and there was no opportunity for learning and improvement of care.
● The provider and registered manager did not have systems in place to identify when things went wrong. This meant they did not have the opportunity to improve the service when things went wrong.
● The provider had worked with an external consultant to develop an action plan to improve the service. The registered manager confirmed that the provider had been working on this action plan since December 2019, when they met with CQC to discuss concerns at the service. Despite this action plan, there remained a number of areas identified on this inspection where no work had taken to improve the quality of care.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection the provider had failed to ensure the registered manager was fit to carry on a regulated activity. This was a breach of regulation 7 (Requirements relating to registered managers) 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 regulation 7.

● People were put at risk of harm as the registered manager did not demonstrate they had the required skills and competency to manage the service effectively and safely. They also failed to provide inspectors with evidence requested during this inspection. This is now the third time the service has been rated as Inadequate. There were multiple continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a continued breach of Regulation 7 (Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last inspection the provider failed to assess, monitor and improve the quality and safety of the service provided. This was a continued 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 regulation 17.

● There was continued evidence that the registered manager did not gather or use information from the daily running of the service such as care plan reviews and accident and incident data to learn and improve the care provided to people. This placed people at ongoing risk or harm from care that was unsafe.
● Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements. For example, checks on slings used to hoist people had not identified that a number of slings were unsafe to use. A visiting health professional confirmed that all but one of the slings were worn, threadbare and incorrect for the people they were used for.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider failed to seek and act upon feedback from people, staff and other professionals. This was a continued 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 regulation 17.

● The provider and registered manager had failed to act on the issues identified on our last two inspections.
● The provider and registered manager had not acted to address concerns raised by the local authority. Local authority quality monitoring visits since October 2019 had identified a number of issues which had not been addressed by the time of this inspection. Ongoing issues were also identified as part of local authority safeguarding investigations into peoples' care, but the provider had not taken steps to address these concerns.
● The registered manager said they did an annual survey for people, relatives and external professionals. This was to get their views on the quality of the service. There was no evidence that these views were used to help drive improvements in the quality of care.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has conditions on their registration, where they are required to send CQC a monthly action plan to show how they are improving the service. Since January 2020, the provider has failed to submit their action plan. This is a breach of Section 33 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Section 33 HSCA Failure to comply with a condition The provider failed to send CQC a monthly action plan in accordance with the conditions of their registration.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people were assessed and managed. Medicines were not managed safely. The service was not clean. Unsafe food hygiene practices put people at risk of food poisoning. The lack of attention to cleanliness and good food hygiene practices put people at risk from acquiring infections.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks identified issues with care and support. The provider and registered manager did not have systems in place to identify when things went wrong. Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements. The provider and registered manager had failed to act on the issues identified on our last two inspections.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured they followed safe recruitment practices. There was no evidence the registered manager had addressed any of the issues relating to staff suitability to work or performance since our last inspection.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers People were put at risk of harm as the registered manager did not demonstrate they had the required skills and competency to manage the service effectively and safely. There were multiple continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.