St Elizabeth's Centre

St Elizabeth's Care Home with Nursing

Inspection report

South End
Much Hadham
Hertfordshire
SG10 6EW

Tel: 01279843451
Website: www.stelizabeths.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St Elizabeth's Care Home with Nursing provides both nursing and personal care to up to 110 people in 11 bungalows and three single occupancy flats, within a campus style community. The service specialises in offering care and support to people with epilepsy, associated neurological disorders, a learning disability and other complex medical conditions. At the time of the inspection there were 86 people living at the home.

People's experience of using this service and what we found
People were at risk of not having their needs met in a timely manner. The provider acknowledged that there were not enough staff available to meet people's needs. They told us they were having to prioritise personal care and safety over supporting people to go out or learn new skills.

The majority of risks in relation to people's health, safety and well-being had been identified and assessed. However, these assessments did not always enable people to be in control of taking calculated risks. Furthermore, records indicated that risk assessments were not always followed by staff, for example, in relation to repositioning, choking or dehydration risks.

We identified a number of issues relating to the environment and repairs required. This included cracked tiles and flooring in bathrooms, exposed hot water pipes and a light fitting hanging from the ceiling in one of the bungalows. Staff told us they had reported these concerns but there was a long waiting list for repairs. Immediate risks were reported to the management team on the day of inspection and interim measures taken to ensure people's safety.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Not all staff we spoke with were aware of the principles of the Mental Capacity Act and these principles were not consistently embedded in their practice. This meant there were restrictive practices in place, such as locked doors. There was no evidence that the provider had considered if this was the least restrictive action to take.

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.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Staff did not always consider people's individual needs nor promote choice and control. The language used in care plans and by staff did not always promote a respectful, personalised

approach and this had not been identified by the management team. For example, care plans referred to people "absconding" from their own homes. A staff member also told us, "This is where people come to die", in reference to the bungalow they were working in.

People's independence was not promoted. For example, in meeting minutes for one bungalow, it stated, "Cooking in the bungalow by residents still needs to be organised as it is time consuming and as staff are busy, it would be as time allows and needs to be planned in advance." This suggested that the development of people's independent living skills was not embedded in the day to day operations of the service

We found that people were not always treated with dignity and respect. For example, staff did not knock on doors when entering people's rooms and we were shown into rooms where people were in bed or being supported with personal care. Care and support plans did not always focus on positive outcomes to improve people's quality of life. There was limited evidence that staff supported people to identify aspirations for the future. Where wishes were identified they were not always personalised or meaningful to the individual.

Due to living within a campus style community, in a rural location, people were dependent on staff to leave the site safely. However, people did not have control over when they could leave, and staff confirmed it would be difficult for them to facilitate any spontaneous trips out, with this situation exacerbated by staffing difficulties and the COVID-19 pandemic. Daily records indicated that people had a limited choice of things to take part in during the day, and infrequent opportunities to leave the St Elizabeth campus.

The management team had not identified issues we found regarding the culture of the service. They had produced a service improvement plan; however, this did not include actions around how they intended to embed the principles of Right support, right care, right culture at the location.

The provider did not clearly distinguish between the responsibilities of the staff employed by the care home and those employed by the on-site health agency. St Elizabeth's Care Home with Nursing is registered to provide both personal and nursing care. However, all nursing care was provided by the on-site health agency. This arrangement meant that records were sometimes disjointed or missing. For example, health records held at the bungalows were not always up to date. We were told this information was managed by the on-site health agency. This meant important information was not accessible to the staff supporting people on a daily basis.

The provider's systems for understanding what was happening within the home were not effective, they had failed to operate effective monitoring of the quality of care. We identified gaps in care plans, risk assessments and daily records. These had not been identified by the provider. Continuous learning was not promoted within the service, with lessons learned following incidents and safeguarding concerns not shared with all staff.

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 January 2018). Since this rating was awarded the provider has altered its legal entity. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
This was a planned inspection based on the previous rating.

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. This included checking the provider was meeting COVID-19 vaccination requirements.'

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 management of risk, staffing, the environment, restrictive practices, developing care that is personalised and the provider's oversight of quality at this inspection.

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 overall rating for this service is 'Inadequate' and the service is therefore 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

St Elizabeth's Care Home with Nursing

Detailed findings

Background to this 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 included checking the provider was meeting COVID-19 vaccination requirements. 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 team was made up of three inspectors, a pharmacy inspector, a specialist advisor who was a qualified learning disability nurse and two Experts by Experience. 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
St. Elizabeth Care Home with Nursing, is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and partner agencies who worked with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and 17 relatives about their experience of the care provided. We spoke with 18 members of staff including the registered manager, director of care, bungalow managers, senior care workers and care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Some people were unable to verbally tell us about their experiences of care, therefore, we spent time observing their interactions with staff.

We reviewed a range of records. This included 20 people's care records and 11 medication records. We looked at three staff files in relation to recruitment. A variety of documents relating to the management of the service, including quality assurance and training records, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risk assessments did not enable people to be in control of taking calculated risks. This meant that people were subject to restrictive practices within their home and were not supported to have choice and control over their lives. For example, the home had only recently started to allow relatives to visit people at home in the bungalows. This was a despite a change in government guidance five months previously. The home told us that this was to keep people safe but had imposed a blanket restriction, instead of considering people's individual circumstances and risk assessing accordingly.

● Whilst risk assessments were in place, they were not always followed by staff. For example, one person had a care plan which indicated they were at high risk of skin breakdown, so they were not to sit in their wheelchair for longer than two hours without being repositioned. During the inspection we observed this person for three hours and they were not supported to reposition. Staff were unable to locate repositioning charts. This put this person at increased risk of skin breakdown.

● In another example, a person's care plan indicated that they were at high risk of skin breakdown. They used a wheelchair to move from place to place but care plans stated the person, "must transfer" [out of a wheelchair], once they arrived at their destination, including rooms within the bungalow, as directed by their physiotherapist. We spent 90 minutes in a bungalow where this person remained in their wheelchair throughout. This meant staff were not following professional advice and the person was put at increased risk of skin breakdown.

● Each person had a personal fire evacuation plan, to guide staff in the safe evacuation of that person. However, in one bungalow we observed there was a lot of equipment, which could potentially impede a safe exit. We also observed instances of fire doors being propped open.

● Risk assessments and care plans indicated where people needed their food modified due to choking risks and where they required support with eating and drinking. However, daily records suggested care plans were not always followed. For example, one person needed to have minced and moist foods, however they had eaten sausage and gravy for tea the previous evening. In another example, a person deemed to require a soft diet, was recorded as having eaten roast gammon, pork meat and chops. Following the inspection, the registered manager confirmed that this was likely to be a recording issue and that meals were prepared in line with people's individual guidelines.

● Where people were deemed at high risk of dehydration, records were not always adequately maintained. For example, one person was identified as requiring 2000mls of fluid per day, however, staff were not documenting how much fluid the person had accepted. In another example, staff were documenting fluid intake for a person but there was no guide as to how much they should be consuming. Records indicated that this person's fluid intake fluctuated between 600 – 1800ml a day. This meant people were at risk of becoming dehydrated and this not being identified by staff.

● Some people's health records were disjointed, missing or not up to date. Where information, such as

people's weight monitoring or epilepsy care plans, were not present in the bungalow, we were told this information was managed by the on-site health agency. This meant important information was not accessible to the staff supporting people on a daily basis, which could put them at risk of receiving incorrect or inappropriate care.

Risk was not effectively managed, and systems were either not in place or not robust enough to demonstrate safety was effectively managed within the home. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider acknowledged difficulties juggling staff absence's whilst ensuring people's needs were being met. They told us they were, "Having to prioritise personal care and safety of residents. Which means that, at the moment, we are having to limit [people's social events], exercise, off-site trips and some of the independence skills training that we would normally offer."

● One staff member told us, "We support eight people in this bungalow. Four of those people are assessed as requiring one to one support. Two further people require the assistance of two members of staff for personal care. We sometimes only have five members of staff working. We do our best, but it sometimes means people are left with no support when they need it." This meant people were at risk of not having their needs met in a timely manner.

● During the inspection, we saw people were supported to bed between seven and nine thirty PM. When we queried if this was people's choice, a member of staff told us, "There are occasions where we are so short staffed that it is safer for people to be supported to bed early. At least once they are in bed, we know they are safe."

● Relatives said the provider had been open and honest with them regarding staffing challenges. Some relatives were satisfied with the measures taken to address this. One relative told us, "Despite the shortages, I do not think my [family member] is suffering." However, another relative said, "The staff are overworked…. I think my [family member] is getting bored. I'm not sure they get their one to one hours."

● Staff confirmed that people did not always receive their one to one hours, meaning they were at risk of not receiving care in line with their assessed needs and activities were restricted. One staff member told us, "It's horrible. We don't have enough staff so people can't go out. It feels like we are punishing them."

There were insufficient staff to support people in line with their assessed needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated a safe recruitment process; appropriate checks were undertaken to help ensure staff were suitable to work at the service. Criminal record checks and satisfactory references had been obtained for all staff before they worked with people.

Learning lessons when things go wrong

● Systems were in place for reporting and responding to accidents and incidents. However, staff told us these were not always followed. One staff member told us, "We check if that person is safe, are they happy and then the incident report will be done the next day…that is how mistakes happen as things are not reported [at the time]."

● Staff gave us mixed feedback about if they received debriefs following incidents. Practice appeared to vary across the bungalows. This meant staff did not always have the opportunity reflect on what had happened and identify any learning for the future.

● Learning from safeguarding concerns and incidents was not consistently discussed at team meetings. There was no clear process for sharing organisational learning across the site.

Preventing and controlling infection

● Staff were provided with Personal Protective Equipment (PPE), including face masks, gloves and aprons. We observed several instances staff either not wearing PPE or wearing it incorrectly, however, this was isolated to one bungalow.

● Processes were in place to ensure relatives were able to visit their loved ones safely.

● We were assured about COVID-19 vaccination and testing processes in place.

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

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

● From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.

Systems and processes to safeguard people from the risk of abuse

● The registered manager understood their responsibilities to safeguard people from abuse. They had systems and processes in place to help identify and report any concerns, but these were not always effective.

● Staff received training and were clear about what would need to be reported and the systems in place for them to do this.

● Despite our findings, relatives told us that staff provided safe care. One relative told us, "[Family member] is safe there, we are very fortunate." Another relative said, "Oh yes, they are very safe."

Using medicines safely

● Records showed that people were being given their medicines as prescribed. Medicines were stored safely and securely.

● The provider was aware of the STOMP initiative and we saw evidence that people had regular medicines reviews. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines.

● Staff received training in medicines administration and had their competency assessed.

● Documents to help staff to administer, "as required" (PRN) medicines were not always in place at the point of administration. There was no record in medicines folders about why a PRN medicine was administered or if it had been effective.

● Medicine audits were completed regularly and learning from these was shared with staff to improve practice.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant the effectiveness of people's care, treatment and support did not 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.

- Not all staff we spoke with were aware of the principles of the Mental Capacity Act and these principles were not consistently embedded in their practice. We observed the dining room in one bungalow to be locked once it had been cleaned for the evening. When we asked the staff member why they said, "We lock the residents out, so they don't get into mischief it is locked, as we clean it." When we spoke with the management team, they had not considered if this was the least restrictive option to keep people safe. This meant people were being restricted in their own home.
- We observed a sign on the entrance door to one bungalow stating that there was a "Precautionary Lockdown." Both people and staff told us that people were not allowed to visit friends in other bungalows. The registered manager told us bungalows had been paired together for the purpose of going to the on-site day centre. However, we saw no evidence that people had the opportunity to mix with friends from other bungalows, aside from the one their bungalow was paired with. This decision had been made in people's best interest but there was no evidence to suggest that they had considered if there was a less restrictive option. In addition, the day centre was closed at the time of inspection, due to staffing shortages.
- Every shower room/ bathroom door was locked in eight of the eleven bungalows. Staff told us this was because people may run a bath or shower and get into it and have a seizure. We saw nothing to confirm this was the least restrictive option, dependent on the needs of people's living in each bungalow and the staffing ratio. This meant people did not have access to all areas of their home. Following the inspection, the registered manager confirmed that risk assessments were being reviewed in all houses to ensure the least restrictive option was being taken.

● We saw no evidence that the provider promoted the use of advocacy services, in order to assist people to express their thoughts and ideas and to ensure their best interests were represented.

The service failed to demonstrate they had considered the "least restrictive" option when making best interest decisions, in line with the Mental Capacity Act 2005. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● During the inspection we identified a number of issues relating to the environment and repairs required. This included a light fitting hanging from the ceiling in one of the bungalows, broken toilet seats and bathrooms being used as storage areas. Staff told us they had reported these concerns but there was a long waiting list for repairs.

● Some areas of the bungalows required a deep clean. In one bungalow this had been identified by a senior manager during an audit in October 2021. The action plan stated, "Managers have a planned deep clean day in preparation for Christmas and for re-opening to families." The registered manager explained that this was an additional clean with other deep cleans scheduled to take place sooner. However, this action had been identified three weeks prior to our inspection but there was no evidence additional cleaning had been undertaken. This suggested action to ensure people lived in a clean environment was not completed in a timely manner.

● Several bathrooms were in need of repair. We saw cracked tiles and flooring, damp and damage to the ceiling. Infection control risks were identified and reported to the manager on the day of inspection. As a result, one bathroom was immediately taken out of use and a refurbishment scheduled.

● We observed exposed hot water pipes in shower rooms on two bungalows. Grab rails were also not in situ. Staff told us they had raised urgent concerns due to the increased risk of burns or falls. A risk assessment had been completed but the management team were unable to provide us with a timescale for these works. Following the inspection, heat resistant form was fitted around the hot water pipes as an interim measure and grab rails filled on one of the two bungalows.

The provider had failed to ensure people lived in a safe and well-maintained environment. This placed people at risk of harm. This was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● People were not always supported by staff who had received the necessary training to support them. Staff told us and records confirmed that the majority of staff had received training in areas such as Health and Safety, Infection Control, Moving and Handling and Safeguarding. However, not all staff received training specific to the needs of people supported. For example, staff received training on how to safely administer emergency medicine to people if they had a seizure, as part of their induction. However, 60% of staff were overdue refresher training for this topic. The registered manager told us further training sessions had been booked as part of the nurses training schedule for 2022, to address this. In addition, only 43% of staff had completed training on supporting people with a learning disability and autistic people.

There were insufficient numbers of suitably trained staff. This placed people at risk of harm. This was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

● Staff supported people to make decisions about what they would like to eat and drink. However, staff did not always support people to be involved in preparing and cooking their meals.

● The provider had recently implemented steps to ensure people's weight and risk of malnutrition was monitored in greater depth. However, these records were held by the onsite health agency, which meant staff did not always have access to information when they needed it. We saw limited evidence that where concerns were identified by the health agency, these were cascaded to staff on the ground.

● People had access to support from a variety of professionals based at the on-site health agency. One relative told us, "We are incredibly lucky that there is a physiotherapist and an occupational Therapist on site."

● Records confirmed people had access to routine medical care appointments, although some of these records were disjointed. One relative told us, "[Family member] has maintained visits with the GP as required, chiropodist every 6 months and the dentist, once the initial lockdown was over."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;

● People's needs were fully assessed before they moved into the home and their care and support needs were thoroughly discussed before support commenced. The registered manager explained how individual bungalow managers worked with people and their families to develop support plans and help them get to know their way around and the facilities available. Impact assessments were completed to consider the effect of any new admission on the people already living in the bungalow and if any changes needed to be made to the staff team.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

● Staff did not always respect people's dignity and privacy. For example, staff did not knock on doors when entering people's rooms and we were shown into rooms where people were in bed or being supported with personal care. We also observed staff speaking about people's personal information in communal areas. Staff told us that this had been identified as an issue, with one staff member telling us, "We have been talking about this through our last meeting and we have been reminded, some staff have not been knocking on doors and we will call each other out on this."

● We observed people in bed with their doors open. We were informed by the management team that this was to ensure their safety, due to potential seizure activity. An audio monitoring system is in place at night, but this only comes on when the night staff come on shift. Therefore, we were told that everybody's door needed to be kept open until then. No consideration had been given as to how these risks could be managed in other ways, on an individual basis, to preserve people's dignity.

● We observed staff sitting in the doorway of a person's room watching them sleep. Staff told us that this was due to the person's epilepsy. When we reviewed their risk assessment, this did not form part of the management plan. This meant this person's privacy was not being respected by staff.

● Staff told us that they supported people to be independent, where possible, however this was not always easy due to current staff shortages. For example, in meeting minutes for one bungalow, it stated, "Cooking in the bungalow by residents still needs to be organised as it is time consuming and as staff are busy, it would be as time allows and needs to be planned in advance." This suggested that the development of people's independent living skills was not embedded in the day to day operations of the service.

● An independence skills programme had been developed by the provider, in order to increase people's independent living skills. However, this had been put on hold due to COVID-19.

Staff did not consistently promote people's privacy, dignity and independence. This placed people at risk of harm. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed people to be comfortable and relaxed in the company of staff. Staff were kind and caring when supporting people. Relatives were very positive about the care provided by individual members of staff, particularly given the challenges posed by COVID-19 and recruitment difficulties.

Expressing Views and Making decisions about Care

● People's care was reviewed regularly, alongside professionals from the multi-disciplinary team. One family member told us, "We have annual reviews. The one last year was in a field due to [COVID-19]. There is good communication between the home and us."
● People had the opportunity to attend resident meetings and provide feedback via surveys. However, these methods of engagement were not always meaningful for the people involved. The provider had not considered alternative ways of supporting people to express their views.
● Due to some people's complex needs, the staff worked closely with people's relatives to support decision making about their care. One relative told us, "The manager of the bungalow is great, and I have a good rapport with her. She is very open and has genuine empathy."

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Care and support plans did not always focus on positive outcomes to improve people's quality of life. There was limited evidence that staff supported people to identify aspirations for the future. Where wishes were identified they were not always personalised or meaningful to the individual. For example, for one person their care plan stated for them, 'To be supported to manage their noise levels.' Staff had not considered if this was what this person wanted or the reasons why they may become vocal. Their support plan framed their communication as "disruptive" to others and did not support staff to try and understand what the person was trying to say.

● Staff did not always consider people's individual needs and promote choice and control. For example, one relative told us about their family member's experiences prior to moving into a different bungalow. "[Name] found it too noisy and would stay in their room all the time. The staff said they could wear earphones. We didn't feel this was how [Name] should have to live in their own home."

● Staff were often task focused, which restricted the time they spent interacting with people. We spent 90 minutes observing staff interactions with people in one bungalow. Staff spent the majority of time attending to medicine administration and people's personal care needs. Three people remained in the lounge, during which time staff made limited attempts to engage with them. One person was watching a film and when this finished, the staff member re-started it, without asking what the person wished to do next and left the room.

● Relatives told us that, prior to COVID-19, people were supported to take part in a range of social events. Some relatives felt this had continued. One relative told us, "During [COVID-19] lockdown. St Elizabeth's ensured that my family member was not only kept safe but that they didn't experience the isolation the rest of us encountered. There were plenty of [things to do] to make sure life went on as normal." However, other relatives told us the combination of staff shortages and COVID-19 restrictions meant their family members were not getting the supported they required.

● One relative told us, "[Family member] is funded one to one but they are not even going out at the moment." Another relative told us that they were taking their loved one off site several times a week to ensure "their mental health was maintained." This was confirmed by daily records which indicated that people had a limited choice of things to take part in during the day, and infrequent opportunities to leave the St Elizabeth campus. One staff member told us, "Because of the pandemic [people] were getting a bit depressed, it's the same old, personal care, breakfast, go for a walk around the site and we can watch tv."

● The management team informed us that activities had been reduced and the on-site day centre shut, in order to keep people safe during the pandemic. However, we saw limited evidence of 'things to do on-site' taking place or individual risk assessments and best interest decisions completed to consider re-starting of

individual or small group on-site activities once restrictions had lifted. For example, on person's records indicated they had spent the majority of the proceeding two months watching TV every day. When asked if they enjoyed watching TV they said, "I watch the telly - I do not like watching TV as there isn't much on. I would like to do more singing."

● People did not have genuine choice about what they would like to do each day. Trips off site tended to be pre-arranged and involved larger groups of people going out on a minibus. One member of staff told us, "Everything has to be planned days in advance." Staff told us that it depended on availability of transportation as to whether people could leave the site.

The support people received was not person centred, did not consider people's individual needs or promote choice and control. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

● People's communication needs were documented in their support plans. People used a range of different communication methods. One relative told us, "[Family member] has an electronic communication aid which the staff are learning to use. They have a manual communication book which they currently use."

● People were not always supported to communicate their views and wishes in ways meaningful to them. For example, some people were unable to verbally participate in residents' meetings, due to their communication needs. The provider had not considered how they could work with people to identify their likes and preferences and provide alterative methods of feedback.

Improving care quality in response to complaints or concerns

● The service had a clear complaints procedure. Relatives told us they were aware of this process and felt comfortable raising any concerns with the service. One relative told us, "I know the procedure to follow to make a complaint. I haven't needed to"

● Any complaints received by the service were recorded and followed up appropriately, in line with the provider's procedure. One relative told us, "I have made complaints to the bungalow manager, but they have been sorted, and not needed to be escalated further."

End of life care and support

● Processes were in place to support people at the end of their life. Where relevant people had end of life care plans in place. The registered manager explained how they would seek support from different processes and work alongside people and their relatives, to ensure people had a dignified death, in line with their preferences. Some staff had attended advanced care planning training and the service had links with the local hospice.

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 good. At this inspection this key question has now deteriorated to inadequate. 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.

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

- The provider had failed to ensure the principles of right support, right care and right culture were embedded at the service and that staff followed best practice in this area. People were not engaged in service delivery in a meaningful way, as partners in their care. We saw limited evidence that people were supported to identify how to achieve their aspirations.
- The provider had failed to promote a culture where people were treated with dignity and respect. People did not have sufficient choice and control regarding their support and were subject to restrictive practices. These had not been identified by the management team.
- The language used in care plans and by staff did not always promote a respectful, personalised approach and this had not been identified by the management team. For example, care plans referred to people "absconding" from their own homes. A staff member also told us, "This is where people come to die", in reference to the bungalow they were working in.
- The provider acknowledged that the model of care provided at St Elizabeth's would not be registered by CQC now, if it was a new service. They had a five to ten year plan in place outlining proposed changes to the model of care provided. However, this did not sufficiently address our concerns about how the principles of right support, right care and right culture would be embedded, in the interim.

The culture of the service failed to support the provision of high-quality care and support. This placed 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.

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; Continuous learning and improving care

- The provider's system for monitoring quality was not robust or effective. We identified gaps in care plans, risk assessments and daily records. These had not been identified by the provider.
- Actions identified via quality assurance processes were not always followed up in a timely manner. Audits were completed by bungalow managers, the management team and trustees. However, actions to drive improvement did not always have timescales for review. This meant some actions reoccurred each month, as appropriate action had not been taken.

● The registered managers oversight of issues, improvements or general quality in each bungalow was limited by the assurance systems in place. Individual bungalow improvement plans were in place but actions from the audits completed did not consistently feed into these. There was also no system for themes and trends from bungalow improvement plans to be fed into the main service improvement plan.
● The service improvement plan was developed and updated during the course of the inspection process and now reflects some of the issues identified. However, there remained a lack of direction around right support, right care, right culture principles.
● The registered manager informed us that they analysed accidents and incidents for patterns and trends. There had been 45 falls in the past six months, by far in excess of any other incident type. The registered manager was able to verbally explain action taken, when asked. However, this information was not used to inform the service improvement plan and we saw no evidence of actions were being shared with the wider team, such as via team meetings.
● Continuous learning was not promoted within the service, with lessons learned following incidents and safeguarding concerns not shared with all staff. For example, whilst incidents and concerns were discussed at nursing team and management meetings, issues were not shared with the wider staff team to promote people's safety and shared learning.
● Care staff were not empowered to get involved in discussions about people's care and support. For example, we saw a support plan had been developed by a professional from the on-site agency to help staff identify early forms of communication and how to support them. Staff told us they had not been involved in this process, despite having the knowledge and experience of supporting this person on a day to day basis. In another example, staff meeting minutes from one bungalow showed staff had concerns about five people's nutritional intake. The notes document that "nurses are on the case," with no further discussion from the team as to how they could support people in the interim.
● The provider did not clearly distinguish between the responsibilities of the staff employed by the care home and those employed by the on-site health agency. St Elizabeth's Care Home with Nursing is registered to provide both personal and nursing care. However, all nursing care was provided by the on-site health agency.

Quality monitoring systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed 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.

● Staff gave us variable feedback regarding how supported they felt. One staff member told us, "I feel supported by my manager, [they are] very good considering what is on [their] shoulders." However, other staff told us formal supervision and meetings could be irregular. Staff told us they did not always feel listened to by senior managers, although they felt this had recently begun to improve.
● The majority of relatives told us they were satisfied with the leadership at St Elizabeth's. They were particularly positive regarding the support provided by individual bungalow managers. One relative told us "The manager of the bungalow is great, and I have a good rapport with them. They are very open and have genuine empathy." Relatives told us they had opportunities to feedback via feedback forms, surveys and family meetings.

Working in partnership with others
● The service worked well with a range of professionals, both those based at the on-site health agency and externally.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not consistently promote people's privacy, dignity and independence. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure people lived in a safe and well maintained environment. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably trained staff to support people in line with their assessed needs. This placed people at risk of harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The support people received was not person centred, did not consider people's individual needs or promote choice and control. This placed people at risk of harm.

The enforcement action we took:

Notice of decision issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The service failed to demonstrate they had considered the "least restrictive" option when making best interest decisions, in line with the Mental Capacity Act 2005. This placed people at risk of harm.

The enforcement action we took:

Notice of decision issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risk was not effectively managed, and systems were either not in place or not robust enough to demonstrate safety was effectively managed within the home. This placed people at risk of harm.

The enforcement action we took:

Notice of decision issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	The culture of the service failed to support the

Treatment of disease, disorder or injury

provision of high-quality care and support. Governance systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm.

The enforcement action we took:

Notice of decision issued