Ian Nicoll

Elliott House Care Home

Inspection report

22 Reculver Road,
Beltinge, Herne Bay,
Kent CT6 6NA
Tel: 01227 374084
Website:

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection was carried out on 22 and 23 October 2015 and was unannounced.

Elliot House Care Home provides accommodation for up to 71 people who need support with their personal care. The service provides support for older people and people living with dementia. The service is a large, converted property. Accommodation is arranged over three floors. A shaft lift is available to assist people to get to the upper floors. The service has 58 single and 5 double bedrooms, which people can choose to share. There were 44 people living at the service at the time of our inspection.

A manager has not been registered at the service since January 2015. The service was being led by two general managers who both planned to apply to be registered with CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run.

Summary of findings

At our previous inspection the provider made a commitment not to admit any new people into the service until the concerns regarding staff and their knowledge and skills had been resolved. They began to admit new people in to the service in September2015.

Leadership at the service had improved and there was an increased level of oversight by the provider and an area manager they had deployed to support staff at Elliott House. Some staff who had resigned previously had returned and new staff had been employed. Staff told us their motivation had increased and they felt more supported. They felt the managers were approachable and were confident to raise concerns they had. Since the last inspection information had been provided to people and their relatives about what was included in the fees that they were paying for their care.

All the staff working at the service knew people and their needs. Staffing levels were consistent but all the staff we spoke with told us an additional staff member on each shift would enable them to spend more quality time with people. There were periods of time when staff were not present in lounges and communal areas. Staff were now clear about their roles and responsibilities.

Staff recruitment systems were in place and information about staff had been obtained to make sure staff did not pose a risk to people. Disclosure and Barring Service (DBS) criminal records checks had been completed.

New staff had completed an induction and most staff had completed the basic training they needed to meet people's needs. Further training and competency assessment was required to make sure that staff had all the skills and knowledge they needed to provide good quality care and meet people's individual needs.

Staff knew the possible signs of abuse; however some staff did not know that they could inform the local authority safeguarding team about any concerns they had. Emergency plans had been reviewed and updated. Some people's emergency plans referred to the use of new evacuation equipment that staff had not been trained to use.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider and staff were unclear about their responsibilities under Deprivation of Liberty Safeguards (DoLS). Following our last inspection the provider had not made arrangements, as the managing authority, to check if people were at risk of being deprived of their liberty. Applications had been made to the local authority to lawfully deprive some people of their liberty and they were awaiting assessments. Action had been taken to obtain information about people who had powers to lawfully act on people's behalf. However, processes were not in operation to assess people's capacity to make decisions.

People's needs had been assessed since our last inspection and care had been planned to meet their needs by the managers. Reviews had been completed, however changes in people's needs had not always been recorded in their care plans. People and their relatives had been invited to be involved in reviewing their care. After the inspection a relative told us that they 'were very happy with the care'.

New emergency evacuation plans had been put in place for each person and included the equipment to be used to move safely. However, staff had not been trained in the safe use of all the equipment and there was a risk that if it was used it would not be used safely. Moving and handling risks had been assessed and staff were following the actions put in place to keep people safe.

Medicines management processes had improved and people received the medicines they needed when they needed them to keep them safe and well. Detailed guidance was provided to staff about the use of prescribed creams to make sure they were used to best effect.

Action was taken to identify changes in people's health and obtain the care and treatment people needed to keep them as safe and well as possible. People who had lost weight had been referred to their doctor or a dietician.

There were mixed views about the food. Food was not always prepared to meet some people's specialist dietary needs, including diabetics and people who were at risk of losing weight. Choices of food were limited and the second options each day were the same.

Communication between staff and people had improved. People were offered choices in ways that they understood and staff took time to present options to people in ways

Summary of findings

that would not confuse them. People were treated with respect and their privacy was maintained. Risks to people's dignity had not always been recognised and acted on.

The activities on offer to people had improved, however we observed people sitting in lounges without the supervision and interaction of staff on a number of occasions.

The provider's complaints policy was being followed and complaints received had been logged and investigated and people had received a satisfactory response.

Regular checks on the quality of the service provided had been completed, however the provider and managers were not aware of the shortfalls we found at the inspection including that some care plans were not up to date as people's needs had changed. Information from people and staff about their experiences of the care had been obtained and people said the service they received had improved.

A dining room on the first floor was being used again and this meant there was more room in the main dining room to accommodate people. Action had not been taken to enable people to find their way around the service easily. Some new armchairs and dining chairs had been purchased and these supported people to remain independent and safe, however, there were not enough for everyone and people told us the old chairs were uncomfortable and difficult to stand from unaided.

Records were kept about the care people received and about the day to day running of the service. Action had been taken to improve the accuracy of records, however not all records were completed at the time the care was given or by the person giving the care which meant there was a risk they would not be accurate if completed retrospectively.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Summary of findings

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 consistently safe.

Requires improvement

Staff knew the signs of abuse, but some staff did not know they could inform the local authority safeguarding team about any concerns they had.

Staffing levels were consistent and there were enough staff to meet people's basic care needs. There were times when staff were not present in communal areas. Staff were checked before they started to work at the service.

People received the medicines they needed to keep them well.

New evacuation plans and equipment were in place. However, staff had not yet been trained to use the equipment safely.

Is the service effective?
The service was not consistently effective.

Inadequate

Some staff were not clear about the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's ability to make decisions and the risk of being deprived of their liberty had not been assessed.

New staff had received an induction. Most staff had completed basic training to meet people's needs. Further training was required to make sure all staff had all the skills and knowledge they needed.

Staff were supported to provide safe and appropriate care to people and to obtain the support people needed to meet their health needs.

Views about the food were mixed. Food was not always prepared to meet people's dietary needs.

Is the service caring?
The service was not consistently caring.

Requires improvement

People's personal laundry was not always returned to them.

Staff knew people well. People told us staff were kind and caring.

Staff maintained people's privacy and treated them with respect. Some improvements were needed to the way staff recorded information.

Summary of findings

Communication between people and staff had improved.

Is the service responsive?

Requires improvement

The service was not responsive.

Care plans had been rewritten. Some care plans had not been updated when people's needs changed. People's personal care preferences were not always supported.

People had been supported to take part in more activities they enjoyed, at the service.

The provider's complaints procedure was followed. Complaints were logged and people received a satisfactory response.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Staff had not been supported to understand and deliver the provider's core values for the service including choice, independence, dignity and fulfilment.

Leadership at the service had improved and staff were more motivated. Staff were working more as a team.

Checks on the quality of the service had been completed. People, their relatives and staff had been asked about their experiences of the care and said it had improved.

Records about the care people received were more accurate.

Elliott House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 23 October 2015 and was unannounced. The inspection team consisted of three inspectors, a specialist professional advisor, whose specialism was in the care of people with dementia and an expert 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.

Prior to the inspection we reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at a recent Health Protection Agency report, previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. Before our inspection we spoke with community nurses, the local authority case managers and commissioning staff and the local clinical nurse specialist nurse for older people who had provided some support to the managers.

During our inspection we spoke with approximate 20 people and ten staff. We looked at the care and support that people received. We looked at people's bedrooms, with their permission; we looked at care records and associated risk assessments for five people. We observed medicines being administered and inspected medicine administration records (MAR). We looked at management records including three staff recruitment files, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the support provided to people in the lounge and dining room of the dementia unit, and both lounges and dining rooms in the main house. We used the Short Observational Framework for Inspection (SOFI) because many of the people receiving care at the service were living with dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We did not see any visitors to speak with during the inspection so we reviewed comments relatives had made on the recent satisfaction survey.

We last inspected Elliott House Care Home in April 2015. At this time we found that the service was rated 'inadequate' and CQC took enforcement action against the provider.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us, “The staff are very good and helpful.” Another person said, “I am very happy here, they do look after me". We observed a third person being told about the care they were going to received, they us "That makes me feel safe, we are well looked after”.

At our last inspection we found that the provider had failed to deploy sufficient numbers of suitably qualified and competent staff to keep people safe and meet their needs. Since the last inspection five experienced staff, who had left under the previous manager, had returned to the service and 23 new staff had been employed across all areas of the home. The number of agency staff working at the service had reduced to two long term agency staff who knew people well. Cover for staff sickness and vacancies was provided by other staff members and now only occasionally by agency staff.

The provider had not introduced a process to help them decide how many staff were required to keep people safe and meet their needs, however, the managers told us they considered people’s needs when deciding how many staff to deploy on each shift. The managers told us that the staffing levels were under review.

The managers had considered returning to the previous shift arrangements with morning shifts starting at 7:30am to support people to get up when they wanted to and afternoon shifts ending at 9:00pm to support people to go to bed when they wished but had not made plans to implement this yet. Staffing levels were consistent across the week. Rotas were planned in advance and staff knew when they would be working next.

Staff told us they were no longer so rushed but that they still did not have time to spend with people other than to meet their basic care needs. They told us that people benefitted from spending time with and chatting to staff. Staff found the time a useful way to get to know people and learn about their likes and preferences. All the staff we spoke with said that an extra member of staff on each shift would support them to do this. We observed that people continued to spend long periods of time with little or no interaction from staff or other people.

People spent most of their time during the day in communal areas including the lounges, and relied on staff checking on them or other people alerting staff to their needs to keep them safe. There continued to be long periods of time between staff checks when no staff were in the lounges with people. People told us they had to wait for a long time for staff to check on them if they needed help and could not reach a call bell. The majority of the falls people had at the home were ‘unwitnessed’ so staff did not know when or how people had fallen. There was a risk that people would not receive the help and support they needed when they needed it. Staff responded promptly to call bells when they rang and very quickly when the emergency bells sounded.

Staff continued to be allocated tasks to complete during each shift, such as bathing people and supporting people in specific areas of the service. The task allocation was not reviewed when unplanned events happened at the service. Two staff were usually deployed to the first floor dining room to help ten people who needed support or prompting with their meals. During our inspection the passenger lift failed to operate and three extra people ate lunch in this dining room. One staff member met everyone’s needs and a second staff member carried hot meals upstairs for people. Some people did not get the support they needed and struggled to eat their meals. Some people left their meals and others became angry and frustrated. Two other staff were completing records and were not redeployed to support people in the first floor dining room. The deployment of staff, especially in response to unusual events, should be reviewed to ensure it is effective.

The provider had failed to deploy sufficient numbers of staff to keep people safe and meet their needs at all times. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew the signs of abuse, such as a change in a person’s behaviour. They knew how to raise their concerns with relevant people inside the organisation, such as managers. Some staff did not know they could also raise concerns they had with the local authority safeguarding team. Most staff had received safeguarding training and other staff were booked to attend training in the month following our inspection. The provider’s safeguarding policy was available to staff at the service. Managers did not know about the local authority safeguarding policy, after we told them about it they printed a copy of the policy for their information.

Requires improvement

Is the service safe?

At our last inspection we found that fire safety plans were in place for each person but these did not include plans to evacuate people from the building in the case of an emergency. We also found that equipment was not available to move people downstairs when the lift could not be used, such as in the event of a fire. We reported our concerns to the local fire and rescue authority who visited the service and completed a fire safety audit in July 2015. New emergency evacuation plans were now in place for each person and these included the equipment to be used to support people to move safely, such as wheelchairs. Some plans included details of the evacuation chair purchased to safely move people down stairs. However, staff had not been trained in the safe use of the new equipment. Plans were in place for staff to receive training and experience the equipment themselves, however there was a risk that if it was used before the training was completed it would not be used safely.

Staff had not been trained to evacuate people safely using specialist equipment in the event of an emergency. This was a breach of Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Contingency plans for different emergency situations had been reviewed to make sure they remained current. The managers were aware of the plans and knew what arrangements were in place to keep people safe. Plans were accessible to staff in an emergency.

Moving and handling risk assessments were in place for people who needed support to stand and transfer. Detailed guidance including the type of hoist and sling to be used were included. Action had been taken to make sure these plans were consistently followed.

Risks to people had been assessed and care had been planned to reduce the risks. The nature of the risks varied from person to person and the care planned reflected people's varying needs and preferences. For example, shortly before our inspection one person had done something that put them at risk of choking. Staff had taken immediate action to keep the person safe and a new risk assessment with actions had been developed to reduce the risk to the person in the future. Details of the incident, the increase in risk and the care planned to support the person had been shared with staff at shift handover meetings to make sure that all staff had the knowledge and information they needed to keep the person safe.

Accidents involving people were recorded and the managers had taken action to review them monthly following our last inspection, to look for patterns and trends. Appropriate support had been obtained for people where risks were identified, such as falling, and care had been planned to include the recommendations of health care professionals.

Maintenance plans were in place for the building, however, works on the plan were often delayed by new jobs which needed to be carried out immediately to keep people safe. One maintenance staff member was employed to complete day to day maintenance work, including checks of the building and equipment. The provider was in the process of recruiting a second maintenance person. At our last inspection we found that the temperature of hot water taps on baths was not checked regularly and staff tested the temperature of baths with their elbow before people used them. Bath thermometers had been purchased and staff now used these to check the temperature of bath water.

Previously people living with dementia could not use the garden as it was not secure. A new secure garden area outside the dementia unit had been developed for people to use in fine weather.

Staff had begun to reuse a small dining room on the first floor, this meant there was more space for people to move around in the main dining area and people were no longer bumping into each other and furniture. The provider was in the process of developing a bigger dining room in the dementia unit as the current dining room was small and there was not enough space for everyone.

Some of the low level wicker chairs which people had difficulty getting out of had been replaced with high back chairs. People told us these were more comfortable and they found them much easier to stand up from. One person told us the wicker chairs were, "Difficult to get comfortable in". A small group of people we spoke with told us they would like more "comfy chairs with straight backs", as the wicker chairs were uncomfortable and did not support their backs. The new chairs appeared to be much easier to clean than the wicker chairs.

Some of the old dining room chairs without arms were replaced during the inspection. People told us that they found sitting and standing from the new chairs much easier

Is the service safe?

as they had arms that they could us to 'push up' on. One person said, "We are loving the new chairs. I find them easy to get out of". Staff we spoke with confirmed that they also found it easier to help people stand from the new chairs.

A number of stained dining chairs and wicker chairs remained in use in busy areas of the home, such as lounges and the first floor dining room, whilst less used areas, such as the library and the new dementia unit dining room, had new chairs which were not being used so much. Several people told us that more chairs were required so that they were available to everyone all the time, staff we spoke with agreed with this. This is an area for improvement.

People told us they liked their bedrooms and their beds were comfortable. One person said, "It's ok here, my room is good and the bed is very comfortable". Another person said they slept well at Elliott House. A third person told us, "I have a comfortable bed so I sleep ok". People were able to personalise their bedrooms with pictures, photographs and other small items.

The building had two passenger lifts, one of which was currently not in use. Several people told us that it would be helpful to them if the second lift was reinstated. One person told us, "The lift is not working and hasn't done for ages; I wish they would fix it as there are so many of us who need it". An alternative lift was in use and we observed people waiting to use this lift.

The one working lift broke down three times during our inspection. It had been serviced the previous week and staff told us that it had not broken down for a long time. The maintenance person contacted the lift contractor and completed the necessary repairs quickly. Staff stopped using the lift for several hours and made other arrangements to provide people with the support they needed, such as more people using the upstairs dining room. Some people were unhappy and cross that they could not follow their usual routine; however staff took suitable action to reduce the risk of them or their meals becoming stuck in the lift. When they began to reuse the lift, staff put a chair in it for people to sit on in case it broke down so that they could sit down.

Staff recruitment systems protected people from staff who were not safe to work in a care service. Sufficiently detailed information about staff's previous employment had been obtained. Staff conduct in previous social care employment had been checked. Disclosure and Barring Service (DBS) criminal records checks had been completed for staff. Information about applicant's physical and mental health had been requested. Other checks including the identity of staff had been completed.

Since our last inspection staff had a received support from the local Clinical Commissioning Group Medicines Management Team. Communication between staff at the service and the local doctors' surgeries had improved and additional systems were in place to check the medicines orders to make sure that medicines were received into the service before people needed them. At the time of the inspection all the medicines prescribed to people were in stock at the service. Systems for checking orders received, administration and disposal of prescribed medicines were in operation.

Some people were prescribed medicines 'when required', such as pain relief. Staff asked people if they wanted pain relief regularly and only gave it when people wanted it. When people were unable to tell staff they required pain relief staff knew the signs that they may be in pain such as a change in their facial expression. Guidance was available to staff, in people's medicines records, about their 'when required' medicine, including how often to offer the medicine, if the person would ask for it when they required it and how to assess if the person needed it if they were unable to tell staff. Detailed records were kept of when people had taken their 'when required' medicines.

The management of prescribed creams had improved. Each person who required creams to keep their skin healthy had a skin care plan in place which included the type of cream and a diagram showing where it should be applied and when. Records were kept of the prescribed creams that had been applied to people's skin. Staff had a good understanding of safe medicine management. They were knowledgeable and able to explain the action they would take to manage medicines safely.

The managers had reinstated the weekly medicine checks stopped by the previous manager. Any concerns, such as missing medicine supplies or poor record keeping were identified quickly and action was taken to address the issues.

Feedback from a health professional about medicines practice was "The team at Elliot House has improved greatly in medicines management."

Inadequate

Is the service effective?

Our findings

People had mixed views about the food at Elliott House. One person said, “The food is very up and down. I have lost weight but I don't know why but the food tastes terrible and is badly cooked. Sometimes I am hungry but I don't ask for anything else. They have wrecked the chips today, they are rock hard".

Another person said, “The food here is okayish but often tasteless I don't know what they do to it. I only want small portions which is fine and there is always cake and biscuits to fill up on".

A third person told us, “The food is ok but sometimes not so good, it’s often tasteless and the evening meal is often late”.

Some people we spoke with about the food said it was not always served hot. One person commented, “The food is ok today but it’s not always like that, sometimes it’s not very hot". Another person said, “The food is ok but sometimes only warm not hot". People told us the food was not always cooked in the way that they liked. One person said, “I like the rice pudding but I like it the old fashioned way with skin on the top”.

Some people told us they did not get a choice of meal. A choice of food was not included on the menu but an alternative was prepared if a person did not want the main meal choices. One person told us they ate what they were given and it was ‘Hobson’s choice’. The same alternative meals, jacket potatoes and omelettes, were offered each day which limited the variety of food on offer as alternatives for people. On the first day of our inspection one person chose a jacket potato as their main meal; this appeared quite a small portion. One of the managers commented, “I saw it and was shocked, it was the size of a marble”. There continued to be a limited choice of pudding and the alternatives were always ice-cream or yogurt.

The cook, working at the service at the time of our inspection, did not understand the different diets people needed to keep them healthy. Five people had been recommended a ‘fortified’ diet by a dietician, which included additional calories, as they were at risk of losing weight. Foods such as custard and mash potatoes were not fortified with butter, eggs and cream or other food stuffs to increase the calories for the people who needed them. Low sugar puddings were not offered to people with diabetes and the cook did not know that some people required a reduced sugar diet.

Food was not prepared to support people to eat on their own. For example, some people struggled to use cutlery but no special ‘finger foods’ were prepared for them as an alternative. Specialised cutlery and crockery was not provided to help people remain independent at mealtimes. People who had difficulty swallowing or were at risk of choking were offered soft or pureed food. Foods were pureed separately and presented in an appetising way so people were able to taste the separate flavours of each food. Staff knew who needed or liked a soft or pureed diet and people were given food which was suitable for their needs and preferences.

People had not been prepared to meet their some people’s nutritional needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered regular drinks. Jugs of squash were available to people who could help themselves and at lunch time. Staff encouraged people to drink and hot drinks were offered to people during the day.

Since the last inspection action had been taken to assess people’s risk of malnutrition and losing weight and to plan their care to support them to maintain a healthy weight. Care plans included instructions to staff about how often people should be weighed. Some people, who were at high risk of losing weight, were to be weighed every week, however this had not been done consistently, and weigh losses had not been identified quickly.

The amount of weight people had lost and gained was recorded. The amount of weight lost had not always been identified as a possible risk to the person. For example, one person had lost 2.9kg (6½ lbs) in two weeks. This had been recorded as ‘lost small amount’ in their care plan and staff had not recognised the person had lost a significant amount of weight and no action had been taken. The person had gained weight since this time but the reasons for this were not explained.

Most people who had lost weight had been referred to the dietician for advice and support. The advice was included in people’s care plans but had not been effectively communicated to staff. For example, one person had lost

weight and the dietician had recommended that they have extra milky drinks, such as Horlicks or hot chocolate to increase their calorie intake. They had not been offered these extra drinks. Staff told us that the person had milk on their cereal in the morning and a milky drink at night but did not know that the person was to be offered the extra milky drinks.

People's skin health had been assessed and pressure relieving equipment was available to people who needed it. Some people needed to use special cushions or mattresses to reduce the risk of them developing pressure ulcers. People were not consistently supported to use these cushions. We observed one person, who was at risk of developing pressure ulcers, not using their special cushion. Staff had supported the person to move from one area of the home to another but had not taken the cushion with them and it was on a chair in another part of the building. This meant that the person did not benefit from the pressure relief the cushion provided.

Care plans provided guidance to staff about the weight that pressure relief mattresses needed to be set at for maximum benefit to the person. Some of the mattresses and pumps the service had hired did not have weights on them and staff did not know how to set them at the correct setting for each person. Action had not been taken to obtain information from the manufacturer about the safe and effective use of the equipment.

The provider had failed to make sure that people received appropriate care and treatment to meet their needs at all times. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that people had not been consistently supported to maintain good health and had not been supported to see health care professionals such as their GP as soon as they needed to. Staff were now supporting people to receive the health care they required. For example, one person fell during our inspection. Staff contacted health care professionals promptly and followed their advice. Paramedics who attended the service to treat the person told us that the staff had taken the correct action and were able to support the person to share all the information the paramedic needed. Doctors were called for people when they needed or requested them and community nurses visited regularly. Action had been taken to offer people regular health checks such as sight tests. People were supported to wear their glasses and hearing aids.

People were supported by staff or people who knew them well to attend appointments, including visits to hospital. This was to support the person to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service. Hospital passports had been written for each person and were ready if they were required. These contained information about people's medical history, medicines and other important information to make sure that hospital staff had the information they required about the person.

We did not see any relatives to speak with but noted comments recorded from relatives on a recent survey included, 'There has been a marked improvement in my Mother's health and well-being.'

Since our last inspection most staff had received training in relation to the Mental Capacity Act 2005. Some staff remained unclear about their responsibilities to assess people's capacity to make decisions.

Some people were able to make decisions for themselves about all areas of their life. They were supported to do this by staff. Other people were not able to make decisions for themselves. Assessments of people's capacity to make particular decisions had not been completed since our last inspection. For example, one person's doctor had given consent for them to be given their medicine without them knowing, as they had been refusing to take it. An assessment of the person's capacity to make the decision to refuse their medicine had not been completed. Staff told us the person had capacity to make the decision but had not been involved in making it. The requirements of the Mental Capacity Act 2005 had not been followed on this occasion.

The managers had contacted people's friends and relatives asking for evidence of any legal powers they had to act on the person's behalf, such as a Lasting Power of Attorney. Some people's families had responded but the majority had not. Some people's families had been asked to make

Is the service effective?

decisions or given consent on their relative's behalf without the relevant authority. Decisions made in the people's best interests had not been made formally and recorded to demonstrate why they had been made.

We observed staff offering people choices and people who were able told staff what they wanted. Staff told us about how they supported different people to make choices, such as showing them two things at one time to minimise the risk of confusion. One staff member told us that they showed one person two items of clothing at a time in the morning so they could choose what to wear. They said, "If they don't want either of the two things I offer them I put them away and offer them another two things and we do this until they are happy with their outfit".

Some people had a 'Do not attempt cardio pulmonary resuscitation' (DNAR) order in place. These had been reviewed since our last inspection to make sure that they remained relevant and still in line with people's wishes.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm.

The provider had not taken action to check if people were at risk of being deprived of their liberty. Staff and managers appeared to be unclear about the requirements of DoLS, despite having completed training. They had not looked for further training but they had sought advice from the local authority DoLS Team.

Following our last inspection staff had applied for DoLS authorisations for most people living at Elliott House, however, they had not assessed people's capacity and did not know if there were at risk of being deprived of their liberty. A process was in place to monitor the progress of the applications and managers knew what stage each one was at. Five people already had authorisations in place.

The provider had failed to take action to make sure that care was only provided with the consent of the relevant person in line with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Twenty three new staff had been employed to work at Elliott House since our last inspection. Care staff had completed an induction when they started work to understand their roles and responsibilities. The induction included shadowing experienced staff members to get to know people and the care and support that they needed. Staff told us they had learnt a lot about people's preferences by shadowing experienced staff. They also told us that the care different staff provided was 'mostly consistent'.

The managers had put a system in place to ensure staff received the basic training they needed to perform their duties. A review of the training staff had completed and when it expired had been completed and a plan had been developed to bring all staff's basic training up to date. The majority of staff, including new staff, had completed the basic training. Staff confirmed that they had completed a lot of training since our last inspection. Some staff said that they had difficulty retaining everything they had learnt as they had learnt so much in a short amount of time. The managers were addressing this by meeting individually with staff and going over the main points of the training at supervision meetings.

Staff had not received training to meet some people's specific health care needs. One person had a particular health care need that they required support from staff every day. The person had this need when they moved into the service and staff had asked the community nursing team for training. Community nurses had been unable to provide the training and all staff had been shown what to do by a senior carer 'who knew how to do it'. Training from other sources had not been explored and the person and staff could not be confident they were completing the procedure correctly.

The provider's staff supervision procedures were being followed by managers and staff were meeting with a manager regularly to talk about their role and the people they provided care and support to. Supervisions meetings were also being used to develop staff skills and a recent meeting had looked at the importance of understanding people's preferences and providing care in the way people wanted. The provider had not yet taken action to implement an appraisal process, to review staff's performance each year, recognise their achievements and plan their learning.

Inadequate

Is the service effective?

Staff had not received all the training and support necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made to the environment to support people living with dementia or with memory problems to remain as independent as possible. Some people had pictures and names on their bedroom doors to help them identify which was their bedroom, other people did not. Consideration had not been given to the décor of the premises to support people to safely find their way around. People relied on staff to tell them where areas of the service, including the dining rooms and lounges were when they could not remember. The provider had not explored relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

Some people could not find their way around the premises easily. This is an area for improvement so we recommend that the provider seeks advice about making the environment more suitable for people living with dementia.

Requires improvement

Is the service caring?

Our findings

People told us that staff were caring towards them. One person told us, "The girls and fellas (staff) are very nice, they always help and that makes a difference". Another person said, "I am very happy here. The staff are very good and helpful". A third person said, “Most carers are kind and caring”. Staff knew people well, their likes and dislikes, their preferred names and how they liked things done. We observed staff and people in the lounges and dining rooms, staff spoke and joked with people individually and people laughed and smiled back.

We did not see any relatives to speak with but noted comments recorded from relatives on a recent survey included ‘Your staff are all lovely’ and ‘I feel very fortunate that (my relative) is at Elliot House.’

People were treated with more dignity and respect than at our previous inspection. Some of the language used by staff in care records was not respectful. For example, the rails used on people’s beds to keep them safe, were referred to as ‘cot sides’. Some people had special underwear to help with their continence products but systems were not in place to make sure that people always received the same underwear back from the laundry. Most staff we spoke to recognised this shared underwear was not a respectful thing to do; however, some staff thought it was acceptable for people to share this special underwear.

Systems were in place to return people’s clothing to them from the laundry but these did not always work. Several people told us they did not always get their clothes back. One person told us that some of their clothes had gone missing despite being labelled with their room number. They said, "They do eventually turn up when I ask about them". Another person told us, "They lose some of my clothes, my jumpers mainly until I ask where they are".

Staff told us that some people preferred to have their care provided by a staff member of the same gender as them. They told us that they made sure that people’s requests were always respected. People told us that this did not always happen, one person told us, “I prefer a lady but I’ve got used to it now”. Another person told us, they had “requested no male helpers" and that staff respected their choice. A third person told us, they preferred a female staff members to provide their personal care but said, "As long as I get the care it doesn't matter who gives it to me".

We observed staff providing support to people in the dining rooms and lounges. On occasions staff did not consider the impact of their actions on the people receiving their support. We observed one staff member tell a person they were, “just going to cut your dinner up for you”. Unfortunately the person had a fork full of food and was just putting it into their mouth when the staff member took the fork from them to cut up their food. The same person had a pudding placed in front of them and then watched as it was taken away and given to the person next to them, with staff saying “because they have a spoon and you don’t”. The person looked very confused about what was going on but was unable to ask for an explanation or share their views with the staff member. On other occasions we observed positive interactions between staff and people and people received reassurance as staff supported them to move from one place to another.

People’s privacy had improved since our last inspection. We observed staff knocking on people’s bedroom doors before entering their room. One person told us, “My door is always open but staff always give it a little tap and I ask them to come it”. Systems were in place to keep people’s personal information safe. Action had been taken to remove personal information from communal records and it was no longer available to other people and visitors to the service. Since our last inspection one person’s care plan, containing lots of information about them had gone missing from the service. This had been reported to the correct authorities including the police, the local authority safeguarding team and the Data Commissioners Office. Action had been taken to reduce the risk of people’s confidential personal information from being lost in the future.

There were no restriction on people’s family and friends visiting the service. People told us that their relatives visited often.

People were able to choose where they spent their time and who with. Some people chose to sit together at mealtimes and at other times and chatted to each other in a relaxed way. People showed concern for each other and offered each other advice and support when that needed it. For example, one person noticed their friend needed a napkin at lunchtime and passed them one. There was a conversation between several ladies on the second day of the inspection about the pink clothing they had chosen to wear to support the services’ breast cancer awareness day.

Requires improvement

Is the service caring?

The communication between staff and people at the service had improved. One person told us, “Staff are always polite”. Staff took time to listen to people and to check their understanding of what they had said. However, staff did not always know the best way to communicate with people. We observed one person being offered their pain relief medicine. They could not hear what the staff member said so the staff member spoke loudly into their hearing aid. The person told us, “[Staff member] is talking into my ear and I wear a hearing aid. He was too close and too loud and I couldn’t understand. I feel such a nit”. The inspector spoke to the person in a clear voice at a normal volume whilst looking at them and the person understood everything the inspector said and answered their questions.

We observed that staff took an interest in people and anticipated their needs and offered them support when they identified people needed it. For example, one person was having difficulty standing. Staff quickly identified that their shoes were not supportive and asked the person to wait whilst they got another pair so that they could walk safely. All staff treated people with kindness and compassion. People appeared relaxed in the company of these staff, and told us they were “lovely”.

Action had been taken to ask everyone and their relatives about the person’s life before they moved into the service. This information, where it have been provided, was accessible to staff and staff knew about people’s backgrounds.

Following our last inspection people had been supported to express their views about the service they received including their care and support and the staff. Resident meetings had been held in August and September a couple of people had raised small issues about the service they received and most people had made positive comments.

Requires improvement

Is the service responsive?

Our findings

Most people, who were able to talk to us, told us they received the care that they needed in the way that they preferred.

Only one person had begun to use the service since our last inspection. An assessment of their needs had been completed with them and their family before they were offered a service. Further assessments of their needs, such as assessments of their skin health and dietary needs had been completed after they had moved in. These assessments had been used to plan the care they received.

Since our last inspection everyone's needs had been reassessed to make sure that staff had up to date information about the care and support people required. The assessments had been regularly reviewed with the aim of identifying any changes in people's needs. Information from assessments had been used to plan people's care.

New care plans had been written and reviewed, including the care and support people required at night. Care plans were written by the managers and included more information about people's preferences which was an improvement since the last inspection. Staff told us that they were not involved in writing the care plans. They told us that they told senior carers when people's needs changed and the senior staff updated care plans. Some people and their families had been invited to participate in review meetings to discuss their care.

Some care plans needed to be updated. For example, one person's plan, which had been reviewed in the past month by the managers, said that they liked to have a bath every week. Staff told us that the person was no longer able to use the bath as their needs had changed and it was not safe. The managers did not know the person's needs had changed and this information had not been updated in the care plan. The person had received a bed bath for several months so was receiving personal care. Although there was no impact on the person, their care plans needed to be updated to ensure consistent care and support. Other care plan reviews had identified changes in people's needs and so changes to their care had been planned.

Care plans had been updated to include improved guidance for staff about how to provide people's care in the way they preferred. However, some areas of the care plans required further information and guidance to staff. For example, one plan instructed staff to support the person to 'make decisions around day to day living' but not what these may be and how they were to support the person.

Other care plan's included more detailed guidance. One person's plan instructed staff to ensure they had a pressure cushion, footstool and blanket if they decided to sleep in the lounge rather than in bed and this was provided.

Managers encouraged staff to support people to remain as independent as possible and had included information about what people were able to do for themselves in care plans. One person's care plan informed staff that they were to assist the person to put toothpaste on their brush but that they were able to brush their teeth on their own.

At our last inspection we found that people did not receive baths or showers as regularly as they wanted. At this inspection we found that although people were having more baths they were still not receiving baths or showers as often as they would like. One person told us, "I like a couple of baths a week but I don't always get one every week". Another person told us, "I don't get a bath as often as I would like. I would like one more often than once a week". A third person said, "A bath, when I get one, makes me feel good". People told us they received the help they needed when they had a bath or shower. One person said, "The staff stay with me. I wouldn't want them to go". Another person said, "I get help with a bath as I am not good getting out and that is good". The person also said that they preferred to have a shower as it felt safer but did not ask for one as they did not know if showers were available at the service. The managers had introduced a system to check who had not had a bath or shower each week and highlighted this to staff.

Care plans were not all updated with any changes in people's needs. People's personal care preferences were not always supported. Care was not provided to reflect people's preferences. This was a breach of Regulation 9(1)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who needed support to manage their continence had had their needs assessed and appropriate aids had been obtained. A process was in place to order these and

Requires improvement

Is the service responsive?

to make sure that each person's stock was held separately, so they always had the aids they needed. Care plans now included the support people needed to manage their continence, including the types of aids they used.

Previously we found that people had little opportunity to follow their interests or to take part in social or physical activities. There had been no activities or social contact available for some people and there was a risk that they were isolated or lonely. Action had been taken to offer people more activities throughout the day. New activities staff had been employed to work at the service since our last inspection. The activities that people took part in had increased and some people told us they had more to do. Other people told us they did not have anything to do and were 'bored' during the day. We observed that a number of people spent their time in the lounges with the television on; they told us that they were not watching it. Other people spent time in the entrance hall watching what was going on.

One afternoon we observed some people were watching a film in a lounge, whilst other people were chatting to each other. No staff were present in the lounge. The people who were talking had disturbed the people who were watching the film and several cross words were exchanged.

Staff in the Poppy wing knew people well and provided opportunities for them to take part if activities they enjoyed, including looking at pictures of places they had lived, doing puzzles with support and dancing with staff. Some people liked to look after their 'babies' (dolls). We observed one person talking to their baby and showing it affection. Staff told us that some people could become agitated at times but calmed down when staff asked them for assistance to look after a baby. Doll therapy is a recognised activity enjoyed by some people with dementia.

People told us they were confident to raise concerns they had with the staff and managers. One person told us, "If anything was wrong I would complain". Information about how to make a complaint was displayed. In the Poppy wing information was available in a way that people could easily understand. Since our last inspection the managers had taken action to listen and act on people's complaints and concerns. A process to respond to complaints was in place and was being followed. People's complaints had been recorded and action had been taken to resolve the complaints to their satisfaction.

Requires improvement

Is the service well-led?

Our findings

Since our last inspection the acting manager had left and the service was being led by two general managers with support and guidance from an area manager. Both managers had been working at the service before our last inspection and had previously held management roles and responsibilities. Everyone we spoke with knew who they were. Some of the management tasks and responsibilities, including monitoring people's care and the day to day management of staff, which senior care staff had previously been completing, had reverted back to the general managers, meaning that senior care staff now had time to complete all the tasks they were responsible for.

Shifts had been planned to make sure that staff knew which areas of the home they would be working in and which tasks they were responsible for. One staff member told us, "The allocation works now and shifts are planned and work. This means the place is calmer and less chaotic". Another staff member said, "It's very different from when you were here before, it's more systematic". During the inspection the passenger lift failed to work, which was very unusual. This led to more people eating their lunch on the first floor than usual so more staff were required in this area. Although this was an unusual event the staff deployment was not altered to make sure there were enough staff in each area so the lunch time experience for people on the first floor appeared to be stressful as staff were rushed. Having plans in place to move staff around the service at short notice is an area for improvement.

The managers were present in communal areas of the service during our inspection and demonstrated some leadership to staff. Staff told us that the managers did not always provide the leadership and support the staff team needed. One staff member told us, "They (the managers) aren't really on the floor, staff don't see them and they don't know what is going on". Other staff, through the staff survey commented that they enjoyed working at Elliot House and felt valued.

At the last inspection staff were not working as a team and were not communicating with each other. Staff told us that team working had improved and we observed staff deciding together who would provide support to who and when. However, staff did not always recognise when other team members were under pressure and change what they were doing to support them. For example, two staff members were completing records at lunchtime and did not recognise that their colleague was struggling to meet the needs of 13 people on their own. The two staff put additional pressure on the staff member in the dining room by asking them questions about what people had eaten. One senior member of care staff told us, "I try to get staff to work as a team but we still have some staff doing their own thing". The managers were trying to address this by having regular one to one meetings with staff. On one of the days of the inspection staff were encouraged to dress in pink and make a donation to a cancer charity. The managers, staff and the provider joined in together with this fundraising activity.

Staff told us that communication at all levels of the organisation, particularly from managers and seniors down to care staff required improvement. One staff member told us, "I feel out of the loop sometimes". Some staff told us that poor communication caused them stress and impacted on the care and support people received. For example, some staff had been told that one person was to be encouraged to eat by themselves and other staff had not. One staff member began to support the person to eat their meal at lunchtime and was challenged by another staff member saying that the person should be encouraged to do it themselves. Staff discussed the support the person should be offered, in loud voices in front of the person. The person became frustrated and angry and started to shout.

The provider's core values of the care provided at Elliott House were described in their statement of purpose and included choice, independence, dignity and fulfilment. Staff were unaware of these values when we asked about them. Staff did not know what the provider's vision for the service was. One staff member told us, "We don't see the provider; he doesn't interact with staff when he visits. I don't know what his plans are. I feel like the service is in limbo. The action taken since your last inspection was reactive rather than proactive". Another staff member said, "At the moment we are reacting to what needs to be done to keep running from day to day".

Previously staff had not felt supported and appreciated by the acting manager and were required to make an appointment to discuss any concerns they had. Some staff told us they felt supported by the two general managers to deliver safe and effective care and that "Their door is always open". Other staff said that they did not feel very supported by the managers and that they did not always

Requires improvement

Is the service well-led?

recognise when staff needed support. One staff member told us, "I am struggling today. I need a helping hand from the manager in [Head of Care's] absence". All the staff we spoke with told us they their morale had increased since the acting manager had left and the general managers supported by the area manager had been appointed.

The provider told us they did not have skills and knowledge required to oversee the quality of the service so they had deployed an area manager, who was also a registered manager at another service, to oversee and scrutinise the service. They had worked with the general managers to monitor the service to make sure people received a good standard of care. Systems and processes had been put in place to check on the quality of the care people received. The area manager and general managers had begun to make it clear to staff what good quality care looked like and how it would be provided. The checks had not picked up all of the shortfalls we found at the inspection including that some care plans were not up to date as people's needs had changed.

Action had been taken to begin to involve people and their relatives in the day to day running of the service. Systems were in place to obtain the views of people, their relatives or staff about the quality of the service. Since our last inspection a quality survey had been completed and people and their relatives had said that the quality of the service had improved. Comments on surveys from people included 'Staff are welcoming, they treat us with courtesy and respect' and 'I don't think anything needs improving'. Comments recorded from relatives included 'It has now improved greatly, we are no longer worried' and 'The home has definitely improved for the better'.

After the inspection a relative told us that they 'were very happy with the care'.

Records in respect of each person's care had improved however, they had not always been accurately maintained. Some people were at risk of losing weight and staff needed to monitor what they ate to make sure they ate enough. Records of what people ate were kept. Some had not been completed and did not show what people had eaten. On one day of our inspection, we checked one person's records at lunchtime and found that their breakfast had not been recorded. There was a risk that staff may not remember accurately the care and support provided and records would not be accurate. Records of what people had eaten were not always completed by the person supporting the person and there was a risk that the information recorded would not be accurate. Other records were accurate.

Medicines administration records (MAR) we checked were accurate and staff had signed to confirm that people had received their medicines, creams and nutritional supplements. Accurate information was available to staff and health care professionals, such as doctors, who may use the information to make care and treatment decisions.

Action had been taken since our last inspection to provide people and their relatives information about the service they were purchasing, such as what was included in the fee. People were now supported to attend health care appointments by staff at no additional cost when a person's family were unable to do this. Arrangements were being put in place to support people to purchase items from outside of the service if they did not have family members to help them. A stock of toiletries had been purchased and staff were no longer purchasing them out of their own money for people.

The provider had taken action to make sure that notifications were sent to CQC as required. Notifications are information we receive from the service when significant events happened at the service, like a death or a serious injury.