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Elreg House

Inspection report

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Ratings

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

Overall summary

We inspected Elreg House on the 20 and 22 April 2015. Elreg House is a family run residential care home that provides care and support for up to 28 people living with various stages of dementia. On the days of the inspections 28 people were living at the home. The age range of people living at the home varied between 70 – 100 years old. The individual care needs of people varied within the home. While some people predominately required support for their dementia, some people also required support to manage their diabetes, mobility and long term health care needs.

The overall rating for Elreg House is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action

Accommodation was arranged over two floors with stairs and a stair lift connecting both levels. Some consideration had been given to the environment, making it dementia friendly. This included the use of signs and pictures to help orientate people around the home.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People and their relatives had mixed views about the quality and running of the home. Some people spoke highly of the home. One person told us, "As far as I am concerned it is a nice place, atmosphere is very calm and I have never had any problems." A relative told us, "There's nothing can they improve on." However, some people felt areas of the home required improvement. One person told us, "No choice of food offered." One visiting relative told us, "We are not getting quality for money."

There has been a history of Elreg House being unable to meet the Regulations of the Health and Social Care Act 2008 since September 2014, when we served compliance actions in relation to consent to care and treatment, records and quality assurance. At this inspection we found the provider had not taken steps to meet the all of the previous concerns we had identified, in addition we found further concerns in relation to cleanliness and hygiene, staffing levels and opportunities for meaningful activities for people living with dementia.

People's safety was being compromised in a number of areas. Staffing levels were insufficient to meet people's individual care and social needs. Staff were under pressure to deliver care in a timely fashion and this was seen to be more task orientated than person specific. One member of staff told us, "We just feed and water people."

There was a significant lack of meaningful activities or stimulation for people living with dementia. Staff acknowledged they did not have the time to provide activities or take people outside. People were at risk of social isolation.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time. However, guidance was not in place for the use of 'as required' medicines and care plans failed to demonstrate the steps required before administering the medicine. This therefore placed people at risk of receiving medicine that they did not require.

People were supported to maintain nutrition and hydration. However, people were not enabled to make day to day decisions on what to eat. There was little involvement from people on what they would like to eat at suppertime. People's food likes and preferences were not always upheld or respected.

Systems were not in place for the prevention of infection control. Standards of hygiene and cleanliness were not maintained and strong odours were present throughout the home making it an unpleasant and undignified place to live.

Staff had a firm understanding of the principles of consent and the person's right to refuse consent. However, the principles of the Mental Capacity Act 2005 (MCA) were not being adhered to. Where relatives were making decisions on behalf of their loved one, there was no evidence that a mental capacity assessment had been completed and the person had been involved in making the specific decision.

Elreg House deployed the use of CCTV (surveillance) throughout the home and outside. However, information was not readily available within the home informing people, relatives and visiting healthcare professionals that CCTV was in use. Consideration had also not been given to the impact this had on people's privacy and dignity. People's privacy was compromised at times and people were observed to be wearing soiled trousers.

Training schedules confirmed staff members had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected.

Summary of findings

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

Elreg House was not safe. There were not enough staff to provide safe and effective care to people. Risks to people were not managed to ensure people's safety. People received their medicine on time, however, guidance was not consistently in place to ensure the appropriate use of 'as required' (PRN) medicines.

Mechanisms for the prevention of infection control were not robust. Strong odours were present throughout the home, and concerns were raised in relation the standards of cleanliness and hygiene.

Staff had a firm understanding of what constituted adult abuse and we found recruitment practices were safe.

Is the service effective?

Requires improvement

Elreg House was not consistently effective. The requirements of the Mental Capacity Act 2005 were not always followed. Decisions made on behalf of people were not made in accordance with people's rights.

People were not consistently involved in making decisions about food and hydration. People's dietary preferences were not always upheld or respected.

People's health care needs were monitored on a daily basis, and people could see health and social care professionals to make sure they received appropriate care and treatment when needed.

Is the service caring?

Requires improvement

Elreg House was not consistently caring. People spoke positively of the care they received; however, care practices did not always respect people's privacy and dignity.

CCTV (surveillance) was in use at Elreg House, such as in the communal areas and hallways. Information was not available to visiting relatives and healthcare professionals making them aware of the CCTV, and little consideration had been given to the impact of the CCTV on people's Human Rights and privacy and dignity.

Staff were seen to interact positively with people throughout our inspection. It was clear staff had built rapports with people and they responded to staff with smiles.

Is the service responsive?

Requires improvement

Elreg House was not consistently responsive. There were not enough meaningful activities for people to participate in as groups, or individually to meet their social and welfare needs; so some people living at the home felt isolated.

Summary of findings

Care plans were personal to the person and included detailed information on their life history. However, care plan reviews failed to demonstrate the person's involvement and the effectiveness of the care plan.

People's concerns and complaints were investigated, responded to promptly and action taken.

Is the service well-led?

Elreg House was not well-led. Morale within the home was low and lines of communication between the provider and registered manager were not supportive or transparent.

The ethos and vision of the home was not embedded into everyday practice. Staff felt the delivery of care was task centred rather than person led.

Incidents and accidents were not monitored for any emerging trends or themes. Feedback from people and their relatives was not used to improve the running of the home.

Inadequate

Elreg House

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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 20 and 22 April 2015. This was an unannounced inspection. The inspection team consisted of two inspectors and an expert by experience, who had experience of older people's dementia care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection, we spoke with 13 people who lived at the home, five visiting relatives, six care staff, the chef, registered manager and the provider.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. On this occasion we did not ask the provider to complete a Provider Information Return (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. This was because we were responding quickly to information and concerns that had been raised with us

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at 11 care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Elreg House. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Elreg House. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

People and their relatives had mixed comments about the level of safety provided at Elreg House. Some people commented they felt safe. One person told us it was, "Perfectly safe." Another person told us, "Fine enough place, nothing wrong with it, very happy place." Whereas a sample of relatives felt their loved ones were not safe. One relative told us, "They've recently had a fall." We also identified areas of practice which were not consistently safe and placed people at risk.

Staffing levels were inadequate and did not allow for people to receive personal and individual care that safely met their care needs. We asked the registered manager what mechanisms were in place to determine the staffing levels. The registered manager told us, "I downloaded this dependency tool which considered how many hours of care people required per week. However, we haven't been using it on a regular basis." The registered manager acknowledged the dependency tool had not been utilised and could not demonstrate how people's needs had been assessed to determine the number of hours of care they required to safely meet their needs. Staffing levels consisted of five care staff in the morning, four in the afternoon and two on the night shift. However documentation and feedback from staff confirmed these levels of staffing were not consistently maintained. For example, on the 15 April 2015 there were only three members of staff on duty during the morning shift. On the 11 April 2015, only three care staff were on duty during the afternoon shift. We were informed by staff that staffing levels varied on a day to day basis, due to staff sickness and not being able to cover the shifts.

Insufficient staffing levels had a direct impact on the quality of care provided to people. One staff member told us, "It's a bit regimented here. In the afternoons especially it's very task orientated, we have to dress the rooms, so we don't spend time with the residents." Another staff member told us, "I think we need more staff, especially in the afternoon. We need more time to do activities, because we have to spend that one to one time with people. We need more staff allocated." Staff members commented that due to poor staffing numbers, they often felt pressured and unable to provide care that centred on the individual. One staff member told us, "We get no time to give to the resident's attention. The attention is personal care; we don't have time to do anything else."

The night shift consisted of two members of staff. However, for people who required the assistance of two care staff to move and transfer and get ready for bed, they had to be put to bed before 8pm before night staff came onto duty. This was because, providing support would take both staff members away from the floor and leave no staff supervising communal areas.

The delivery of care was being based on staffing numbers rather than individual preference. We spent time sitting with people in the dining room and communal lounge. For significant periods of time, people were left unattended, with care staff passing through every 10 to 20 minutes. Some people were able to move around independently, for others, they required assistance from staff members to move and get up. Due to the care needs of people living with dementia, they may try and get up independently. This can place them at risk of potential harm or falls. While spending time in the lounge, we observed one person trying to stand independently, but they were extremely unsteady on their feet. A staff member fortunately entered the room at the same time and provided support, but the person was at risk of harm due to lack of staff supervision.

Incidents and accidents identified a number of un-witnessed falls and altercations between people. For example, one person was found in the dining room on the floor after missing their chair when sitting down. An altercation between two residents also took place in the hallway where staff found one resident on the floor. The number of un-witnessed incidents and accidents reflected a lack of staff presence, supervision and consequently placed people at risk of harm.

Due to concerns with insufficient staffing levels which placed people at risk of harm, we have identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the biggest barriers to enabling people with dementia to have more control over their lives is an overly cautious approach to risk. People living with dementia should be supported to live autonomous independent lives, whilst being supported to take day to day risks. Risk assessments had been devised and implemented. Risk

Is the service safe?

assessments included falls, moving and handling and behaviour that challenged. However, risk assessments were not consistently followed by staff or lacked robust guidance and support for staff. One person who had exhibited behaviour that challenged, had a clear risk assessment in place which included steps for staff to take if their behaviour escalated. Part of the risk assessment included staff to complete incident and accidents forms to provide a clear audit trial and demonstrate the steps taken to manage the situation and de-escalate the person's behaviour. Staff members confirmed they had not been doing this and reflected they hadn't the time to read care plans and risk assessments. One member of staff told us, "I know there are personal details of people in the care plans, but I haven't had a chance to read them."

Risk assessments are integral to providing safe care to people whilst also respecting people's autonomy. However, risk assessments have no relevance if they are not read or followed by staff members. One person had been assessed at risk of falls if mobilising on the stairs unsupervised. Guidance documented for staff members to provide supervision when the person was mobilising on the stairs. However, a recent incident reflected the person had sustained a cut when mobilising on the stairs unsupervised. The registered manager acknowledged that the stairs within Elreg House were problematic, but also identified increased staffing levels would allow staff to safely supervise people when mobilising on the stairs.

Each person had a risk assessment in place which considered slips, trips and falls, poor balance and mobility problems. However, when someone was identified as being disoriented or unable to assess risks to themselves, the risk assessment documented stated 'to follow the care plan'. However, we could not locate a specific risk assessment or care plan to follow which identified and considered people's inability to assess risk and how that impacted upon their safety and level of autonomy. Where people had suffered falls, we could not see how their care plan had been updated to reflect the measures required to reduce the risk of further falls. The registered manager told us of the actions they had taken. For example, moving someone downstairs, so they no longer had to navigate the stairs. However, care plans failed to reflect the actions taken.

Risk assessments are integral in ensuring people receive safe care that respects their independence and autonomy. Failure to update risk assessments leaves staff without appropriate guidance and support and places people at risk of harm.

Due to the concerns identified in regards to poor risk assessing and guidance not being available for staff members we have identified a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt medicines were handled safely. One person told us, "If I ask for my headache tablet, I always get it." However, there was shortfalls in the management of 'as required' (PRN) medicines. PRN medicines can be prescribed for people living with dementia to manage levels of anxiety, behaviour that challenges or periods of anxiousness. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. PRN care plans were not consistently in place for the management of PRN medicines and the steps to take before administering it. One person's Medication Administration Records (MAR) chart reflected PRN medicine being administered on a regular basis. Documentation failed to reflect the steps taken before administering the medicine, the person's mood, presentation or how their behaviour presented. Records also failed to reflect the effectiveness of the medicine and to make sure it was working for the purpose it was prescribed for. Staff members were able to tell us the steps they took before administering PRN medicine and how the person's agitation presented, but acknowledged documentation needed improving. One staff member told us, "I think the record keeping is terrible. I've raised it, as it's not detailed enough. How are you meant to know what has happened. What has gone on, where is the evidence."

The lack of clear guidance meant people could be at risk of receiving PRN medicine inappropriately. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by the prevention and control of infection. Throughout our inspection there were unpleasant odours in many areas around the home. On the first day of the inspection, we were informed the domestic member of staff was on annual leave. Therefore, no

Inadequate

Is the service safe?

cleaning staff were present. Walking around the home, we found bins were full and omitting a strong unpleasant odour. Bathrooms were dirty with strong unpleasant odours and relatives raised concerns regarding the standards of cleanliness and hygiene. With permission, we visited people's bedrooms with their relatives. One person's commode and toilet had not been cleaned and there was no soap or hand gel. Dirt on the bed sheets was identified and the floor was dirty. On the second day of the inspection, a domestic staff was present and standards of cleanliness and hygiene had improved, however, unpleasant odours remained. Armchairs throughout the home were soiled and wet, with a sample of armchairs having plastic bags covering the cushions.

The steps taken by staff to protect people and staff from infection represented an important element in the quality of care. Systems and audits are integral in making sure that high standards of infection prevention and control are developed and maintained. The registered manager completed an internal infection control audit. However, the audit failed to identify whether infection control policies and procedures were being adhered to. Alongside the infection control audit, the registered manager was completing weekly health and safety checks which included infection control. However, the weekly checks failed to highlight the levels of concerns with infection control. For example, the weekly checks did not identify that all hand gel dispensers throughout the home were empty or that chairs in the communal lounge were soiled.

Maintaining a clean and hygienic environment for people is fundamental in providing care that is safe and protects people's well-being. Throughout the inspection, we observed care staff using personal protective equipment (PPE) appropriately along with appropriate hand washing techniques. However, systems and mechanisms were not consistently utilised to identify the shortfalls within infection control. Due to the concerns regarding cleanliness, hygiene and unpleasant odours throughout the home, we have identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to tell us confidently what they would do if they suspected abuse was occurring at the home. One member of staff told us, "I can recognise the signs of abuse. I'd know what to do if I saw it happening." It was clear staff understood their own responsibilities to keep people safe from harm or abuse. Safeguarding policies and procedures were up to date and appropriate for this type of home. Where safeguarding concerns had been raised, the registered manager had worked in partnership with the Local Authority to ensure protection plans were in place for people and any risk of future harm was minimised.

Recruitment processes were safe. Staff files confirmed that a robust recruitment procedure was in place. Files contained evidence of disclosure and barring service (DBS) checks, references included two from previous employers and application forms. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions. It also prevents unsuitable people from working with people who require support and care.

Requires improvement

Is the service effective?

Our findings

People spoke highly of the staff. One person told us, "Yes, staff are alright here." A visiting relative told us, "Staff are kind and compassionate. My loved one is and safe and I cannot think of anything needs improving." Another person told us, "Staff are very good." However, our own observations and the records we looked at did not always reflect the positive comments some people had made.

At the last inspection in September 2014, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008. This was because the provider was not completing Mental Capacity Assessments under the Mental Capacity Act 2005 (MCA), and the provider was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Improvements had been made, but there were still areas that required addressing.

The registered manager was committed to involving relatives in the formation and designs of care plans. Relatives were currently involved in planning future care which considered the person's end of life care, spiritual wishes and specific wishes. However, where relatives were making decisions, these were not underpinned by the person's involvement, or a mental capacity assessment to ascertain whether they had the capacity to make the specific decision. The Mental Capacity Act 2005 (MCA) is designed to protect people who lack capacity to make a specific decision. The philosophy of the legislation is to maximise people's ability to make their own decisions and place them at the heart of the decision making.

Where family members were making significant decisions, such as not being admitted to hospital, the registered manager and provider had failed to ascertain the legal status of family members when making decisions for people. Such as whether the family member had lasting power of attorney for health or had been appointed by the Court Protection. The registered manager reflected that due to the level of dementia each person experienced, they would not be able to make some decisions and therefore they were actively try to involve family members. It was acknowledged by the registered manager that they had not yet completed Mental Capacity Assessments to underpin and evidence when a person was unable to make a specific decision and the steps they took to try and empower the person to make the decision. One person's relative had informed staff they did not wish for their loved one to receive any further medical treatment regarding an on-going condition. This was clearly reflected in the care plan but there was no underpinning mental capacity assessment to determine that the person was unable to make that specific decision.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used. In March 2014, changes were made by a court ruling to DoLS and what may now constitute a deprivation of liberty. If a person is deemed under continuous supervision and control and not free to leave, they may be subject to a deprivation of liberty. The registered manager told us that DoLS applications had been made for all people living at the home, but only one had been authorised by the Local Authority.

For people subject to a DoLS, their independence, autonomy and right to choice should not be prohibited and providers should regularly review whether care and treatment could be delivered in a way that does not deprive the person of their liberty. Care plans and documentation failed to reflect that DoLS authorisations had been submitted and when the application and authorisation should be reviewed. For the person under a DoLS, their care plan failed to acknowledge they were under a DoLS, what it meant for them and how to provide care in line with the DoLS authorisation. Only one staff member could tell us who was under a DoLS and what it meant for that individual. The meaning and impact of DoLS is only relevant if all staff are aware of who is subject to a DoLS and how to provide care in line with the DoLS authorisation.

Due to concerns identified regarding the absence of mental capacity assessment and staff's lack of understanding of DoLS we have identified a breach of Regulation 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People commented on how they felt the food was good. One person told us, "I like the dinners here, quite nice." A visiting relative told us, "The food is really good." However,

Requires improvement

Is the service effective?

some people, relatives and staff raised concerns with the quality and variety of the food. One visiting relative told us, "The food quality and variety is not good." A staff member commented, "The teatime food is terrible. I feel terrible serving it up, especially to the diabetics. We don't buy any diabetic food."

People looked well hydrated and nourished. On a monthly basis, people were weighed and documentation confirmed no one was experiencing any significant weight loss and on occasions, people had gained weight since moving into Elreg House. Where concerns had arisen regarding a person's nutritional intake, documentation confirmed appropriate action had taken place.

Concerns were raised regarding people's lack of choice. We were informed people would be asked at breakfast what they would like for lunch. However, on the second day of the inspection, the chef told us, "We only have one choice today, Roast Beef, every Wednesday and Sunday, we always have a roast." For vegetarians, we saw the meat supplement was replaced by a vegetable alternative but this was decided by the chef what the alternative should be. We asked people if they knew what they would be having for lunch. Two ladies commented they never really knew but the food was ok.

People were not given any choice regarding the supper time meal. We asked the chef how people were involved in deciding what to have to eat for supper. We were informed this decision was made by the chef, but with an awareness of people's likes and dislikes. On the first day of the inspection, everyone was given the same meal, chicken Kiev, vegetables and mash potato. For vegetarians, they merely had mashed potato and vegetables. Food and fluid charts demonstrated that for four consecutive days in April 2015, people had chicken nuggets for supper. Where people had expressed a dislike to certain foods, this preference was not always respected. One person had documented they disliked sausages. However, their food chart reflected they had sausages for lunch and supper on three occasions in April 2015.

Older people need to be seen as individuals and given a voice to express who they are and what they want (maintaining identity). Making day to day decisions such as what to have to eat helps people feel valued and in control of their life. Removal of their daily choice makes people feel disempowered. Due to concerns raised regarding people's lack of choice around nutrition, we have identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt confident in the skills of the care staff. One visiting relative told us, "The staff work incredibly hard and do an amazing job." The provider offered an induction period to new members of staff. This enabled staff members to work alongside more experienced members of staff and complete an induction handbook. However, staff questioned the effectiveness of the induction. One staff member told us, "I've still got a few bits of induction to do. It's not that good. I've got a workbook, but I've not done it all." Another member of staff told us, "There is no formal induction. I was supposed to be shadowing someone, but that didn't happen, I just had to get on with it." A robust and effective induction is integral in assessing staff's competency and introducing staff to the workplace alongside understanding their roles and responsibilities.

Training schedules confirmed not all staff had received essential training on dementia awareness. One member of staff told us, "I received very little training here, most of my training I did at my old employer's but that included dementia training." Some staff had a firm understanding of what good dementia care consisted of and spoke freely on the training they had received. Whereas other staff felt additional understanding and training on dementia awareness would be helpful. Good quality training can help improve the lives of people living with dementia. Training should help staff understand what a difference they can make to peoples quality of life by providing good quality person centred care. Staff need to be hopeful about what can be achieved with people with dementia and training should encourage positive attitudes towards dementia. The absence of dementia training meant staff did not consistently have the knowledge and skills to provide good dementia care which promoted positive outcomes for people. One member of staff told us, "I'm still on my probation and I'd like more training around dementia." We have therefore identified this as an area of practice that needs improvement.

The registered manager was committed to providing as much support as possible for staff. Staff received on-going supervision. One member of staff told us, "The manager

Requires improvement

Is the service effective?

listens and she's supportive". Regular supervision provides an insight into what the role of the person being supervised entails, the challenges they face and what support they need. It is an aspect of staff support and development.

People's health and well-being was monitored on a daily basis. The district nursing team visited the home on a regular basis and documentation confirmed staff regularly liaised with GPs, dieticians and speech and language therapists. People commented they felt their healthcare needs were met. One person told us, "Doctors visit regularly." Visiting relatives commented they felt confident in their loved one's healthcare needs being maintained. One relative told us, "They keep me up to date and always inform me if the GP has visited or they have any health care appointments." Staff recognised that people's health needs could change rapidly and for people living with dementia, they may not be able to communicate if they felt unwell. The registered manager told us, "Through behaviour or mood and knowing our residents we can ascertain if someone is unwell or in pain." Where people's behaviour or mood was a cause for concern, documentation confirmed staff took regular urine dips to see if the person may be suffering from a urinary tract infection. This enabled them to take prompt action and gain input from healthcare professionals.

Requires improvement

Is the service caring?

Our findings

People spoke highly of the care they received. One person told us, "Staff are very caring and I feel safe." Another person told us, "It's marvellous here." Visiting relatives also commented on the kind and caring nature of staff. One relative told us, "The staff are kind and compassionate." Although people spoke positively of the care they received, we observed care practice which was not consistently caring.

The environment can have a significant impact on someone living with dementia. It can cause anxiety and confusion, and make it difficult for people to orientate themselves. A safe, well designed and caring living space is a key part of providing dementia friendly care. A well designed dementia environment includes the use of signage and memory boxes to help orientate people. The use of signs were displayed throughout Elreg House to help orientate people, such as where the toilets or lounges were . However, consideration had not been given to help orient people to their own bedroom. For example, people's bedroom doors had their name written on in small writing, but no picture or identifying objects to help the person recognise it was their bedroom. Throughout the inspection, we observed people freely coming and going from their bedroom to the communal areas, however, we also heard people asking, "Where do I go?" People were therefore dependent on staff to orient them and this impacted upon their ability to walk around the home independently. We have identified this as an area of practice that needs improvement.

For people living with dementia, incontinence can greatly impact upon a person's feeling of self-worth and dignity. Good continence care involves robust toileting support and recognising non-verbal cues of when the person may need the toilet. The registered manager told us, "Staff regularly take people to the toilet, but in-case of accidents people also have continence pads." Throughout the inspection, we observed two people standing up and their trousers being wet from incontinence. Staff promptly identified and assisted the person to the toilet and into a clean pair of trousers. However, staff commented that due to shortages in staffing numbers, this impacted upon their ability to implement regular support for people to use the toilet and they were re-active rather than pro-active. One staff member told us, "We don't get enough time to interact; we just feed them and water them."

Elreg House deployed the use of CCTV (surveillance) outside the home and inside (communal areas and hallways) for the purpose of safety and investigating incidents. The legal framework requires that any use of surveillance in care homes must be lawful, fair and proportionate and used for purposes that support the delivery of safe, effective, compassionate and high-quality care. Information was available outside the home informing people of the use of CCTV, however, there was an absence of information inside the home informing relatives, people and visiting healthcare professionals that CCTV was in use inside the home. Therefore people visiting the home may not understand that there image was being recorded via a live CCTV stream.

The registered manager informed us that relatives were informed informally of the use of CCTV. However, there was no documentation to confirm people living at the home had been informed of the use of CCTV and the impact this may have on their privacy and dignity and Human Rights (Human Rights Act 1998). Care plans contained no information or consideration to the use of CCTV. Policies and procedures were in place providing guidance on the use of CCTV which included information on the access to the recorded images. However, information was not readily available on how Elreg House had ensured people's Human Rights; particularly Article 8 (the right to respect for private and family life) had been consulted and reviewed. The registered manager understood and recognised the impact on people's privacy and dignity, but acknowledged, consideration had not been given to this when assessing people's needs and devising care plans.

Due to concerns raised regarding people's dignity being compromised and lack of consideration given to the use of CCTV and how it impacted upon people's dignity and Human Rights, we have identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Everybody has the right to be shown respect and treated with compassion. For people living with dementia this is particularly important in helping to recognise them as individuals, and acknowledging their difficulties in being able to express their wishes. We did see some staff

Requires improvement

Is the service caring?

interacting with people in a kind and compassionate way. When talking to people, staff maintained eye contact and knelt down next to the person. Laughter was heard during some parts of the inspection and it was clear staff had built rapports with people.

Staff spoke with kindness and compassion for the people they supported. One staff member told us, "There are some lovely carers and residents and we give good care." Another staff member told us, "It's not a bad home. The care is really good. The staff interact really well, get down to eye level. The residents aren't treated as a number. They are not a nuisance, we will always stop when we get the chance and we respect them."

Throughout the inspection, staff engaged and spoke with people in a polite and respectful manner. People told us that the care staff encouraged them to do things for themselves so they remained as independent as they could be. One staff member told us, "I'd put my mother here, I think so. The staff are so lovely, and we try to maintain people's independence. I always take a step back, give them choice, I try to think what would I like or not like. We seem to know them and what they want." During the inspection, we observed staff providing reassurance and support to people experiencing anxiety and distress. The registered manager was seen providing comfort to a person who was visibly upset, spending time with them and easing their distress.

People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting. The registered manager and provider were seen interacting with family members. Visiting relatives told us they felt involved in their loved one's care and were kept informed of any changes.

Requires improvement

Is the service responsive?

Our findings

People, relatives and staff had mixed opinions and feelings regarding the opportunities for social engagement and interaction. One visiting relative told us, "Mum has plenty to do, there's arts and crafts, painting, tea tasting." While staff members commented, "We need more time to do activities."

Engagement in meaningful activities is important for good dementia care. It can help people to maintain a level of independence and functional ability, and improve people's quality of life. As with other aspects of caring for people living with dementia, understanding personal preferences and abilities will help to provide truly meaningful engagement and activities. The provider employed a dedicated activities co-ordinator, but they had been off work for four months. The registered manager and provider commented that staff members tried to do activities in the afternoons for people, however, no specific member of staff had taken over as activities coordinator, ensuring on a day to day basis, activities would be taking place.

During the inspection, we observed people sitting in the dining room and lounge with no stimulation. The television and radio was off and people were seen walking without a purpose or sitting down with no engagement. On the first day of the inspection, we observed a ball game which lasted for approximately ten minutes. On the second day of the inspection, staff members organised a game of bingo at 15.30pm. However, throughout the duration of the inspection, staff did not encourage people to pursue their own individual hobbies or interests. For example, one person was seen walking throughout the home, picking clothes up and asking if everyone was ok. Their care plan reflected they use to work within the health and social care industry and enjoyed doing the laundry. Little consideration had been given to providing this person with activities such as folding the laundry to help promote feelings of identity and self-worth.

Staff members raised concerns regarding the lack of activities and opportunities for social engagement. One staff member told us, "It would be nice to do the activities in the morning, but we don't have the time." Another staff member told us, "More activities are needed." A few visiting relatives also raised concerns surrounding the lack of stimulation. One relative told us, "I am concerned the home is not doing enough to stimulate her." We asked people if they enjoyed doing activities. One person told us, "I'm so bored, I brought my knitting with me but there's nothing to do." Another person told us, "Don't know if anything is organised for today."

For people who were bed bound or preferred spending time in their room, we raised concerns as to how staff ensured their social and psychological care needs were met. For example, one person spent all day in their bedroom. The radio was on, however, there was no other stimulation. The person was experiencing advanced stages of dementia and from documentation; the only stimulation they were receiving was when care staff provided personal care. Documentation failed to demonstrate whether staff members were sitting with the person, spending time with them and ensuring their social needs were met. We therefore raised concerns that people were at risk of social isolation.

High quality approaches to providing meaningful and enjoyable activities are a key part of enabling people residing in care homes to live well with dementia. Due to the lack of stimulation and interaction we have identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in September 2014, the provider was in breach of Regulation 20 of the Health and Social Care Act 2008. This was because care plans were not accurate or fit for purpose. Information was missing and they were not up to date. Improvement had been made but areas of improvement were still identified.

Each person had an individual care plan which covered topics such as medication, medical history, continence, mobility, family and friends and personal care. Care plans were written from the perspective of the person and how they perceived their care needs. Information was readily available on the person's life history which included information on their family, likes, dislikes, hobbies, interests and important memories. The registered manager told us, "I've been trying to work on the care plans, making them as personal to the person as possible."

Care plans were reviewed on a monthly basis. The monthly review indicated minimal changes to the person's needs, such as whether they had been referred to the continence team. However, they failed to demonstrate whether the person had been involved in the review, whether the care plan remained effective, what was working well or what

Requires improvement

Is the service responsive?

wasn't working so well. Visiting relatives felt they had some input into the care plans. One relative told us, "Fully informed me of the care plan." However, the role and purpose of the care plan is to ascertain what is important to the person and how they wish to receive their care and support. A care plan review is to ascertain whether the person remains happy with the delivery of the care and support and that it is meeting their needs. We have therefore identified this as an area of practice that needs improvement.

Staff were kept aware of any changes in people's needs on a daily basis. This was supported by systems of daily records which were filled out in the home's communication diary. There were also verbal handovers between staff shifts. Staff members were responsive to the individual healthcare needs of people. For people living with dementia, the monitoring of their psychological and emotional wellbeing is vital in maintaining and promoting their wellbeing. Staff members recognised that people may not always be able to verbal communicate how they are feeling but understood that people's body language, facial expressions and behaviour also reflected their feelings. Documentation confirmed the staff worked in partnership with the local dementia and mental health team. Staff members confirmed that if they had concerns over someone's wellbeing, these concerns would be escalated to the registered manager and provider.

The complaints policy was on display in the hallway and there was a suggestion box for people to use. Information was also available in people's individual care plans on the complaints procedure and the timescales of responding the complaints. People told us they felt confident and comfortable raising concerns. One person told us, "Go and talk to the lady manager, she knows what is going on, she would listen." Records demonstrated that complaints had been taken seriously by the provider and registered manager, responded to in a timely manner and learning gained from each complaint. Where complaints had raised safeguarding concerns, the registered manager took appropriate action and worked in close liaison with the local safeguarding team.

Inadequate

Is the service well-led?

Our findings

People spoke highly of the registered manager. One person told us, "The boss lady is very nice." However, staff members and relatives had mixed views regarding the leadership of the home. One staff member told us, "The manager is really good, she listens and makes changes, but she's not supported." Another member of staff told us, "I don't think the manager's approachable. She's too stressed out."

Elreg House is a family run care home that has been within the provider's family since 1979. The leadership of the home was governed by the provider and registered manager. The provider is the owner of Elreg house and responsible for ensuring all regulated activities (such as personal care) are registered with the Care Quality Commission. The registered manager is the person appointed by the provider to manage the regulated activity on their behalf, where the provider is not going to be in day-to-day charge of the regulated activities themselves. A well-led organisations means that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture. The relationship between the provider and registered manager is one that is supportive, open, transparent and honest. During the inspection, concerns were raised regarding the channels of communication and level of support between the provider and registered manager.

Although the provider visited the home on a daily basis, we could not see how the registered manager and provider communicated and discussed the running of the home and how to make improvements. The registered manager told us, "I don't get formal supervision; we might sit down and talk. I've recognised that there are issues, but I've not had time to do things properly, all the things I've suggested. It's not transparent." The inspection identified that the registered manager was trying to manage the running of the home, completing care plans, quality assurance, staff rotas and other tasks, and acknowledged it was too much. The registered manager told us, "I need an experienced deputy who can take on some of these tasks. We just struggle to recruit and retain deputy managers." Staff members raised concerns regarding the level of support for the registered manager, and questioned what would happen if the registered manager went off sick as no one would be able to adequately provide day to day leadership in their absence.

Staff morale was low. Feedback from staff was that staffing levels were not adequate and consequently this impacted upon morale within the home. One staff member told us, "Staff morale is so low, staff are coming in, but they're not staying here." Another staff member told us, "We could do with more staff and better organisation. We could do with more support." Staff reflected they had raised concerns with the provider and registered manager, but felt the provider was not supportive. One staff member told us, "The owner isn't supportive enough." Another staff member commented, "The owner interferes and says no." Minutes from staff meetings reflected that staffing numbers were consistently on the agenda and discussed. We queried with the provider and registered manager what action was being taken to increase staffing numbers. The provider reflected that there was an ongoing recruitment campaign, but could not provide a rationale on why the numbers of staff allocated on the staffing rotas had not been increased to reflect the consistent feedback around the need to increase staffing.

Positive workplace cultures are central to an organisation's success or failure, and are never more important than when the service is providing people with care and support. Positive workplace cultures in social care not only address productivity and the health and wellbeing of staff, but also look to improve outcomes for those who need care and support services. The culture within Elreg House required improvement. Staff members felt they didn't have the time to provide high quality care and consequently the delivery of care was task centred rather than person led. One staff member told us, "We get no time to give to the residents." Staff however spoke positively of the care team and how they all worked together despite the difficulties. Comments included, "It's a nice little home, we all get on well with each other" and "Staff are very supportive of each other. We cover each other."

The ethos and vision of Elreg House was not made readily available to staff or embedded into day to day practice. The home's statement of purpose reflected, 'At Elreg House, we believe that all individuals should have the same rights and opportunities as everyone else. Elreg House exists to help meet the needs of people who have a mental health

Inadequate

Is the service well-led?

difficulty. We encourage and support individuals to take control of their lives.' Throughout the inspection, we spent time sitting with people and interacting with people. We could not see how people were supported to take control of their own lives. For example, on both days of the inspection, it was warm and sunny outside. At no point did we see people sitting outside enjoying the sunshine or staff supporting people to go outside. For people living with dementia, the ability to make day to day decisions such as what time to eat, when to go outside, what to do, should not be taken away and people should be enabled to have control of their lives. However, through interacting with people and our observations, we could not demonstrate that people were enabled to live autonomous independent lives while residing at Elreg House.

At the last inspection in September 2014, the provider was in breach of Regulation 10 of Health and Social Care Act 2008; this was because systems were not in place to monitor incidents and accidents for any emerging trends or themes. Improvements had not been made.

Following an incident and accident, documentation was completed which looked at where the accident/ incident occurred, the date and time, person involved, nature of the injury and whether it was witnessed or unwitnessed. However, mechanisms were not in place to monitor incidents and accidents on a regular basis to help identity any emerging trends or themes. Such as if people were falling more at night or during the day. Providers and registered managers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents. The registered manager told us, "Informally I go over the incidents and accidents, but I don't document any patterns or trends."

Systems were in place to gain feedback from people and their relatives. A yearly satisfaction survey was sent out to people to obtain their views and feelings on the running of the home. The last satisfaction survey was sent out in June 2014. Feedback from people included both positive and negative comments. One person requested more singing, while a relative raised concerns in respect to staffing numbers and their relative's needs not being promptly attended to. However, documentation failed to demonstrate how the provider acted upon these concerns or made improvements. We asked the registered manager whether the survey results were analysed for any emerging trends or themes, and what happened following negative feedback. The registered manager acknowledged that the survey results had not been used for improving the running of the home, or addressing people's specific concerns. We have therefore identified this as an area of practice that requires improvement.

Alongside satisfaction surveys, staff and resident meetings were held on a regular basis. These provided staff and people with a forum to air their views and provided opportunities for staff to contribute to the running of the home. During one resident meetings, people were encouraged to think of ideas of activities they would enjoy doing. Suggestions included afternoon trips out, classical music afternoons, exercise sessions and reminiscence sessions. However, despite people's suggestions. These suggestions were not acted upon. The only activity implemented was a tea tasting session which was suggested by the home. Therefore people's ideas and suggestions were not acted upon and implemented to improve the running of the home.

Involving people in the running of a care home and acting upon their feedback is vital in creating a culture of transparency and integrity. Feedback and suggestions from people should be listened to and responded to. It should also be used in analysing the quality of the care provided and driving continual improvement.

Due to concerns found in relation to incidents and accidents and mechanisms not being in place for the auditing of incidents and accidents and feedback from people not being acted upon, we have identified a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and Respect 10(1) – The registered persons had not ensured service users were treated with dignity and respect. 10(2)(a) – The registered person had not ensured the privacy of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment 12(2)(a) – The registered person had not assessed the risks to the health and safety of service users of receiving the care or treatment 12(2)(g) – The registered person had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and Equipment 15(1) (a) The registered person had not ensured the environment was clean.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing 18(1) – The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. 13 (5) - A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for Consent 11(1) - The registered person had not ensured care and treatment of service users must only be provided with the consent of the relevant person.

The enforcement action we took:
A warning notice has been served. The service is to be complaint within one month of receipt of the warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (a) Assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

(e) Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

The enforcement action we took:

A warning notice has been served. The service is to be complaint within one month of receipt of the warning notice.