Runwood Homes Limited

Elizabeth 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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Elizabeth House provides accommodation and personal care for up to 108 older people and people living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Our previous comprehensive inspection to the service was on 11 and 19 December 2017, 9 and 18 January 2018. The overall rating of the service at that time was judged to be 'Good'. A focused inspection was completed on 9 and 10 April 2018 to review the domains of 'Safe', 'Effective' and 'Well-Led'. The inspection was prompted in part by a specific incident. 'Safe' was judged as 'Requires Improvement' and 'Effective' and 'Well-Led' were judged as 'Good'. No breaches of regulation were highlighted.

This inspection was completed on 26, 27, 28, 30 July 2018 and 7 August 2018 and was unannounced. There were 100 people living at the service.

We took urgent action to restrict admissions to the service and placed several conditions on the provider's registration because we were concerned about people's immediate safety.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Since our last inspection in April 2018 and following a serious incident at the service in July 2018, the registered manager had resigned. Following their resignation, the registered provider made the decision for an existing registered manager from within the organisation to manage Elizabeth House. 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 2008 and associated Regulations about how the service is run.' The registered manager has applied to be registered at Elizabeth House.

Quality assurance checks and audits carried out by the registered provider and former registered manager were not robust, as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm and where their health and wellbeing was compromised. The registered provider and management team of the service had not taken appropriate steps to ensure they had sufficient oversight of the service which ensured people received safe care and treatment. The lack of managerial oversight had impacted on people, staff and the quality of care provided and they were unable to demonstrate where improvements to the service were needed, how these had been addressed; and lessons learned to ensure compliance with regulatory requirements and the fundamental standards.

Significant Improvements were required to ensure sufficient numbers of staff were effectively deployed to ensure people's individual care and support needs were met in a timely manner and the care provided was 'person-centred' rather than 'service-led'. Substantial improvements were required to ensure people received their prescribed medication as they should and medication practices and procedures were robust. Improvements were needed by the management team to respond to and help manage infections.

The standard of record keeping was poor and care records were not accurately maintained to ensure staff were provided with clear up to date information which reflected people's current care and support needs. Suitable control measures were not always put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered, and risk assessments had not been developed for all areas of identified risk. People were at risk of harm due to poor manual handling practices by some members of staff.

Although appropriate recruitment procedures were in place to check staffs' suitability to work with vulnerable people before they started work, improvements were required to make sure these were robustly completed for all prospective staff to ensure safer recruitment practices.

Not all staff had received a robust induction and the role of senior members of staff was not effective in monitoring staff's practice and providing sufficient guidance and support. Training and development was not sufficient in some areas to demonstrate that people's care and support needs were fully understood by staff and embedded in their everyday practice. Staff had not received regular supervision or an annual appraisal of their overall performance.

The registered provider and management team had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people using the service, we observed some interactions which were not respectful or caring and failed to ensure people were treated with respect and dignity.

Although people's capacity to make decisions had been assessed, people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

Not all of a person's care and support needs had been identified and documented. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for them becoming anxious and the steps staff should take to comfort and reassure them.

People were supported to have enough to eat and drink, however improvements were required to demonstrate people living at the service had received sufficient nutrition and hydration. People were supported to maintain good healthcare and have access to healthcare services as and when required.

Staff were aware of their responsibilities regarding safeguarding people from abuse and knew how to report concerns. People were supported to maintain relationships with people who were important to them.

We have made a recommendation about record keeping relating to people's nutritional and hydration needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not identified for all areas of risk. Risks were not suitably managed or mitigated to ensure people's safety and wellbeing. Significant improvements were required relating to medicines management.

Sufficient numbers of staff were not always available to meet people's needs and to support people safely.

Improvements were required to ensure the management team responded at the earliest opportunity to manage infections at the service.

Although arrangements were in place for reviewing and investigating incidents when things go wrong, lessons were not always learned.

Improvements were required to ensure 'Pre-Employment Checks' and recruitment procedures were reviewed to ensure these are safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staffs' knowledge and understanding of training was embedded in their everyday practice.

Not all staff had received a robust induction, regular supervision or an annual appraisal of their overall performance.

The dining experience was observed to be satisfactory, however improvements were required relating to how people's nutritional and hydration needs were recorded.

Staff's knowledge and understanding of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS] was sound and people's capacity to make decisions were appropriately assessed.

In general, people's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services as required.

Is the service caring?

Inadequate

The service was not caring.

People using the service did not always receive good quality care or always treated with kindness, respect, dignity and compassion. Care provided was primarily task focused.

Staff did not always effectively communicate with people using the service, particularly people living with dementia.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care and support that was responsive to their individual needs.

Improvements were needed to ensure all of a person's care and support needs was recorded and the information accurate.

People were confident that their complaints would be taken seriously and acted upon. Minor improvements were needed to show how conclusions had been reached and ensure all complaints acknowledged in line with the registered provider's policy and procedures.

People were supported to participate in a range of social activities.

Is the service well-led?

Inadequate

The service was not well-led.

Although systems were in place to regularly assess and monitor the quality of the service provided, improvements were required as these arrangements had not highlighted the areas of concern we identified as part of this inspection.

Quality monitoring processes were not robust and working as effectively as they should be to demonstrate compliance with regulatory requirements and to drive improvement.

Systems were in place to seek the views of people who used the service and those acting on their behalf.

Elizabeth 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 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.

The inspection was prompted in part by notification of an incident following which a person using the service died unexpectedly. This incident is subject to a police investigation and as a result this inspection did not examine the specific circumstances of the incident. However, the information shared with the Care Quality Commission about the incident indicated potential concerns about the management of risk of falls, monitoring people who use the service and staffing levels. This inspection examined those risks.

This inspection took place on 26, 27, 28 and 30 July 2018 and was unannounced. On 26 July 2018, the inspection was undertaken by two inspectors and a 'bank' inspector. On 27 July 2018, the inspection was undertaken by one inspector, a 'bank' inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia. On 28 July 2018, two inspectors undertook a visit to the service between 5.00am and 9.00am. On 30 July 2018 the inspection was completed by one inspector. Feedback relating to the inspection findings was provided to the management team on 7 August 2018 by the lead inspector and an inspection manager.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and registered manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 people who used the service, six people's relatives, four Care Team Managers, nine members of staff, the service's chef, one person responsible for facilitating social activities, two deputy managers, the new manager and the Regional Operations Director.

We reviewed 10 people's care plans and care records. We looked at the staff personnel records for seven members of staff, including staff training information and supervision records. We also looked at the service's arrangements for the management of medicines, safeguarding, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

A focused inspection was completed to the service on 9 and 10 April 2018 as concerns were raised with the Care Quality Commission about people's safety and wellbeing. The focused inspection was prompted in part by a specific incident in which a person using the service died. This raised concerns about the management of falls at the service. The domain of 'Safe' was judged at this inspection as 'Requires Improvement' as risk assessments required more detail describing how identified risks were to be mitigated. Staffing levels were not being monitored to ensure people living at Elizabeth House received prompt support, and communal lounge areas were not always appropriately staffed to make sure people were safe. The above was discussed with the registered provider and former registered manager and immediate actions were put in place. Namely, a detailed analysis of falls was undertaken to identify any themes and trends and an extra member of night staff was deployed to the service for one month to see if this helped to reduce the number of falls at the service.

At this inspection, whilst there were arrangements in place to ensure all staff who administered medication were trained and had their competencies assessed, this did not ensure their practices were safe. We looked at the Medication Administration Records [MAR] for 13 of the 54 people who resided on Poppy Unit and found several discrepancies relating to staff's practice and medication records. Additionally, not all medicines were securely stored. Pain relief medication and antihistamine creams were found in two people's rooms. This meant medication could be easily accessed by others not authorised to do so.

Some people did not receive their prescribed medication as they should. For example, one person was prescribed a pain relief gel to be applied by staff twice daily to their knees. Records showed this was not applied for a consecutive period of 24 days. Records available did not provide a clear indication detailing if the person was in pain or not. Another person had not received one of their medicines as the service had been 'awaiting stock' since the 15 July 2018. This medication was used to treat several medical conditions. Information available showed a facsimile was forwarded to the person's GP surgery for a repeat prescription on the 7 and 24 July 2018 and had not been pursued further by the Care Team Managers [CTM]. One person had not received their once weekly transdermal patch [strong pain relief medication] on 26 July 2018 as scheduled. This is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the blood stream. A rational for this discrepancy and oversight was not apparent or recorded.

The MAR forms for six people showed there were unexplained gaps whereby staff had failed to initial the MAR form to evidence their prescribed medication had been administered. In some instances, this was solely a recording issue as the medication had been administered, however for three people their medication remained in the blister pack. Another person's MAR form recorded they were prescribed a short course of antibiotic medication. The MAR form showed 21 tablets were received but 23 entries were recorded. Where people were prescribed a topical cream to be administered at regular intervals each day, the MAR form recorded 'F' other define'. A rationale for the use of this code was not recorded on the reverse of the MAR form and no records were kept in people's room to indicate the topical cream had been applied by staff.

Medication audits had been completed each week since April 2018. These regularly showed gaps on the MAR forms and staff not following the registered provider's topical cream policy and procedure were a regular occurrence. An action plan detailing how this was to be addressed and monitored was not routinely completed. This showed ineffective measures were in place to make the required improvements and to monitor compliance. Following our inspection, the Local Authority completed a visit to the service to review the service's medication practices and procedures. The visit showed required improvements had still not been made and lessons learned.

Not all risks to people's safety and wellbeing had been identified, and suitable control measures had not always been considered and put in place to mitigate the risk or potential risk of harm for people using the service. We were told by a member of night staff on the morning of 28 July 2018, one person was sleeping in another room as the bed had bedrails fitted and this was judged safer for them. A bedrail assessment had not been completed to determine the bedrails were suitable for the individual person so that any risks identified were balanced against the anticipated benefits.

During an early morning visit to the service on 28 July 2018, inspectors noted three people's sensor mats on Bluebell Unit were pushed under their beds, with people remaining in bed asleep. The risk of potential harm remained because the sensor mats were not in place to alert staff when the person mobilised. No action had been taken by staff to address this when they completed their night checks and observations. This also demonstrated that lessons had not been learned following a previous incident to enable appropriate measures to be put in place to mitigate the risk of reoccurrence.

Although staff had received manual handling training, we observed poor staff practice in relation to moving and handling on four separate occasions. We observed a permanent member of staff and an agency member of staff assist a person to move in a way that was unsafe and put them at risk of harm. Staff transferred individuals from their comfortable chair to a wheelchair in the main communal lounge by placing their hands and/or arms under the person's armpits and assisting the person to their wheelchair. This technique is unsafe, can hurt and cause injury because the person's armpits and shoulders have too much pressure on them. The agency member of staff was also observed to mobilise a person into the communal lounge in their wheelchair. The person only had one foot on the footplate and one foot was seen to drag on the floor. Inspectors immediately intervened whereby the person's trailing foot was placed by the agency member of staff back on the footplate.

Staff understood their basic responsibilities for maintaining appropriate standards of cleanliness and hygiene; and following food safety guidance. However, there was a risk that people were not always protected by the prevention and control of infection. When inspectors arrived at Elizabeth House at 5.10am on 28 July 2018, they were told that four people residing on Poppy Unit had a rash and this had been reported to the deputy manager on duty. Nevertheless, following the inspection when we reviewed their daily and multidisciplinary records, we found that although the rash had been noted and recorded on 28 July 2018, no further action had been taken. Advice had not been sought from the NHS helpline and people were not seen by a GP at the earliest opportunity. The GP and Health Protection Agency were not contacted until eight days later. Only on the ninth day were people's next of kin informed and a decision made for Poppy Unit to be closed to visitors due to a possible infection outbreak. The above demonstrated the management team of the service had not complied with the Department of Health's 'Code of Practice' on the prevention and control of infections and related guidance.

Furthermore, a CTM was observed to administer people's medication. They walked up to a person and tipped the pot of tablets into the person's mouth. Two tablets stuck to the bottom of the pot, having unsuccessfully tapped the pot against the person's mouth, the CTM was observed to pick up both tablets

with their fingers and place the tablets directly into the person's mouth. This was not good practice or hygienic and there was a risk of poor infection procedures and cross contamination.

These failings constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not positive about the service's staffing levels. One person stated, "You can press your call bell and then wait a long time for someone to come, this frequently happens of a night time." Others told us they had used their call bell to summon staff assistance as they required their comfort needs to be met. However, staff did not always respond in a timely manner and because of this there were occasions when they soiled themselves. Arrangements were not in place to ensure the numbers of staff on duty were suitable to meet people's needs. We found there were insufficient night staff on duty between 8.00 p.m. on the 27 July and 8.00am on the 28 July 2018 on Poppy and Bluebell Units. The deputy manager told inspectors that nine staff should have been on duty but only seven staff were evident across both units; this included three agency members of staff, two of which had not previously worked at Elizabeth House. Staff failed to use the registered provider's formal 'on-call' protocol to inform senior managers of this shortfall. The impact of this meant on Poppy Unit, staff were providing personal care [washing, dressing and continence pad changes] to people on their own, even though some people required two members of staff to have their needs met safely. Additionally, because of insufficient staff on duty, staff confirmed people were still being assisted to bed at 1.00am and the evening medication round on 27 July 2018 did not complete until 11.00pm. This demonstrated people were exposed to the risk of harm because they had not received their medication in a timely manner and people going to bed in the middle of the night could increase their risk of falls, and resulting in subsequent injuries.

On the 28 July 2018, five people were left without staff support within the first-floor communal lounge on Poppy Unit for a timed period of 30 minutes. One person was known to exhibit behaviours that can be distressing and anxious to themselves and others. Daily care records showed this person was frequently agitated and challenging towards others. Although we did not observe the person to become distressed and anxious during this time, the lack of staff presence placed others at potential risk of harm.

Due to inadequate staffing levels, we found on the 28 July 2018 staff were regularly not completing required documentation, including observations for people at risk of falls, malnutrition and dehydration. The observation records for four people showed their last observation by staff was completed on 27 July 2018 between 6.55pm and 10.15pm Additionally, at 7.00am on 28 July 2018, inspectors found 26 peoples' daily care records had not been updated between 2.12 pm and 7.00pm the previous day. The night staff meeting minutes dated 25 July 2018 demonstrated the management team were aware that staff were finding it hard to complete all required paperwork.

Relatives told us there were never enough staff around. One relative expressed serious concerns and was emotive about their family member not receiving appropriate support due to a consistent lack of staff. The failings they noted included not providing basic personal care and assistance with meals and fluids for their member of family. For this reason, they visited Elizabeth House frequently because they were so concerned about their family member's safety and welfare. All staff spoken with stated there were insufficient staff to meet peoples' needs. Comments included, "Staffing levels are causing a problem with morale, we really need a review of staff numbers. We really do our best under very difficult circumstances" and, "Staffing levels are very tight." Night staff stated because of insufficient staff they had to leave people unattended, even those they knew who were at risk of falls.

The Regional Operations Director told us the service's staffing levels were determined each month using

specific tools to assess a person's activities of daily living and dementia. Although people's individual dependency needs were recorded and the total hours required each week calculated, this did not consider the specific number of hours required for each unit or the layout of the environment. Staffing levels had not been determined in May and June 2018.

These failings constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records for four members of staff were viewed. Relevant checks had been completed before a new member of staff started working at the service. An application form had been completed, written references relating to an applicant's previous employment was evident, proof of an applicant's identity had been sought and a criminal record check with the Disclosure and Barring Service [DBS] had been undertaken for all staff. However, when checking another member of staff's file because of concerns relating to their practice and behaviours, information recorded in a letter stated they had previous criminal convictions. No information was available to demonstrate what their convictions had been and why these had not been declared on their application form and on the registered provider's 'Criminal Record Declaration' form in line with the registered provider's 'Pre-Employment Checks' procedures. No risk assessment or rationale for them working with vulnerable adults had been completed by the former registered manager.

The staff training information provided to us showed staff employed at the service had received up-to-date safeguarding training. Staff demonstrated a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. However, no staff had raised safeguarding concerns about the poor quality of care some people received until this inspection.

Requires Improvement

Is the service effective?

Our findings

Effective was rated as 'Good' at our last inspection on 9 and 10 April 2018. At this inspection, we found that 'Effective' was now rated as 'Requires Improvement.'

The training plan provided demonstrated most staff had attained mandatory training in line with the registered provider's expectations. Although our observations showed some staff were effectively able to apply their learning, others were not and improvements were required to ensure their training was embedded in their everyday practice. As already highlighted, improvements were required in relation to manual handling and medication practices. Because of our concerns the manager confirmed that all staff were to receive refresher manual handling training on 13 and 14 August 2018 and all staff who administered medication would receive training on 10 August 2018. Not all staffs' interactions, exchanges and communication with people using the service was observed to be appropriate. These exchanges, particularly for people living with dementia were primarily routine and 'task-led'. This referred specifically to the provision of drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs.

There was no evidence to show staff newly employed had received an 'in-house' orientation induction. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life. Where concerns about one member of staff's conduct were highlighted as part of the inspection process, we reviewed their staff file to look at their induction and what this entailed. The member of staff had not attained a NVQ or QCF qualification or commenced and completed the Skills for Care 'Care Certificate.' This was confirmed as accurate by the newly appointed manager.

Agency staff confirmed when working at Elizabeth House for the first time, their induction solely consisted of being shown the fire exits. This was confirmed as accurate by a CTM. CTM's did not have access to agency staff profiles at the weekend or when there was no management presence at the service. This meant CTM's were unable to determine and confirm if the agency member of staff was suitable to work with vulnerable people and if their training was appropriate.

All staff spoken with told us they did not feel valued or supported by the organisation or management team at Elizabeth House and morale was low. Staff commented they did not always feel the management team and CTM's actively listened to what they had to say or were proactive in addressing their concerns, difficulties and negative experiences. For example, inequitable workloads and high usage of agency staff and the impact this had on the quality of care people received.

Although the registered provider's expectation was that staff should receive bi-monthly formal supervision, records viewed showed not all staff had received regular supervision or an annual appraisal of their overall performance in the last 12 months. For example, a member of staff who was employed in August 2016 last received supervision in October 2017. A member of staff who was employed in August 2017 received a probation review in October 2017. No evidence of further supervision was evident for the latter. The deputy manager and regional operations director confirmed this was accurate. Where discussions had been held as

part of disciplinary proceedings and probation reviews for the above members of staff, and which suggested follow-up action and monitoring was required, information to demonstrate this was not available. This was confirmed as accurate by the deputy manager. This demonstrated staff's conduct and performance had not been monitored, despite issues relating to poor medication practices, lack of observations and record keeping and monitoring of people's sensor mats.

These failings constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about the quality of meals provided was positive. Suitable arrangements were in place to ensure that the service's chef was aware of people's individual dietary requirements, including known allergies. Improvements were required to ensure people's nutritional and hydration records were completed to an appropriate standard. At the time of the inspection, the country was experiencing a sustained period of very hot and humid weather conditions. Although assurances were provided by staff that people were being hydrated, particularly people who remained in their room, records did not always provide sufficient evidence to determine if their fluid intake was sufficient. Additionally, where people had declined their food, it was not clear if staff routinely offered alternatives.

We recommend that the service seek guidance and support to look at ways to better record people's nutritional and hydration needs.

The dining experience across the service was seen to be positive, relaxed, friendly and unhurried. People were supported to make choices from the menu provided and received food in sufficient quantities. Meals were presented in an attractive way, particularly for people who required a soft and pureed diet. People were supported to use suitable aids to eat and drink as independently as possible, such as, to eat their meal using a spoon and use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance and support to eat and drink this was generally provided in a sensitive and dignified manner. People were not rushed to eat their meal and were able to enjoy the dining experience at their own pace. Improvements were required to ensure where support was provided by staff, rather than standing up, staff sat next to the person.

The service worked with other organisations to ensure they delivered joined-up care and support. This included the dementia support team, District Nurse services, local falls team, mental health teams for older people and the local NHS hospital 'step-down' team. The latter refers specifically where people no longer require the level of care from an acute medical setting such as a hospital but are not ready to return to their own home. This was particularly apparent where people's healthcare needs had changed and they required the support of external organisations and agencies to ensure people's welfare and wellbeing. People suggested to us that their healthcare needs were met and they received appropriate support from staff. Care records showed that people's healthcare needs were recorded, including evidence of staff interventions and the outcomes of healthcare appointments. However, following the inspection we found advice had not been sought from the NHS helpline and people were not seen by a GP at the earliest opportunity in relation to infection control concerns.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack the mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff demonstrated a good knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Information available showed that each person who used the service had had their capacity to make decisions assessed. Where people were deprived of their liberty appropriate applications had been made to the Local Authority for DoLS assessments to be considered for approval. However, people were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. Evidence to support this is detailed within other sections of the report.

Inadequate

Is the service caring?

Our findings

Caring was rated as 'Good' at our last comprehensive inspection on 11 and 19 December 2017 and 9 and 18 January 2018. At this inspection, we found that responsive was now rated as 'Inadequate.'

People's and relatives' comments about the quality of care provided at Elizabeth House were variable. Where positive comments were recorded, these included, "My care is very good, but I do a lot for myself", "The staff who care for me are usually good" and, "The staff are lovely." Where relatives' comments were favourable, they told us staff cared for their family member to a good standard. However, this contrasted with other comments received. Primarily people told us staff did not have the time to sit and talk with them, there were insufficient staff to meet their needs and there was a high usage of agency staff.

We saw that staff's practice and behaviours were not always caring or person-centred. Whilst some staff's interactions were observed to be kind and caring, and staff engaged with people in a meaningful and helpful way, most interactions were task and service-led and not all effectively communicated with the people they supported. This concurred with the manager's meeting held in June 2018. This recorded improvement was needed relating to staff's engagement with people using the service. For example, a staff member was observed to call across the communal lounge to a person using the service who was attempting to stand. The staff member's tone and volume of voice increased as their frustration grew whilst they tried to explain to the person they were at risk of falls. It did not occur to the member of staff that they should approach the person and speak to them, explaining the potential risks posed and asking them to sit down.

An agency member of staff was leading a person using the service by the hand along a corridor, they then turned and directed the person in the opposite direction. They passed an open door leading to the garden where a permanent member of staff was sitting, presumably on their break, smoking a cigarette. The agency member of staff called across to the member of staff stating, "What do you want me to do with her?" The member of staff remained seated and called back, "Put her in the lounge." The agency member of staff looked up and down the corridor, decided on a direction and led the person away. The person was not consulted and asked where they would like to go and was not referred to by name by either member of staff. Additionally, we observed one CTM whilst undertaking the medication round to call to people from their bedroom doorway regarding the need for PRN 'as required' medication, rather than discreetly consulting the person.

One member of staff on two separate occasions was observed to be loud, intimidating and aggressive when talking with one person living at Elizabeth House. The person using the service was overheard to say to the member of staff, "What's it all about?", to which the staff member stated, "Don't know what you are talking about mate", and then walked out of the communal lounge without any further interaction or explanation. Previously, a discussion had been had about the same person requiring staff support to have a comfort break. When told by the member of staff, "Let's go", when the person queried this, the staff member again in a loud, intimidating and aggressive manner answered the person by saying, "Do you want the toilet or not?" The reactions by the member of staff were not kind, considerate or caring towards the person and the management team were advised to raise a safeguarding alert as this practice was considered abusive.

Following the inspection, a safeguarding alert was duly raised with the Care Quality Commission and Local Authority.

Staff's practice did not always ensure people using the service were treated with respect, dignity or consider peoples' preferences. People on Poppy and Bluebell Units were being washed, dressed and placed back in bed. This practice had already begun and was in progress by the time we arrived at the service at 5.10am on 28 July 2018. Both day and night staff spoken with confirmed there was an expectation that night staff would get as many people washed and dressed and 'up' prior to day staff coming on shift. This was confirmed as accurate by a CTM who had come on duty on 28 July 2018 at 8.00am. Staff stated the above was a common occurrence and part of the culture at Elizabeth House. The night staff meeting minutes dated 25 July 2018 demonstrated the management team were aware that staff were getting people up in the morning, as early as 4.00am, 5.30am and 6.00am. This is institutional practice and does not allow people using the service choice or consider their preferred preferences and routines when being supported.

One person was moved to a communal lounge whilst sitting in their wheelchair. The agency member of staff pushed the wheelchair into the middle of the communal lounge and left the person in the middle of the communal lounge for 35 minutes. The person was seated facing the wall and was unable to communicate with others or to watch the television. Staff were seemingly oblivious to this, walking around the person, until inspectors intervened and asked a member of staff to assist the person to sit in a comfortable chair.

These failings constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they were aware of their care plan and the information contained within the document. Not all people were able to tell us about their care plan, what it was or if they had had sight of it. However, relatives spoken with confirmed they had been involved with their member of family's care plan.

Inadequate

Is the service responsive?

Our findings

Responsive was rated as 'Good' at our last inspection on 11 and 19 December 2017 and 9 and 18 January 2018. At this inspection, we found that responsive was now rated as 'Inadequate.'

People were not always supported by staff in a way that met their needs or provided care that was responsive. Care provided was task focused rather than in response to people's individual needs and preferences. Observations showed that people did not always have control over their day-to-day lives, such as, when they got up, when they went to bed or support provided at a time of their choosing.

As previously stated, people were being supported to get up and go to bed at staffs' convenience rather than at a time of their personal preference. On the morning of 28 July 2018 between 6.00am and 7.15am, five people were observed to be awake on the first floor of Poppy Unit, four people were seated in a comfortable chair and one person was walking around within the communal lounge. Despite these people having been awake for this length of time, no-one had been offered or provided with a drink.

One person on Bluebell Unit required support and assistance by staff and told us on the morning of 28 July 2018, "I would like to get dressed, I have pressed the button [call alarm] twice but no-one has come up." The person's call alarm facility was pressed again at 6.24am and had still not been answered by 6.44am. The person told us, "I have come to the conclusion, I am just a fool and they [staff] do what they like with me." We requested information detailing staff response times to people's call alarm facility for the period 8.00pm 27 July 2018 to 8.00am on 28 July 2018. Information provided showed that staff's response time for 14 people varied between 6.51 and 34.33 minutes. This showed that care and support provided by staff was not responsive and placed people at potential risk of harm or injury.

Care plans did not always fully reflect people's holistic care and support needs or provide sufficient guidance for staff as to how these were to be met. Improvements were needed to ensure care plans included accurate information relating to a person's specific care needs and the delivery of care to be provided by staff. For example, one person was observed on two separate occasions to receive different manual handling support by staff, including use of a specific item of equipment. The person's care plan clearly stated the person could stand with staff assistance and explanation but did not provide any information to suggest they had been assessed to use manual handling equipment. This meant there was a risk that relevant information was not captured for use by care staff and professionals, or provided sufficient evidence to show that appropriate care was being provided and delivered.

Staff told us there were some people who could become anxious or distressed. A CTM told us, and daily care records evidenced, one person could become anxious and distressed and this could result with them being unsettled and displaying inappropriate behaviours towards staff and others living at the service. This referred specifically to them shouting, swearing, walking up and down the corridors and into other's bedrooms, banging on doors and physically threatening people they lived with. No care plan or risk assessment was evident for this person detailing
the reasons for them becoming anxious and the steps staff should take to reassure and support the person

to reduce their anxiety and keep others safe. Daily care records did not always provide sufficient evidence of staff's interventions and 'ABC' charts detailing the types of behaviours observed and the events that precede and follow the behaviour were not routinely completed.

These failings constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had the choice to participate and join in with activities and events held at the service. During the inspection one person responsible for facilitating activities was observed to undertake 'music and movement' with a small group of people which they appeared to enjoy. On another occasion the staff member initiated a sing-a-long, however few people took part and the activity was undertaken for over an hour. This was too long as few people remained engaged with the activity.

People were supported to enjoy 'Happy Hour' each week as the service had their own bar for people to enjoy a drink and chat. There was also a café where people could enjoy a variety of refreshments with their relatives or others living at Elizabeth House. Information available showed people were supported to maintain links with the local community by attending coffee mornings at the local Salvation Army café, local schools periodically visited the service and religious observance was available each week. In addition, people could participate in the popular 'knitting club', cinema afternoons and a shop was located within the service selling a range of products for people to purchase.

The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service. Records showed there had been 10 complaints since our last inspection in April 2018. A record was available detailing the specific nature of each complaint, however there was a lack of evidence to show how conclusions had been reached. Not all complaints had been acknowledged by the previous manager in line with the registered provider's timescales and expectations.

A record of compliments was maintained detailing the service's achievements. Additionally, since our last inspection in April 2018, seven reviews had been posted on a well-known external website about the quality of care and facilities at Elizabeth House. These were positive and rated the care home 'four out of five'.

Inadequate

Is the service well-led?

Our findings

Well-led was rated as 'Good' at our last inspection on 9 and 10 April 2018. At this inspection, we found that well-led was now rated as 'Inadequate.'

Since our last inspection in April 2018 and, following a serious incident at the service in July 2018, the registered manager had resigned. Following their resignation, the registered provider made the decision for an existing registered manager from within the organisation to manage Elizabeth House. The new manager was supported by two deputy managers and because of current concerns at Elizabeth House was also supported by the service's Regional Operations Director.

Although there were many audits and checks in place which were completed at regular intervals to inform the registered manager's monthly report, these checks had failed to identify and address the concerns found as part of this inspection. This was because there were inadequate arrangements in place to effectively monitor the quality of the service, ensure that the service was operating safely and lessons learned when things go wrong were ineffective. It was apparent from our inspection that the lack of robust quality monitoring and auditing was a contributory factor to recognise breaches or potential breaches with regulatory requirements and to help drive and sustain improvements.

The culture of the service was not always positive. Systems in place did not always promote a 'person-centred' culture that centred on people's needs and valued them as individuals. The care and support delivered by staff was not consistent to ensure people received safe care. Not enough had been done by the registered provider to address our previous concerns, such as, ensuring staffing levels and the deployment of staff at the service were always suitable to meet people's needs. The standard of record keeping was poor and the completion of observation records were inconsistent and not being monitored.

Staff did not always feel listened to, valued or supported. Staff suggested to us they did not always feel well-led and received a lack of consistent direction and guidance from the senior management team. Our observations demonstrated the management team and CTM's were not as an effective role model as they should be as many of our observations, as highlighted within the main text of this report, had not been picked up. The CTM's main role and responsibilities related to the management of medication and liaising with healthcare professionals rather than supporting staff's practice. Significant progress was also required to ensure key members of staff were effective role models and induction procedures for newly appointed members of staff and agency staff were robust.

We noted that checks relating to the quality of the service were largely based on auditing the records and paperwork in place. The quality assurance arrangements failed to effectively measure the experience of people being supported and cared for at Elizabeth House. This meant there was a lack of oversight based on observations of actual care being provided by staff and being experienced by people living at the service. The registered provider's quality assurance arrangements had failed to recognise and address staff's practice and competencies where concerns were highlighted about a member of staff's performance. Additionally, in relation to poor manual handling practices, poor care practices resulting in people not

always being treated with the utmost respect and dignity and ensuring care provided was 'person-led' rather than 'service-led.'

Where issues were highlighted and recorded for action as detailed within the registered provider's auditing arrangements, there was a lack of evidence to show if these actions had been addressed and completed. For example, medication audits had been completed each week since April 2018. Several audits recorded areas for improvement, such as, unexplained gaps on the MAR forms and CTM's not following the registered provider's topical cream policy and procedures. An action plan was not completed detailing how compliance was to be achieved and improvements monitored. This was not an isolated case as the monthly manager's self-audit for April and May 2018 showed that although an action plan had been devised, there was no evidence to demonstrate actions highlighted had been addressed. No manager's report was completed for June 2018 and this was confirmed as accurate by the service's Regional Operations Director.

Following our last inspection on 9 and 10 April 2018, and concerns raised relating to staffing levels, an unannounced night visit was conducted by the Regional Operations Director on 13 April 2018. Their report recommended a further unannounced night visit was to be repeated within six weeks. The Regional Operations Director confirmed this did not happen and management presence within the service did not take place until and following the serious incident on 19 July 2018, whereby a person died unexpectedly. This showed that lessons learned were not effective. Had these been undertaken more frequently, it was probable that issues relating to staff's poor and institutional practice, would have been monitored and addressed.

Staff meetings were infrequently held to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service and minutes of the meetings confirmed this. No evidence was available to show CTM meetings had been held between December 2017 and July 2018. This was confirmed as accurate by a deputy manager and we were advised these should be held bi-monthly. Meetings for people using the service and those acting on their behalf were also infrequent.

These failings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and their relatives had been given the opportunity to complete an annual satisfaction survey. The registered manager and Regional Operations Director confirmed 100 satisfaction questionnaires were sent out and it was envisaged these would be returned, collated and analysed between August and September 2018.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Improvements are needed to ensure people using the service receive person-centred care that meets their needs. People's care plans accurately reflect their care and support needs and how these are to be delivered by staff.

The enforcement action we took:

Imposed Urgent Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Improvements are needed to ensure all people using the service are treated with respect and dignity at all times.

The enforcement action we took:

Imposed Urgent Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected by the provider's management of medicines. Risks to people's care and support needs must be highlighted, recorded and mitigated.

The enforcement action we took:

Imposed Urgent Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The

arrangements in place were not effective in identifying where quality or safety were compromised.

The enforcement action we took:

Imposed Urgent Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment of staff and staffing levels must be available to meet people's needs at all times. Improvements were required to ensure staff receive a robust induction, training is embedded in their everyday practice and staff receive regular supervision.

The enforcement action we took:

Imposed Urgent Notice of Decision