St Elizabeth's Centre

St Elizabeth's Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
St Elizabeth's Care Home with Nursing provides both nursing and personal care to up to 110 people in 11 bungalows and three single occupancy flats, within a campus style community. The service specialises in offering care and support to people with epilepsy, associated neurological disorders, a learning disability and other complex medical conditions. At the time of the inspection there were 85 people living at the home.

People's experience of using this service and what we found

Right support
People were not always supported to pursue their interests, Although there had been more opportunity since the last inspection, People were still not able to have regular involvement in the local community and we saw a large number of people continued to have days where they did not have the opportunity to do different things. Due to staffing restrictions there were times where people could not have a fulfilling and meaningful everyday life.

Staff did not adhere to safe practices when wearing personal protective equipment (PPE) and manual handling. This meant that people were at risk of harm.

The provider failed to ensure people were supported with their medicines in a way that promoted their independence and achieve the best possible health outcomes.

The provider failed to support people to have maximum possible choice, control and independence. We found there were decisions that restricted people without this being in their best interest.

People did not live in an environment that was safe, clean or well-maintained. The environment required extensive works to ensure it was fit for people's needs, however the provider had planned to complete works and this had started during the inspection.

Right Care
People were not always supported by a service that had systems in place to report and respond to accidents and incidents. Staff did not always understand how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse, however we observed staff providing care that was not safe.

People did not always receive kind and compassionate care. We observed staff supporting people in a way that did not respect their privacy or dignity. Staff did not always understand how to respond to people's individual needs.

The service failed to ensure there were enough appropriately skilled staff to meet people's needs and keep them safe.

There was fluctuation of staffing within the service. People and staff shared there were times where they were short staffed, and this affected people's care.

People's care and support plans failed to always reflect their range of needs. There was limited detail about promoting their wellbeing and enjoyment of life. People did not always receive care that supported their needs and aspirations. Staff did not focus on people's quality of life or followed best practice.

Right culture
People did not always have risk assessments in place, to identify risks people faced and how staff should manage these, information found was not always current or accurate, Staff were not always knowledgeable about the content of these risk assessments. When risks to people were identified actions to mitigate the risks were not always resolved in a timely manner which put people at risk of harm.

People were supported by staff who did not always understand best practice in relation to supporting people with a learning disability, there were areas of improvement needed in relation to training and ensuring staff had the right skills, however the provider had started to address this.

People's quality of support was not enhanced by the providers quality assurance system the provider had in place. Actions were not always documented, and it was unclear if actions were completed. This had an impact on people's care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 02 March 2022). At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 02 March 2022 During this inspection the provider did not demonstrate that adequate improvements had been made. Therefore, the service remains rated as inadequate overall and remains in Special Measures.
Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Elizabeth's care home with nursing on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to keeping people safe, not having enough staff which impacted peoples day to day life, systems surrounding peoples medicines were not managed well, people were supported by staff who did not promote kind and compassionate care which resulted in safeguarding issues, the environment was not fit for purpose and required work to ensure it was a nice environment to live in, people were not always supported with the least restrictive option and the management oversight did not always identify where improvements were needed and did not action this in a timely manner at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St Elizabeth's Care Home with Nursing

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team was made up of three inspectors, a member of the CQC medicines team, a specialist advisor who was a qualified in epilepsy and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Elizabeth's Care Home with Nursing is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. St Elizabeth's Care Home with Nursing is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We communicated with 11 people who used the service and seven relatives about their experience of the care provided. People who used the service who were unable to talk with us, used different ways of communicating including using Makaton, pictures, photos, symbols, objects and their body language. We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with four people to tell us their experience.

We spoke with 20 members of staff including the nominated individual, registered manager, managers, staff in the training department, human resources staff and support workers.

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

We reviewed a range of records. This included sixteen people's care records and a number of medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to ensure risk were managed effectively. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People's risk assessments were not always clear or coordinated to ensure people were getting the support they needed. We found several examples where we saw risks that were not managed effectively. For example, Risk assessments were not completed to identify whether people were at risk of pressure sores. This had been identified at the last inspection and the provider acknowledged no action had been taken. While therapy exercise plans were in place to reduce the risk of skin breaking down, staff and records confirmed that they were not repositioning people when required or supporting them with these preventative exercises.
● People had risk assessments where they had a risk of choking, however we observed a staff member not adhering to the risk assessment which put the person at risk. The risk assessment indicated the person needed staff to sit with them whilst eating due to the risk of choking, however, staff did not sit with the person during their meal.
● People's risk assessments were not always person centred. For example, the epilepsy nurse stated that the SUDEP risk assessments for people living with epilepsy were a uniform document and not person specific. This document was key to ensuring staff were aware of how to reduce the risk of SUDEP. SUDEP is the sudden, unexpected death of someone with epilepsy, who was otherwise healthy. The epilepsy nurse stated they were not routinely involved in these but would make recommendations if the bungalow requested support.
● People were not always supported safely with correct moving and handling techniques. For example, A person's risk assessment indicated if the person could not stand unaided after three attempts, staff were to use a standing aid, however we observed the staff member lift the person underneath their arms to help transfer. This put the person and staff at serious risk of harm if they person was dropped, or staff fell.
● We observed people who require emergency intervention medicines leave their home without taking this with them. The staff described that they would carry around a walkie talkie, in the event the person may need the emergency intervention they would alert the nurses, who would then run to the home pick up the emergency medicine and meet the person. In some cases, a person needed their emergency medicines within five minutes of a seizure. We asked the nursing staff if this process could be achieved in this time, in which they said this may be difficult.

● People were not protected from the spread of infection. The service did not have effective infection, prevention and control measure to keep people safe. We observed staff not following government guidance when using personal protective equipment (PPE). We found staff either not wearing masks or not wearing them correctly. This put people at risk of cross infection.
Risk was not effectively managed, and systems were either not in place or not robust enough to demonstrate safety was effectively managed within the home. This placed people at risk of harm.
This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient staff to support people in line with their assessed needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At the last inspection the provider spoke about their drive to recruit new staff and were open about the staffing levels and the difficulties they had to face. Since the last inspection the provider has focused their efforts on employing new staff, however it is still evident that staffing shortages continued to impact on people's care.
● Staff confirmed that people did not always receive their one to one hours, meaning they were at risk of not receiving care in line with their assessed needs. We saw several occasions where staff were having to support more than one person at a time. On one occasion, a staff member was supporting three people at one time where they had each been assessed as requiring one to one support. One staff member told us, "It is really difficult with staffing. All 3 people have one to one and only one staff member is here at the moment. We are short in here and there are a number of people that need 2 staff to help with their personal care." During this time, we observed three people who required support to remain continent. When speaking to staff there had not been enough staff on duty to support them to use the toilet in a timely manner. This had resulted in all three people having to sit with bodily fluid on their clothes and body.

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

● The provider operated a safe recruitment process; appropriate checks were undertaken to help ensure staff were suitable to work at the service. A disclosure and barring service (DBS) check and satisfactory references had been obtained for all staff before they worked with people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● People's relatives on the whole felt that the staff employed had the right skills and values to support their family member. One relative said, "The level of support depends on the what bungalow you are on." Whereas other relatives said, "The nurses help with medical issues, with so much expertise and a job well done. And "Staff adapt to a [persons] illness and always somebody looks after them."

Using medicines safely
● People were not always supported by staff who followed safe systems and processes to administer, record

and store medicines safely. Following on from the previous inspection we found areas of improvement had still not been implemented. For example, documents to support staff to know when and how to administer 'when required' (PRN) medicines were not in place.

● Where people were prescribed medicines such as Diazepam to manage seizures or anxiety, records around why these were administered were often incomplete. We could not be assured that these medicines were being used appropriately, as the prescriber intended and, in the persons, best interest. Some people were prescribed medicines for seizures or to help with their moods, records were not clear about why the medicines were being used. We could not be assured these medicines were being used appropriately.

● People prescribed seizure rescue medicines were not accurately recorded. Seizure records would simply state 'Y' if an intervention was given. There was no information as to what was given, how much was given or if it had been effective. Information in the seizure records did not always match those of the MAR charts and we were unable to account for why some seizure medicines had been given for some people.

● Training records confirmed that training levels were low with staff being competent to administer medicines, with only 29% of staff were trained to administer emergency intervention medicines. Staff said there were times where untrained staff would support people to go out for walks. This meant in the event of an emergency the person would not be with trained staff to administer their emergency medicines.

● People were not always supported to mitigate risks with their epilepsy. We observed over six occasions where people did not take their emergency medicines with them when leaving their home. Staff explained they had a system in place if the medicine was needed. They would call the nurses to ask for them to get the drug and meet them. Peoples epilepsy plans indicated in some circumstances they needed these within 5 minutes. Staff confirmed that this time frame would not always be achievable to receive the medicines in time.

Peoples support needs were not met when manage their medicines safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not always kept safe from avoidable harm or treated with respect and dignity. During the inspection we identified a number of safeguarding concerns which put people at risk of harm.

● People were not supported by staff that were responsive to people's needs. For example, we found a person not being supported with their personal care and was left in an undignified way Staff were not adhering to safe practices when supporting people with their epilepsy, which put them at significant risk of harm.

● People did not always feel safe where they lived. One person said, "I do not get on with everyone living here and one person can say some mean things. Staff will get so worked up they tend to mistreat other good people." Another person said, "They (staff) are sort of firm and strict. I try to keep out of trouble. When they [person] throw hard things at you, they hurt me and I tell staff and they say they are not on anyone's side, but I can see that they are." Another person said, "I do not really like living here and do not feel safe."

● Despite this when speaking with relatives they said they felt overall their relatives were safe. One relative said, "The residents are like part of the family. They are teaching them to be independent. We could not expect better …" However, one relative had concerns about their relative's safety. "They don't prompt [relative] to do more. They say to [relative] they have not got time to wash under arms. Keeping them safe is keeping them clean it is not happening. Medication changes not informed -it is getting worse."

People were not safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Where we identified safeguarding concerns, they implement additional measure to ensure the immediate risks were mitigated.

Learning lessons when things go wrong

- The management team shared some of their lessons learnt between the leadership team and in parts the wider service. Where safeguarding's and risks emerged, the registered manager gathered the information relating to accident and incidents, however, did not effectively look at the overall trends and themes. This meant the registered manager and staff team were not able to learn from these.
- The management team had completed a post incident review to identify lessons learnt following a death, we found that these lessons learnt had not be completed. This meant that improvements could not be implemented to ensure staff were providing safe care.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure there were enough suitably trained staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At the last inspection we identified that people were not always supported by staff who had the relevant training or skills. We continued to find staff had not received the relevant training and, in some cases, there had been a reduction in compliance of training. For example, 28% of staff were signed off to give intervention medicines, with 92% of people prescribed emergency intervention medicine. When speaking with staff they said there were times where people who were not trained to administer these medicines would support the individuals.
● We observed staff who did not use safe manual handling practices or were confident in using the equipment. Following on from an incident where it was identified staff needed to have up to date training, we found only 12% of staff had completed this update following the incident.
● The provider was not ensuring they were adhering to their epilepsy policy in terms of staff training. The policy indicated staff should be trained yearly, however this was not the case and records showed staff had not received up to date training.
● People were supported by staff that did not recognise poor practice. We observed staff not being respectful when supporting people with intermate care.
● Records indicated that nurses did not have regular supervision to review their clinical knowledge.

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

● The provider acknowledged their need to improve training and understood the impact on people's care. Training had been booked on for staff, however due to staffing difficulties they had to ensure staff were present in the bungalows.
● Despite, this staff and relative's felt the staff had the right training. One staff member said, "Yes, I feel that I

have the right training and that I am well supported. I have had enough epilepsy training. If I need any extra advice about anything, I know I can go to the nurses. They will come to the bungalow straight away." One relative said, "I am happy with the place, but more staff required. Staff are extremely good, and I feel offer professional care."

Supporting people to eat and drink enough to maintain a balanced diet

● People spoke about how they were supported with their meals, one person said, "I like the food and drink here." Another person said, "My best meal is breast of lamb, I would like to eat it more but when the staff can get it, I will have it." Although another person said, "Staff tell me I am overeating, when I want to eat and drink [staff] bother me."

● There was limited opportunities for people to get involved in preparing their own meals. Staff spoke about how people would order their main meal of the day from the canteen and staff would prepare food in the evening.

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

At our last inspection the provider had failed to ensure people lived in a safe and well-maintained environment. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15

● People continued to live in an environment that was not always well-maintained or met their support needs. Although we found people to have personalised bedrooms, some communal spaces were not always homely.

● Some areas of the bungalows continued to be damp, with damage to the ceilings, repairs to kitchens and bathrooms work had still not been undertaken to improve these areas.

● The management team had acknowledged the need for extensive work to be carried out with in the homes and had developed a plan for this. The works had started during the inspection.

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

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider failed to demonstrate they had considered the "least restrictive" option when making best interest decisions, in line with the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11

● At the previous inspection we found people to be restricted in parts of their home with no clear rationale for this. The management team reviewed these restrictions and felt it was not proportionate in cases to lock the bathroom doors, however we found doors were still locked. When speaking with staff there were either unclear as to the rationale or stated this was something that they have always done. The provider took immediate action to remedy this.
● People were not provided with information regarding all aspects of the surveillance built in each of their room. We spoke with some people who were not sure on the purpose of this. Where people did not have capacity to make the decision to have the surveillance in their room, there was no evidence of making a best-interest decision or in fact that people consented to this being present.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
● Care and support plans did not always reflect people's needs and aspirations. Support did not always focus on people's quality of life outcomes. For example, one person described they felt the skills and qualifications they had, had been "wasted" and gone "down the pan" as they had not been able to use the skills.
● Some people said they wanted to be more involved in the development of their care. We spoke to one person and asked them if they felt staff listened to them about how they wanted to be supported, they said, "No they do not have time to listen, because they are so busy." Another person said, "I would like to make it better by having more friendships and more staff if they are good. I would like to go out in groups to more places like holidays and to clubs, music, bands and concerts… The staff tell me what to do, "Stop doing this, do that"."
● Peoples support plans did not always identify person centred approaches and did not consider the least restrictive. For example, people we spoke to said staff woke them up to administer their medicines. One person said, "I will take the tablets in the morning and in the morning, they have a hand over staff comes to my bedroom and the staff open my bedroom door. I tell the staff I am asleep, and they come in." Another person said, "They wake us up when we need medicines, I feel tired when they wake me up." There was no consideration with partner agencies to see if their medicines could be administered at a different time to fit in with the person's lifestyle.
● People had input from a multi-disciplinary team of professionals who were situated with in the providers service. This included, occupational health, epilepsy nurse and positive behaviour team. We found therapy plans that had been developed, however staff did not adhere to these therapy plans which meant people

were not enabled to improve or maintain their health and well-being.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure that quality monitoring systems were either not in place or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- At the last inspection we found the providers systems for monitoring quality was not robust or effective. At this inspection, the provider spoke about a new quality assurance system they were planning on implementing, however this was yet to be introduced, because of this we found the systems were still not effective.
- The provider failed to ensure they consistently captured improvements in the service. The audits and checks varied in quality across the bungalows, with audits lacking in information or highlighting improvements with no outcomes or actions.
- The provider had started to capture lessons learnt and shared these with management, however support workers were not able to share with us what lessons had been learnt over the previous months. We found examples were lessons learnt and actions had been identified but these had not been shared. This meant staff were not able to change their support practice for the better.
- The provider captured themes from accident and incidents, however they did not analyse these in a robust way and action the findings. We found clear themes identified but these were not transferred on their improvement plans which meant people continued to receive the same level of poor care. For example, there had been a number of medicine errors with one bungalow, however they had not identified this on their action plan as an area of improvement.
- We identified a lack of oversight for pressure care in our last inspection. At this inspection there continued to be no checks or systems in place to support people to be comfortable and safe with their skin integrity.

Quality monitoring systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite this, relatives felt the service was well managed and there was good communication. One relative

said, "Good communication between us and St Elizabeth's about care and medication. It is an open and honest service."
● Staff felt supported by their management team. One staff member said, "The management are doing really well. [Registered Manager] always comes to the bungalow to see how we are getting on."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure the culture of the service supported the provision of high-quality care and support. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● At the last inspection we found the provider failed to ensure staff understood what good care looked like and what support looked like where people were empowered to have a fulfilling life.
● Although the registered manager and the provider had taken steps to educating staff through culture workshops and we found some staff spoke with people in a kind way, we still found several examples where people were not treated with dignity and respect. People did not have sufficient choice and control regarding their support and were subject to restrictive practices. For example, we observed a staff member insisting a person needed to go to bed, the person said 'no' and the staff member insisted, when we asked for the reasoning behind this the staff member said, "Because [person] usually goes to bed at 8pm."
● The management team were able to be open and transparent about the improvements that were required and spoke passionately about making the changes, however we found systems and staff knowledge and skills were not to a standard that would be able to drive these improvements.

The culture of the service failed to support the provision of high-quality care and support. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had been open and honest about the recent inspection. The provider had offered meetings to discuss this with staff, people living in the service and family members.
● The provider had started to seek feedback from people and those important to them about the development of the service, however these suggestions still needed to be embedded into the service.
● The provider had recently sent out a survey to relatives, people and staff, however, we did not see evidence that the findings of this had transferred into an action plan to drive improvements for people.

Working in partnership with others
● Following the previous inspection, the provider had engaged with a number of professionals working closely with them to help improve the support of people. Professionals we spoke to said although the provider had acknowledged the areas of improvement, they had observed practices that still needed to be addressed. One professional said, "There is a failed communication between managers, they change bungalow managers at an alarming rate, so they do not get to know people and actions are not seen through."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.