Shaw Healthcare Limited

Elizabeth House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 14 and 17 February 2017 and was an unannounced inspection.

Elizabeth House provides accommodation and care for up to 60 people older people, most of whom have a diagnosis of dementia. The home is purpose built. It consists of six units, two on each floor, each equipped with a living and kitchen area. Bedrooms are en-suite and there is an assisted bathroom for each unit. There are lifts between the floors which people could access freely. Fifty of the beds at the home are commissioned directly by the local authority for dementia care. At the time of our visit there were 59 people living at the home.

The service has a registered manager. 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.

Since our last inspection, the registered manager had made improvements in how staff identified and responded to risks in people's care. The breach in regulation was met. There had also been improvement in the activities available to people, with an increase in activity staff providing one to one support and company. One relative had written a note of thanks to staff saying, 'I'd just like to say my Mother did well at Elizabeth House and all the staff are wonderful. It's a good place with lots to do and lots of nice people'.

Although we found staff understood and managed risks to people's health and safety, the provider did not have a system to adjust the staffing levels to respond to changes in people's needs. This meant that staff were often stretched and were not always able to effectively monitor communal areas. There were not always sufficient staff on duty to keep people safe and we have asked the provider to take action.

The provider had not always ensured timely action to address areas identified as needing improvement. Records relating to people's care were not always accurate or complete. At the time of our inspection, staff were in the process of transferring people's care plans and records to a new format devised by the provider. The lack of accurate records could lead to inconsistent care being provided and would not support staff to identify and respond to changes in a person's needs. We have asked the provider to take action.

In other respects, the systems in place to monitor and review the quality of the service and to track planned improvements worked well. Suggestions on improvements to the service were welcomed and people's feedback encouraged through regular meetings and surveys.

Feedback from people and relatives was very positive. People told us they felt safe at the service, that they enjoyed support and friendship from a regular staff team and that they were regularly asked for their views and opinions.

People told us staff treated them respectfully and that they felt involved in decisions relating to their care. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely.

People had developed good relationships with staff and had confidence in their skills and abilities. There was an established team of staff at the home, which offered continuity of care for people. Staff had received training and were supported by the management through supervision and appraisal. Staff were able to pursue additional training, including in dementia care, which helped them to improve the care they provided to people.

People were involved in planning their care and in making suggestions on how the service was run. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People enjoyed the meals at the service and were offered choice and flexibility in the menu. Staff monitored people's weight to ensure that they were receiving enough to eat. Where concerns were identified, action had been taken.

Staff used handovers to share information and respond to changes in people's health. Where appropriate, referrals were made to healthcare professionals, such as the GP, community nurses or dementia crisis team and their advice followed.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in all respects.

Staff knew how to care for people safely and mitigate risks in their care.

There were not always enough staff to keep people safe. There was little flexibility in the staffing level to respond to people's changing needs.

Medicines were managed safely.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

The provider was continually improving the premises and garden to enhance the environment for people.

Is the service caring?

Good

The service was caring.

People received individualised care from staff who cared and who knew them well.

People were involved in making decisions relating to their care and were supported to be as independent as they were able.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans included good detail on people's preferences. Staff understood how to support people and communicated relevant changes at handover meetings.

People were able to participate in a variety of activities and had the opportunity to spend one to one time with activity staff.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

Is the service well-led?

Requires Improvement

The service was not well-led in all respects.

The provider and registered manager used a series of audits to monitor the delivery of care that people received but the provider had not always taken timely action to ensure improvements were put in place.

Staff were in the process of transferring care plans to a new format. Records of people's care were not always complete or accurate.

The culture of the service was open. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager and staff said they felt supported.

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.

This inspection took place on 14 and 17 February 2017 and was unannounced.

Two inspectors and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed three previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

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 also observed care in the communal areas of the home during the morning and afternoon. We looked at care records for eight people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at four staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 10 people using the service, eight relatives and friends, the registered manager, deputy manager, four team leaders, five support workers and one member of the activity team. Following the inspection, we contacted a social worker, dietician, dementia nurse specialist, oral healthcare trainer and the local authority contract manager to ask for their views and experiences. They consented to share their views in this report.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in November 2015, we found the provider had not taken reasonably practicable action to mitigate the risks to people's health and safety. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We set a requirement and asked the provider to take action. At this inspection we found improvements had been made in how staff assessed and responded to changes in risk. This helped to minimise risks to people and keep them safe. The requirement was met.

Before a person moved to the home, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, skin integrity or from behaviour that might challenge, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support people required from staff. For example, one person was prompted to change their position on a regular basis to minimise the risk of skin breakdown. It was noted that their ability to do this varied from day to day and described how staff should assist them if they were unable to adjust their position independently. Records relating to people who required assistance to reposition, to ensure regular bowel movements or whose fluid intake was monitored to reduce the risk of dehydration were completed and checked.

Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and to reduce the risk of future injury. People who lived at the service were generally mobile and some had sustained falls. On each occasion an incident form recorded the details such as the time, location and whether the person was injured. The registered manager checked to see if there was any pattern in the time or location of falls. This information was also shared through the computer system with the provider's quality team. Where appropriate, referrals had been made, including to the falls prevention team and for additional equipment such as wheelchairs to aid a person over longer distances or outside. We found, however, that inflexibility in staff deployment meant people at risk of falling did not always receive appropriate supervision or support to keep them safe.

Throughout our inspection we observed that staff were busy as they cared for people. During the day, each of the three floors was staffed by a team leader and three support workers. In addition activity, kitchen, domestic and administrative staff were employed. The registered manager was also available during the week and could offer additional support if required. At night the staffing level reduced to one team leader and six support workers for the home. We reviewed the rotas over a period of four weeks and found these levels were maintained with just a few exceptions where the registered manager had generally been available to help on the floor.

We discussed people's dependency and how staffing levels were calculated with the registered manager and staff. Although the service had not received any complaints or negative feedback relating to staffing levels in the past 12 months, we found that there was very little flexibility to enable staff to respond to changes in people's needs. For example, if a person was at high risk of falling or receiving end of life care and required additional support, there was no provision to quickly increase the number of staff on duty. Staff told us that during the winter months people's needs had increased due to viruses and colds and this had

placed staff under increased stress. A team leader told us, "Some residents need more one to one but it is impossible to give one to one for any length of time". Another told us, "If we need extra, such as if someone is at end of life, that'll be the team leader. They don't increase the numbers". The deputy manager explained that the team leader acted as the fourth person on each floor but we saw in practice this was not always possible. During our visit, team leaders were busy administering medicines, arranging hospital appointments, contacting the GP and liaising with relatives. They told us they were also busy working on the new care plans and that no additional hours had been allocated for this task.

The layout of the floors meant it was not always feasible for staff to monitor the communal areas effectively. Staff told us they were required to have at least one staff member in the lounges at all times. It was, however, not possible for one staff member to view all areas of the lounges. At times, we observed no staff were present because they had been called upon to attend to people's needs in their bedrooms. This put people at increased risk of falling because staff were not always available to supervise and support them, or to prompt them to use their walking aids. We noted that of the 'Found on the floor' incidents recorded in February 2017 to-date, more than half had occurred in communal areas. Guidance in care plans such as for staff to be aware of a person's whereabouts at all times was not followed as we saw one person, who required support, walking independently in the 'Street' area of the home without their walking frame. A team leader told us, "I gave (name of person) one to one the other night. It is very difficult to keep that gentleman safe. We try to be with him but it isn't possible to supervise him 24/7". A second person whose care plan stated they used a frame with the assistance of one or two staff was seen trying to get up from their chair in the lounge area. Two staff were present preparing tea and this person was not in their line of sight. The person managed to stand but could not walk forward as they did not have their frame handy and were very unsteady. They eventually fell back into their chair. One support worker told us, "Other than the falls we can manage with three people". Another said, "You do feel under pressure to get it all done".

The registered manager told us that the dependency calculation, on which the staffing levels were based, had been completed up to three years earlier. The provider advised that, in addition to carefully assessing the needs of people before they moved to the service, a 48 hour diary would be completed if staff felt they were not able to meet a person's needs within the current staffing numbers. These diaries measured the care that a person needed in terms of the number of hours. The provider explained how this system had been successful in securing either additional funding or alternative placements in order to better meet the person's needs. We found, however, that the staff deployment did not always ensure people's safety and that the staffing levels did not flex quickly enough to respond to changes in dependency.

The provider did not have a system to continuously review the dependency needs of people or to respond quickly to changes. There were not always sufficient numbers of staff on duty to keep people safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a team of regular staff who worked at the home and agency staff were rarely used during the day. The registered manger told us, "I'm lucky, I've got staff who are long term". We noted from the rotas that in recent weeks there had been a number of agency staff working at night. The registered manager explained that this was due to sickness and vacancies but advised that new night staff were due to start in post. In addition, she told us that the same agency staff had worked in the home, which helped them to get to know people and understand their needs. Each member of agency staff had a profile detailing their skills and experience and had received an induction to the home. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Medicines were managed safely. The provider had adopted a new electronic medication management system. Staff told us the system worked well. One team leader said, "It flags any overdue, you can't really make a meds error on those. It's much easier and clearer and it saves time". Another told us, "We record medication errors on the system. We don't get many as the system provides prompts". We looked at how medicines were received, stored, administered and disposed of. The systems in place were working well and there were clear records of when people's medicines had been administered. If a person had refused their medicine or was sleeping, this was clearly recorded. Topical creams and ointments were dated on opening. This helped to ensure that they were used within the timeframe recommended by the manufacturer and remained effective. Medicines requiring refrigeration were stored in a locked fridge and staff monitored the temperature daily.

Team leaders were responsible for administering medicines. They had received training and their competency had been checked. There was guidance in the care plans on how people liked to take their medicines. For example we read, 'Finds it easier to take his tablet from a spoon, able to express if needs PRN pain relief'. PRN medicines are those prescribed on an 'as needed' basis, such as laxatives or pain relief. We found that guidance on some PRN medicines lacked detail. For example one person was prescribed a medicine to help control their anxiety. The direction to staff was to give, 'Up to twice a day for acute agitation'. There was no information on how this person would present to help staff ensure the medicine was consistently administered. Team leaders felt confident they knew when to give the medicine. One told us, "If you knew this lady you would know acute agitation with her. We don't give it lightly". A second person preferred to take their medicines crushed, due to a fear of choking. We discussed with staff how changing the format of a medicine should be checked and approved with the pharmacist, to ensure that its effectiveness is not compromised. By the second day of our visit, staff had received written guidance from the pharmacy which permitted the practice and this was added to the person's care plan.

People told us they felt safe at Elizabeth House. One person said, "I do feel so safe here. I don't want to be on my own now. I'm quite content to just be in my room and listen to the radio or watch TV but it's so much nicer to know I have someone I can call on. The staff are so good and they look after me". A relative told us, "It is very safe here. I think it is a real home from home". Staff had attended training in safeguarding adults at risk. They explained the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One team leader explained safeguarding as, "Making sure people are safe at all times. If I see anything I feel is not correct, obviously I am going to report that. If they are not treated the way they should be I will go to our manager, I could also go to CQC". Staff told us they felt able to approach the registered manager if they had concerns. Information about safeguarding, whistleblowing and how to raise a concern was displayed on notice boards in the home.

Good

Is the service effective?

Our findings

People told us they received good care and were happy with the support provided. One relative told us, "I can't fault the care they give". Another had given feedback on an external website saying, 'He is now mobile, gets involved, watches TV and eats at the table. He even makes meal choices. His skin condition is very much improved. He is clearly happy and healthy. The staff are always happy and seem to genuinely care. All the family are delighted with his care. Fantastic'. A third relative had written to the provider to express their thanks. We read, 'My last memory of Mum at Elizabeth House was a very positive one. I hadn't seen her looking so well and happy in years'.

Staff received training to enable them to provide effective support to people. One team leader told us, "The courses are there to go on. It's a mix of e-learning and face to face courses". Another told us that there were plenty of opportunities for further training and explained how they had been able to progress in their career. New staff completed a period of induction, which included training and shadowing of experienced staff. This helped them to understand their role, to get to know people and their support preferences. They also attended a four day practical induction course run by the provider. All new recruits who had not previously worked in care were expected to complete the Care Certificate, which is a nationally recognised qualification. One support worker who had recently started told us that the induction had been, "Very informative". They explained that it included sensory experiences such as wearing ear muffs to give them insight into people's sensory experience.

Each year, staff attended refresher training in areas made mandatory by the provider. This included moving and handling, safeguarding, infection control and fire safety. Records showed that staff were up to date with this training. Where training was due, staff had been prompted to complete e-learning courses. Staff had also received training in dementia care, the Mental Capacity Act 2005 and behaviours that challenge. They told us they felt confident in their skills and understanding. Some staff had attended specific courses including catheter care, oral health care and end of life care. One staff member was participating in a year-long programme run by the local authority to become a 'safeguarding champion'. They told us, "It's about the needs of the person, ensuring they have a good quality of life and pushing that to other staff members". They also said it had been a good opportunity to share ideas and good practice with staff from other homes.

The home specialised in supporting people living with dementia. A dementia nurse specialist told us, 'The staff are very caring and conscientious, and specific staff excel in their understanding of dementia care and the processes and management of difficult situations'. Staff had received training in dementia care and had a good understanding of people's needs. Some team leaders had completed a year-long dementia care course. One told us, "I went on a great dementia course. It was one of the best I've ever been on. Everyone gets to go on them". The home had also benefited from support from the 'Care Home In-Reach Team' (CHIRT). This team, from the local NHS Trust, worked with staff between December 2015 and April 2016. Staff had attended workshops in dementia awareness and communication, physical health in dementia and behaviours that challenge us. They had also been supported to try new approaches in people's support. In the report following the intervention, we read, 'Throughout our time with you it was very evident to see how

committed you and your staff are in the care of your residents, and that you were also very willing and showed an interest in taking on new ideas to further improve your residents' wellbeing. All your staff were keen to give us time and engage with us'. The report also noted how staff had been willing to make changes to the physical environment of the home so as to better support people living with dementia. This included purchasing items for the sensory room and making changes to the bathroom environment. We also observed that bedroom doors were clearly marked, often with the person's name and an image of a bed. There were also 'This is me' posters on some doors which included photographs. These methods can help people to orientate themselves in their environment and be more independent.

Staff felt supported and received regular supervision with their line managers. This gave staff an opportunity to discuss any concerns and consider their professional development. One support worker told us, "They asked me if there was anything I needed but I'm happy". Another described how senior staff provided ongoing support and guidance. They said, "If I'm not doing something right they have pulled me up and helped me". Staff had also attended group supervisions. These covered general points of practice such as reminders to sign necessary paperwork and sharing the findings of quality audits. Each year, staff attended an appraisal which considered their achievements and looked ahead to the coming year. We noted that some staff appraisals were overdue. The registered manager explained the plans in place to try and spread appraisals over the year, rather than having them all in one month. A team leader said, "Supervisions and appraisals are kept on top of. We are given a list of what is due and they chase us up".

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, staff had made applications on behalf of people who were considered to be deprived of their liberty. Five applications had been authorised and 53 were awaiting assessment by the local authority team. The registered manager had a system to record the renewal date of DoLS that had been authorised. This prompted staff to reapply in good time if the restrictions were still considered necessary to maintain the person's safety. We noted that two people had moved to the home with DoLS authorisations relating to their former places of residence. DoLS are not transferrable and once we discussed this with the registered manager, she ensured that new applications were sent off the same day.

We checked whether the service was working within the principles of the MCA. We observed staff involving people in day to day decisions, offering assistance and waiting for people to respond to questions. Records demonstrated that where people had refused support on occasions this had been respected. Staff understood the requirements of the MCA and put this into practice. One team leader described the purpose of the MCA as, "It's trying to work out how to help them make decisions. Every person is different; even if they have dementia they have some capacity. We have to support them to make decisions; if they cannot, we do a best interest decision with the family or GP. We have to use the least restrictive option that is safe for everyone". We observed that information on the MCA was displayed on staff noticeboards as a visual reminder and reference.

Where people had been assessed as lacking capacity for specific decisions, staff had taken appropriate action. We reviewed the records of best interest meetings. These included a decision not to admit a person

to hospital, to use a sensor mat to alert staff when a person was up and walking and the management of a person's finances. When one person needed to make a decision regarding dental treatment, staff had involved the services of an Independent Mental Capacity Advocate (IMCA) to ensure that the person's views were understood and presented as part of the decision making process. The new care plans directed staff to consider the person's capacity in relation to each area of their care. If the person lacked capacity the form stepped staff through the actions they should consider, including best interest meetings and DoLS.

People were happy with the food served at the home. One person told us, "It's lovely home cooked food, plenty of it and there is a good choice". Another said, "Lovely food and we don't even have to wash up. That'll do for me!" People were offered a choice from the menu. If they did not appear to be enjoying their meal, staff offered alternatives. For example, one person appeared to be finding their curry a little hot and were served another meal, a second had cheese and biscuits. A third person refused all meal options but was happy to drink a milkshake. The mealtime was relaxed and people who required assistance to eat were supported. We observed that drinks were available throughout the day. We observed one person being supported to drink by staff. The staff member took time as they helped the person, ensuring that they took manageable sips.

Staff had a good understanding of people's dietary needs and preferences. There was information in the kitchen about people who required specific diets including a fortified diet to promote weight gain, pureed meals to aid swallowing and those who were gluten-free or had known allergies. At lunchtime we observed one person having a different hot option from everyone else. Staff explained that they needed a gluten-free diet. Staff monitored people's weight and assessed their risk of malnutrition. In June 2016, a community dietician had completed an audit of the home's use of a recognised malnutrition screening tool. As a result of guidance provided by the dietician, the home had renewed their focus on fortifying meals and had introduced milkshakes made with fortified milk. Where appropriate, referrals had been made to the dietician for further advice. We noted that many people had been successfully assisted to gain weight through the use of fortified diet plans.

People had access to healthcare professionals and the service worked in collaboration with professionals to ensure that people's needs were met. Records confirmed that people had been supported to meet with a variety of healthcare professionals including the GP, community nurses, dementia crisis team and speech and language therapist . Where necessary staff had requested specialist equipment including wheelchairs and pressure relieving boots . People told us they were able to request a consultation with healthcare professionals. One person explained, "All I need to do is tell the head one over there (pointing to the team leader's office) and it will be sorted".

The home was clean and warm. Communal areas and corridors had been decorated in a variety of styles. The bathrooms were decorated to give a homely feel. One had fish and boats on the walls. They were also equipped with grab bars and a bath hoist to facilitate people's independence and ability to use the bath. The garden had a nautical theme, including a boat as a flowerbed, windsurf boards and buoys. There were brightly coloured seats and benches and raised beds to make it easier for people to participate in planting and weeding. The registered manager spoke of further work planned, including making a barbeque area and clearing brambles to create a new area for people to walk and enjoy. On an external website, one relative had commented, 'The home is spacious and full of natural daylight. This allows residents to walk from area to area finding secluded spaces to sit and talk to relatives'.

Good

Is the service caring?

Our findings

People told us they were very happy living at Elizabeth House. One person said, "They're lovely, I can't find fault at all". A second said, "I am very happy here and I have the best daughter anybody could have. She knows everyone here and they love her too. They are all my family". Relatives were equally complimentary. One told us, "This place is clean and well run and I'm satisfied with how things are done and with Mum's personal care. Everyone here is motivated and involved. I visit here a lot and I've never heard a sharp word. I really rate this home. The staff are so caring". A second said, "There is consistent staff here and that's the key". A third relative had written to the home saying, 'Thank you for all the love, care and devotion you have and are giving to (name of person)'.

Throughout our visit we saw that people were treated with respect. Staff were caring and showed compassion. They were friendly and patient when offering and providing support. We observed staff having a coffee with one person, accompanying a second on a walk and reassuring others when they were anxious. The deputy manager told us one person had come to see them in their office, thinking it was a travel agency. She recounted how they had discussed various destinations and settled on a trip to Spain. During our visit another person was often with the registered manager as they enjoyed office and paperwork. Staff told us that they enjoyed their work. One support worker said, "It's something (the job) you walk away from and it gives you satisfaction. You have to build up trust with people". They told us they knew people well and were able to take time to chat with them. When people needed to attend external appointments, such as at the hospital, they were accompanied by staff if a relative was unable to attend. This would help to reassure them and ensure their safety in an unfamiliar environment.

People were involved in planning their care. We saw that individual choices and preferences were reflected in people's plans of care. In one we read, 'She generally goes to bed between 10-11pm however she will often choose putting on her night clothes early evening'. One person told us they had decided not to go to church for the time being. They said, "I could go to church, they would take me but it's too cold just now". Staff were directed to involve people on a daily basis. For example we read, 'If given simple choices and time to respond (name of person) can express his preferences. Carers need to make eye contact when connecting with (person), he has a lovely sense of humour and loves banter' and 'Needs full support to wash his body. He has capacity to consent to assistance. He can wash his own face and hands when prompted. Needs assistance to shave'.

Where people were unable to participate fully in planning their care, relatives or representatives were involved. One relative told us, "They consult me and I have attended meetings, at their instigation, regarding on-going care". A second said, "I have been completely involved. Mum is going downhill and we've had the talk here about end of life care and all that kind of stuff. I'm completely confident that my input is wholly regarded". A third said, "Yes, Dad and I are fully involved".

People were supported to maintain their independence. Care plans guided staff as to the tasks people could manage and where they needed help. We read, '(Name of person) is able to brush hair on a good day, at other times he'll need help to do this' and '(Name of person) may be able to express what he would like to

wear, please encourage this'. Some people used equipment such as raised toilet seats to promote independence. On an external website, one relative commented, 'The staff at Elizabeth House welcomed her and recognised her need for independence right from the start. Their ongoing support is sensitive and unobtrusive. Without exception, each staff member has treated mum with dignity, kindness and respect. Their support has extended to our wider family during a difficult and anxious time'.

Throughout our visit, we observed that people were treated with dignity and respect. Staff described how they promoted this. One support worker said, "We shut the door and close the curtains during personal care. We take people aside to discuss anything private". A social worker told us, 'In my experience, staff at Elizabeth House have a good knowledge of the people they are supporting and the staff I have dealt with appeared very respectful and caring towards residents'. A relative had written on an external website, 'Whenever I visit my Nan, she is always happy and seems very comfortable. The staff always give us space and I'm usually greeted with a cup of tea for both of us. I am comfortable and confident in Elizabeth House's care and I am never worried'.

Good

Is the service responsive?

Our findings

People had been asked how they wished to be cared for and about what was important to them. This information was included in a care plan which provided information to staff about the person and their support needs. The care plans included sections such as eating and drinking, personal hygiene, sleeping, pain and medication. There were also specific care plans relating to known medical conditions and additional guidance about the condition to aid staff understanding. When needed, staff devised end of life care plans for people which reflected their expressed wishes and documented regular monitoring of their health and wellbeing.

The care plans were personalised and demonstrated that staff had taken time to get to know people and understand their wishes. We read that some people preferred to be supported by male or female staff. In one person's sleep care plan, we read how they liked time to settle with a hot drink before going to bed. They liked to wear pyjamas, sleep on their back and have the lights off and door closed. Staff also had a good understanding of people's needs and were aware of the little things that mattered to them. One relative told us, "The staff here know the residents they care for well, for example who likes to lie in bed later and how people like their drinks". Another said, "They let her phone me if she is anxious and that calms her down". The care plans included a profile of the person and a life map describing their family, employment, holidays, hobbies and memorable events.

Staff were in the process of transferring information about people's care to a new format. We identified some inconsistencies and gaps in the records, perhaps due to the transition. You can read more about this in the 'Well-led' section of this report. Despite the shortfall in record-keeping, we noted examples of staff responding quickly to changes in people's needs. These included requesting a medicines review with the GP, identifying infections, monitoring people closely after they sustained a fall and ensuring that equipment to make the person more comfortable was provided. For example, when one person's health declined and they were unable to sit safely in a lounge chair, staff arranged for a recliner chair which enabled the person to continue enjoying company in the communal area. One relative told us, "My mother caught a chest infection but they spotted it quickly and caught it early. They are quick on the ball and informed me immediately". A social worker said, 'Staff have been responsive to changing and fluctuating needs of the people I have been involved with'. Staff attended regular handover meetings between shifts which helped them keep abreast of changes in people's needs.

At our last inspection, we made a recommendation about promoting people's involvement in activities to ensure their social and emotional needs were met. At this visit, we found that activity provision had improved. The atmosphere in the home was bright, warm and active. During the morning a visiting entertainer gave a performance of songs and actively involved those who attended. We observed activity staff interacting with people in groups and on a one to one basis. Activity records showed that people had received one to one time and that those who found it difficult to participate in group activities received additional one to one attention. There were posters around the home detailing the week's activities. These included piano, balloon bouncing, quizzes, film club, pampering, arts and crafts. Activity staff had recently completed a course in hand massage which they said was popular with people and often took place in the

sensory room for added relaxation.

People had been asked about their hobbies and interests. We saw that a 'Preferred activity questionnaire' had been completed for each person and updated in 2017. There was detail about individual interests such as gardening, woodwork and knitting. Staff told us how one person enjoyed gardening and they had secured a grant from the provider's charitable foundation to purchase a shed, tools and compost bin. A second person showed us a beautiful blanket they had made. They told us, "I'm not so quick now but I made this blanket". The home worked with local organisations including a local college who laid on special events for people. Recently six people had enjoyed going out for a Valentine's lunch. One relative told us, "They bring people in to entertain, they play games with the residents, they even had children come in before Christmas to help make decorations, everyone is so thoughtful, I can't ask for anything more".

People felt able to express any concerns to staff. One person told us, "I know I can speak with the manager, or the staff. I know if I had a problem they would help me". Residents and relatives we spoke with all regarded the manager as approachable and effective. They said they would have no hesitation in speaking to her if they had any complaints and said exactly the same of her deputy and the team leaders who were on hand to assist. One relative said, "(Name of team leader) has always got time to talk to you if something is wrong". Relatives who had raised concerns, told us these had been addressed, or that there had been no repeat incident. People were encouraged to share their views and experiences at resident meetings. In the minutes, we saw that entertainment and meals had been discussed. People had also been asked if they wished to voice any complaints. One person had commented, 'We are very lucky. Staff are approachable and will sort stuff out for us'.

The provider had a complaints policy, which was clearly displayed in the home. Details on how to complain were also included in the service-user guide. This explained how to make a complaint and the anticipated timescales for response. Complaints received had been investigated and resolved in line with the provider's policy. Each complaint was logged on the system and could be reviewed by the provider's quality team. We noted that action had been taken to minimise the risk of a repeat occurrence. Where necessary, staff had been spoken with or new procedures put in place. One relative told us, "I complained once and they addressed that".

Requires Improvement

Is the service well-led?

Our findings

The provider had not always ensured that timely action was taken in response to areas of concern. A bi-annual 'Quality of life' audit was conducted by the provider. The most recent audit, in December 2016, noted progress in a number of areas. There was further action required, however, in record keeping and care plans, including the completion of topical medication records and daily records being reviewed and countersigned by team leaders. As action had not been completed in these areas, highlighted in the May 2016 audit, the registered manager lost some of their score on the audit. These areas were highlighted for action but no additional resources had been allocated to ensure their completion.

We found that records relating to people's care and treatment were not always accurate or complete. The provider had introduced new care plans which team leaders were working to put in place. This work was planned when we visited in November 2015 but had only started at the end of 2016 and was in the early stages. One team leader told us, "There's loads to these new care plans, it's a case of if and when. Care has to come first".

The proposed new file was large and somewhat unwieldy. Staff explained that they were required to keep all sections in the care plan, whether or not they were relevant to the person's care and support at that time. We also found that information could be recorded in a variety of places, which led to inconsistencies and difficulty in finding information. For example, we were looking for a behaviour support plan for one person where incidents of a physical nature had been directed towards staff. Staff agreed that there was no behaviour care plan but told us this information could be recorded under 'mental wellbeing' or in the 'dementia plan'. One team leader said, "We seem to write the same thing over and over". In another care plan we saw a detailed assessment, but much of the information had not been transferred into the care plans meaning that several sections were blank. We identified inconsistencies in some areas, such as a continence care plan that stated the person managed toileting with minimal prompting and their sleep care plan that said they were doubly incontinent. Where the monthly reviews of the care plans contained significant changes, these had not always been reflected in the body of the associated care plan, meaning staff would have to read all of the reviews to keep abreast of the person's needs.

Records relating to the care delivered were not always complete. Each person had a personal hygiene record where staff were to record support given to wash, checks on the person's skin, oral care and bed linen changes. We noted that very few instances of support with oral hygiene were recorded. For one person the records indicated they had been supported to clean their teeth or dentures once in February and not at all in January. For a second person there were no records of support in this area in 2017 to-date. Support workers were also required to record when people had been assisted to apply topical creams. These records contained gaps and sometimes the most recent form in the file was dated December 2016. For one person who had a cream prescribed twice daily there were just 17 signatures in January, of the 62 expected. Body maps had not been used effectively. The new forms in place guided staff to record each observation, such as a bruise or skin tear, on a separate form. There was then space for it to be reviewed and signed off. The body maps had been used a number of times to record different dates and parts of the body. This made it difficult to read and unfit for purpose. There was also no evidence that staff had reviewed the injuries to ensure

healing. People told us they were very happy with their care and we did not identify concerns in how people had been supported. The records, however, were incomplete and would not support staff to recognise changes in a person's needs in order to respond appropriately and offer consistent care at all times.

We also identified concerns over staff numbers and deployment during our inspection. You can read more about this in the 'Safe' section of this report. The staffing parameters had been set by the provider and the registered manager had limited flexibility to adapt staffing levels in response to changing needs. This concern, meaning that people's needs may not have been safely met at all times, had not been identified or addressed by the provider.

The lack of timely action to make improvements and the lack of accurate and complete records in relation to each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other respects, the systems in place to monitor the quality of the service worked effectively. The provider had a programme of audits spread over the year. This included audits of medication, catering, infection control and fire procedures. Actions identified during these audits were logged on the system and reviewed by the registered manager and a representative of the provider. We saw that action had been taken to improve the service. The registered manager had also received feedback from external auditors. A kitchen audit had been completed by the local authority in January 2017. The action plan had been annotated by the chef to show progress. Following our last inspection, the registered manager had taken action to respond to concerns around risk management and activity provision.

The provider used surveys to seek feedback from people and their relatives. Results from the recent 'Living in the home' and 'Visiting the home' surveys were positive. Feedback was that the home provided a safe environment, was clean and tidy and that they felt involved in decisions. One relative had written, 'I am very happy with the care and attention my husband receives. I would highly recommend Elizabeth House. Even I feel at home here'. A second wrote, 'Everything that could possibly be done for (name of person) was instantly on hand'. The registered manager also held regular relatives' meetings. In the August 2016 meeting, feedback from the surveys had been discussed and any points that were raised were openly addressed.

There was a friendly and open atmosphere at the home. One person told us, "It's very relaxed here and we're taken care of". A relative said, "One of the great things about Elizabeth House is that they have a very open policy. I can come any time I want, there are no restrictions which I think means nobody is trying to hide things". Monthly newsletters were displayed along with forthcoming events so that everyone could be involved. The home had links with the local community, both organisations and individuals. We saw that these people were invited to events at the home such as relatives' social evenings or the annual National Care Home Open Day. Relatives had also contributed, for example one family had donated new garden furniture in memory of a loved one. Another family had written to express their thanks at being able to use the home's facilities for a birthday celebration and to staff for decorating the room. On an external website, one relative wrote, 'A lovely, happy environment, with fantastic, caring and friendly staff. My Uncle could not be better cared for'. A second wrote, 'An extra homely touch is the home's resident pets, fish tank, rabbit and lovely cat, who all the residents make a fuss of!' 'A third, There is not enough praise I could give for this home'.

As a result of positive feedback from relatives and visitors, the home had been awarded the provider's 'Star Award' for the second year running. Staff had donated the cash prize to the amenity fund which helped to put on events for people who lived at the home. One staff member had organised a fundraising event in aid of the Alzheimer's society. There was also an information board about Alzheimer's disease which might help

relatives or friends to better understand their loved ones' needs.

The registered manager was well-respected. One relative told us, "She always speaks with me, she isn't aloof". Another said, "They're (staff) all pleased to work for her". Staff spoke highly of the support they received. One team leader told us, "She is a nice, kind person and very approachable. The deputy also. They are a good team together. They are fair and they support you". A second said, "She'll listen in confidence. She pops around and has a chat. She acts on things". The registered manager was supported by a deputy who split their time between managerial work and team leading. One support worker said, "The management are lovely. If I have any queries or questions they are always approachable and friendly".

Staff felt valued and told us their views and opinions were taken on board. There were regular staff meetings throughout the year, both for team leaders and for all staff. We saw that staff had been thanked and acknowledged for their hard work, especially over the festive period. There had also been a discussion about points raised in the staff suggestion box. This provided an opportunity for staff to raise any concerns or ideas anonymously if they wished. The meetings were also used as an opportunity to provide important updates to staff and to review their understanding of key policies and procedures.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not taken timely action to address necessary improvements. The provider had not maintained an accurate and complete record in respect of each service user. Regulation 17 (2)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff on duty. Regulation 18 (1)