Mrs Vijay Ramnarain & Surendra Dev Lutchia & Mr Vivek Obheegadoo

Elizabeth House Residential Care Home

Inspection report

2 Church Hill Avenue
Mansfield Woodhouse
Mansfield
Nottinghamshire
NG19 9JU

Tel: 01623657368
Website: www.ramnarain.us

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service
Elizabeth House Residential Care Home is a care home which can provide personal care for up to 16 people. Accommodation is provided over two floors. The service supports people who have needs associated with ageing or are living with a dementia related illness. At the time of this inspection six people were using the service.

People's experience of using this service and what we found
People were not safe. Risks to people were not always assessed, reduced and monitored. Medicines were not used safely. The service was not clean. Lessons were not learnt when things went wrong. The provider and registered manager did not follow safe recruitment practices.

There were enough staff to keep people safe.

People's needs had not been adequately assessed and recorded. People's care was not designed to include any of their desired outcomes or goals. The provider and registered manager did not ensure staff received the induction and training required to provide good quality care. People were not supported to have a balanced diet. The service required redecoration and refurbishment. The registered manager confirmed there was no overall plan to improve the building. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice.

People were not consistently treated with dignity and respect. People were not supported to express their views or make decisions about their own care. People were not offered choices in ways which were meaningful to them. People were not supported to maintain their independence.

People were not involved in planning or reviewing their own care. Care plans were not always up to date and did not always reflect people's current needs. People were not supported to take part in activities that were meaningful and enjoyable for them. People were not fully supported to make a complaint or raise concerns. People's care plans regarding end of life care were basic and not personalised.

The service was not well-led. People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks identified issues with care and support. The provider and registered manager did not develop any clear plan of action to address issues found from internal or external audits. The provider and registered manager did not have systems in place to identify when things went wrong. The provider and registered manager had failed to act on the issues identified at this inspection and from our previous inspection.

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 19 August 2019) and there were multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified ten breaches in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 of their registration.

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

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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Elizabeth House Residential Care Home

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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors on the first day, and one inspector on the second day.

Service and service type
Elizabeth House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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. The registered manager is also one of the partners for the provider.

Notice of inspection
This inspection was unannounced.

What we did before the 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service. We spoke with four care staff and two staff involved in housekeeping and maintenance. We spoke with the registered manager. We looked at a range of records related to how the service was managed. These included five people's care records and how medicines were managed for people. We also looked at three staff recruitment and training files, and the provider's quality auditing system. During the inspection visit we asked the registered manager to send us additional evidence about how the service was managed, and they did this.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

- The provider and registered manager failed to ensure risks to people were assessed and managed. Risks to people were not always assessed, reduced and monitored.
- Risks associated with the use of bedrails were not managed safely. One person's bedrail had a gap of 130mm, which was sufficient to trap an arm or leg. The person's care plan stated the gap should be a maximum of 60mm. This was an issue we also identified on our last inspection. The registered manager said bedrails were checked regularly to ensure they were safe, but we identified one was not safe. A gap of 130mm exposed the person to the risk of entrapment and injury.
- Another person was assessed as being at risk of skin breakdown if they were not repositioned regularly. We observed they were not repositioned for over seven hours on the first day of our inspection. Staff did not know how often the person should be repositioned, and the person's care plan did not say how often. As the person was not mobile and spent their time either in a chair or in bed, this put them at risk of skin breakdown.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

- Medicines were not used safely.
- Guidance for PRN (as and when required) medicines did not contain sufficient information to guide staff on when PRN medicines were needed by people. For two people with limited verbal communication, there was no guidance or assessment tools in place to ensure PRN medicines were used appropriately. This put people at risk of not receiving medication when they needed it.
- Staff did not record why PRN medicines were used, which is best practice. This meant there was no way to

analyse the use of PRN medication to see if continued to be appropriate. For example, this was important for one person who had medicine for agitation. Their care plan did not tell staff what steps to take to reduce agitation without the use of medicine. This put the person at risk of being given a sedative medicine when it was not necessary.
● There were no regular audits of the use of medicines, or the stock of medicines. The registered manager confirmed the last medication audit was done in October 2019. There was a risk that issues with people's medicines were not identified quickly so action could be taken.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure the service was clean, or that infection control measures reduced the risk of cross contamination and spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

● The service was not clean.
● Medicine pots were dirty and not stored hygienically. We found an aero chamber (a device to assist a person taking inhaled medicine) for one person's inhaler was dirty. This placed people at risk of infection.
● We identified furniture and fixtures where the surface was scratched or chipped, including in toilets. This meant they were unable to be cleaned effectively.
● Fabric chairs had an unpleasant odour of urine, and chair seating pads were grimy with dirt in the seams.
● In one person's bedroom, there was dirt and cobwebs on the sill of the patio door. The hoist in the bedroom was also dirty.
● The registered manager's monthly audit identified areas needing cleaning, but did not ensure action was taken to address this.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection the provider had failed to assess, monitor and improve the service, putting 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. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● Lessons were not learn when things went wrong.
● Accident and incident analysis had not been completed since May 2019. There was no evidence of learning from accident or incidents.
● The provider's policy on managing accidents, incidents and near misses stated the manager would complete a monthly analysis. The registered manager could not explain why audits were not being carried out in accordance with the provider's policy.
● This meant people were placed at risk because issues with the quality of care were not identified quickly through an auditing process, and there was no opportunity for learning and improvement of care.

This was a continued breach of regulation 17 (Good governance) 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 safe recruitment practices were in place. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 19.

● The provider did not follow safe recruitment practices. For example, previous employment references were not always obtained, copies of photographic ID were not always kept on file, and there was no evidence of whether appropriate recruitment interviews had always taken place.
● The provider and registered manager could not demonstrate that prospective staff were suitable to provide a regulated activity as they had not done due diligence checks to ensure prospective staff were suitable to work in a care service.

This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's basic care needs. People told us there were generally enough staff to meet their needs. Staff said there were enough of them to assist people throughout the service in a timely way when needed. Our observations during the inspection showed us that people were supported by enough staff.
Systems and processes to safeguard people from the risk of abuse
● Staff had received safeguarding training and were able to describe the signs of abuse they needed to look out for and report. However, we observed care practices that put people at risk which staff had not reported. The provider was unable to demonstrate that staff put their learning into practice.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider had failed to carry out a full assessment of each person's up to date needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● People's needs had not been adequately assessed and recorded to ensure they were met in line with standards and national best-practice guidance. For example, care plans did not consistently have up to date information about people's needs.
● ● People's desired outcomes or individual goals were not taken into account when their care was planned. This included their emotional and social needs.
● People's pain management care plans had very limited information on their non-verbal communication. There was no guidance or assessment tools in place to ensure staff consistently understood when people were in pain or discomfort. This was identified at the previous two inspection, but the registered manager confirmed they had not taken action to address this.

This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received the induction and training they required. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 18.

● The provider did not ensure staff received the induction and training required to provide good quality care.
● There were no records of recently employed staff receiving an induction into the service.
● One member of staff had not done any pressure area care training since October 2016, and six staff had no pressure care training recorded. One staff member had not had a medicine competency check since June 2018, and two staff had no medicine competency checks recorded. One member of staff had not had training in dysphagia since August 2017, and seven staff had no record of training in dysphagia.
● The registered manager could not provide any evidence of any more recent training for staff, or that they

or the provider were carrying out any competency checks on staff.
● The lack of training and competency checks put people at risk of care that was not safe or up to date.

This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to manage people's needs in relation to food and drink. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

● People were not supported to have a balanced diet.
● People were not offered a choice of food at mealtimes. There was no menu available for people to view and, where people were able to ask for another meal option, they were not always offered an alternative of a balanced and nutritious meal. For example, one person did not want soup, and was given a meal of prawns and buttered white bread, with no salad or other vegetables.
● The provider and registered manager did not ensure people with complex needs were supported to eat and drink effectively. One person was assessed as high risk of choking. Professional guidance and the care plan said staff should ensure the person was alert and sat upright to eat and drink. We observed staff did not do this, and saw the person did not swallow most food and drink offered to them. The person was also given food that was not the recommended texture for them. This put the person at risk of dehydration, malnutrition and choking.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to ensure the premises and equipment were safe and suitable for people. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 15.

● The service required redecoration and refurbishment. The registered manager confirmed there was no overall plan to improve the building.
● The environment had not been adapted to meet the needs of people with dementia related illnesses. For example, the service was cluttered and had a lack of storage space. Bedrooms upstairs that were not in use were being used to store excess equipment.
● Flooring on the first floor was very uneven. This meant people walking there were at increased risk of falls. Staff told us the uneven floor made it difficult to push people who used wheelchairs.

This was a continued 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

At our last inspection the provider had failed to ensure valid consent for care and had not followed the Mental Capacity Act 2005. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 11.

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.

● The provider and registered manager did not ensure that consent to care was sought in accordance with the law.
● Where people were able to express their views and give consent to personal care, this was not recorded. Assessments of people's capacity to consent to various care decisions were not time or decision-specific as required by the MCA.
● Best interest decisions that were in place did not show the views of the person or involvement of relevant others, such as families in the decision-making process.
● Some people's relatives had signed their plans of care but there was no evidence available that they had the legal authority to do so.
● The provider had installed CCTV in the communal interior parts of the service. Consent to this was not always validly obtained from each person or their legal representative. There was no consideration for the MCA or best interests for each person where they lacked capacity to make a decision about CCTV. The registered manager confirmed CCTV was in use in the communal areas of the building, but could not demonstrate that the use of CCTV was proportionate and less restrictive.
● People were at risk of their rights not being upheld, and of care being disproportionately restrictive.

This was a continued breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were not consistently supported to have healthier lives.
● Six people did not have their oral healthcare needs assessed, and were not supported to maintain good oral care. We observed two people whose teeth were visibly not clean and had food debris stuck in their teeth. We also found one person's denture bath full of liquid with food debris floating in it. This meant the dentures had not been cleaned prior to soaking overnight.
● Two people's toothbrushes had not been used recently, and one person did not have a toothbrush. The registered manager confirmed no-one had an oral health care assessment or care plan; and said staff did not record details of people's oral health care. People were at risk of poor oral hygiene and pain, as their oral health care needs were not met.

● Guidance from professionals, such as that provided by the Speech and Language Therapy service was not always clear in people's care plans.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service worked with other agencies to provide consistent care for example, district nurses and GP's.
● Staff accompanied people to medical appointments if needed.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

At our last inspection the provider had failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 10.

● People were not consistently treated with dignity and respect. We heard staff use undignified terms to address people. We also saw staff behaving unprofessionally when supporting people. For example, chatting about their personal lives to other staff when supporting one person to eat. This meant staff were not focussed on the person's support in a caring way.
● We observed staff discuss one person's continence needs in front of other people.
● During our inspection, the radio was on in one dining area. Staff did not ask people sitting in this area whether they wanted the radio on, or what they would prefer to listen to.
● Between personal care tasks or recording care, we observed that staff spent time talking with each other or having breaks, rather than spending time with people in activities or conversations.
● People were not supported to express their views or make decisions about their own care. People were not offered choices in ways which were meaningful to them. For example, meal options were given to people verbally and there was no use of pictorial menus or show plates so service users could see what their choices were. People were not involved in menu planning and were only given one meal choice. People who had difficulty expressing their views verbally were unable to ask for other meal options.
● We spoke with the registered manager about people not being treated in a caring way. The registered manager said they were aware of this and confirmed they had not taken any action to address these concerns. This put people at risk of continuing to receive support that was not dignified or respectful.

This was a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
● People were not supported to maintain their independence. Care plans did not contain information about what people could do for themselves, or guide staff on how to promote people's skills.
● There was no evidence that people were supported to experience social or other activities in the local community. This put people at risk of becoming isolated and reduced their ability to live more independent

lives.

● We saw interactions between staff and service users where there was no communication from staff about what care or support they were about to offer. People were not encouraged to continue with personal care activities they could do for themselves.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people were treated with dignity and respect. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● The provider and registered manager failed to ensure personal care was person centred. People were not involved in planning or reviewing their own care. There was no evidence in care records that people had been asked to express their views about their care, and the registered manager confirmed this was the case. This put people at risk of being given care that did not meet their current needs.
● Care plans were not always up to date and did not always reflect people's current needs. The use of agency staff increased the risk of inconsistent or inappropriate care.
● For people who primarily used non-verbal communication, or had a limited vocabulary to express themselves, there were inadequate communication care plans in place. Staff confirmed they did not use anything for any person to assist effective communication like pictures, symbols or objects of reference.
● The registered manager told us they expected that one staff member would take the lead each morning with activities. However, there was no evidence this happened and we observed, throughout the inspection, that people were unoccupied, passive and socially withdrawn.

This was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The registered manager confirmed they did not offer people information in ways which were meaningful to them. The registered manager was not aware of the Accessible Information Standard and had not assessed people's communication needs to identify how to meet those requirements.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People were not fully supported to make a complaint or raise concerns. Information about making a complaint was not available to people in ways which were easily understandable to them For example, there was no easy-read guide to making a complaint.
● The complaints procedure displayed in the service did not have accurate information on who to contact if people or relatives were not happy with the provider's response to a complaint.
● The registered manager told us that no complaints had been received since 2010. However CQC records showed there was a complaint made by a relative in July 2018. CQC had contacted the provider for a response, so the provider and registered manager were aware of the complaint. This complaint was not logged in the complaints records at the service, and there was no evidence that the provider or registered manager had investigated the complaint or taken any action.

This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● At the time of this inspection no one was receiving end of life care. However, we looked at how end of life care was planned. We noted that people's care plans regarding end of life care were basic and not personalised, beyond information about their resuscitation status and any known funeral plans. There was no evidence of people's views or cultural and spiritual needs about how they wanted to be supported as they approached the end of their life. Staff confirmed it was not clear whether some people and relatives had not been asked, or if they had not wished to discuss it.

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; 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

At our last inspection systems in place to assess, monitor and improve the quality and safety of the service were not effective. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

- The service was not well led. People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks identified issues with care and support.
- Audit systems were not comprehensive or robust. For example, the last medication audit was October 2019. The provider's policy on managing medicines stated, "Regular, weekly audits will be carried out and the results will be recorded."
- The registered manager could not explain why audits were not being carried out in accordance with the provider's policy. This meant people were placed at risk because issues with the quality of care were not identified quickly through an auditing process, and there was no opportunity for learning and improvement of care.
- The provider and registered manager did not develop any clear plan of action to address issues found from internal or external audits. For example, the fire safety risk assessment, dated December 2019, highlighted a number of issues that needed to be addressed. The provider and registered manager had not developed an action plan from this, detailing what needed doing, by when and whom, and what evidence would show the risks had been reduced.
- Records were not accurate. For example, records relating to one person's fluid intake were not accurate.
- The provider and registered manager did not have systems in place to identify when things went wrong. This meant they lacked sufficient information to improve the service when things went wrong.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection the provider had failed to ensure the registered manager was fit to carry on a regulated activity. This was a breach of regulation 7 (Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 7.

● People were put at risk of harm as the registered manager did not demonstrate they had the required skills and competency to manage the service effectively and safely.
● The registered manager failed to demonstrate their skills and competency to manage the service well for people. This was demonstrated by multiple continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a continued breach of Regulation 7 (Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last inspection the provider failed to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● There was no evidence that the registered manager gathered and used information in the daily running of the service such as care plan reviews and accident and incident data to learn and improve the care provided to people.
● Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements.
● The registered manager was unable to demonstrate a commitment to continual improvement and was not keeping up to date with current best practice guidance. Policies we looked at did not reflect up to date legal requirements. For example, the provider's "Policy and Procedures for the Handling of Medication" referenced the Care Standards Act 2000, and not the Health and Social Care Act 2008.

This was a continued 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; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider failed to seek and act upon feedback from people, staff and other professionals. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● The provider and registered manager had failed to act on the issues identified on our inspection. The majority of these issues had been identified as concerns at our last inspection.
● The provider and registered manager had not acted to address concerns raised by the local authority. These external quality monitoring visits in October and December 2019 had identified a number of issues which had not been addressed by the time of this inspection.
● The registered manager told us they did an annual survey for people, relatives and external professionals. This was to get their views on the quality of the service. There was no evidence that these views were used to help drive improvements in the quality of care.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always treat people with dignity and respect. This included calling people by undignified names and talking about service users care needs in ways that breached their confidentiality.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to personal care was not sought. The provider did not follow the MCA for service users who lacked capacity to consent to a range of personal care activities.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always being assessed, reduced and monitored. This included risks associated with bed rails, choking, skin integrity, continence support, scalding from hot water, moving and handling, oral care, medicines and infection prevention and control. People were at risk of harm from care that was not safe.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service required redecoration and refurbishment. The provider had no overall plan to improve the building. The environment had not been adapted to meet the needs of people with dementia related illnesses.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People were at risk of not knowing how to make a complaint or raise a concern, and the provider did not have a system in place to ensure complaints and concerns were investigated and lessons learnt.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit systems were not comprehensive or robust. The provider's policies did not reflect up to date legal requirements. The provider did not develop any clear plan of action to address issues found from internal or external audits. There was a continued lack of improvement from feedback from other external agencies.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not follow safe recruitment practices.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager failed to demonstrate that they had the necessary skills and competencies to manage the carrying on of the regulated activity at Elizabeth House Residential Care Home. This is demonstrated by X breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 found on this inspection, and a failure to act on our findings on previous inspections.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have up to date training or assessment of their care skills to provide personal care safely.

The enforcement action we took:

Following representations and appeals, CQC have acted to cancel the provider and registered manager's registration.