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Elizabeth House Care Home Adults

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Elizabeth House Care Home Adults (known to the people who live and work there as 'Elizabeth House') on 16 and 17 January 2017. The first day of the inspection was unannounced. This meant the home did not know we were coming.

Elizabeth House is a care home for up to 20 people with mental health issues and/or learning disabilities. It consists of two large terraced houses knocked into one, situated in a quiet residential area of Portsmouth. The home has 18 bedrooms, two of which were originally for two people to share. The home has four floors. Offices and meeting rooms are on the lower ground floor; the kitchen, two lounges, the dining room, a smoking room and some bedrooms to the ground floor; and other bedrooms and bathrooms on the first and second floor. There was a stair lift on one short section of stairs between the first and second floor, but no other lift access in the building.

The registered manager told us people no longer wished to share rooms so the home accommodated a maximum of 18 people. One the first day of inspection there were 17 people living at the home, although one moved to a different care home later that day.

Elizabeth House was last inspected in May 2014. At that time it was found to be compliant in all areas examined. This was the first inspection to give the home an overall rating and for the different aspects of care.

The home had a registered manager; he was also one of the partners who acted as registered providers of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We identified various issues with medicines administration and management. The registered manager, who was responsible for medicines at the home, had not been on medicines training for 20 years.

Most aspects of the building, utilities and equipment had been checked on a regular basis. However, the registered manager had not taken steps to reduce the risk of a Legionella outbreak at the home.

People and their relatives told us there were sufficient staff deployed to meet people's needs. Our observations on inspection supported this view.

Accidents and incidents had been documented at the home, although records lacked detail about actions taken to prevent further occurrences. Care staff could describe how they supported people with behaviours that may challenge others, and we observed them doing so effectively. However, some people's behavioural management care plans lacked detail.

People and their relatives told us they thought the home was clean. Whilst the décor of the home was tired in places, we found the home to be clean and odour-free.

Training records could not evidence staff had received the training they needed to meet people's needs effectively. Whilst staff told us they felt supported, the registered manager had not provided staff with supervision or appraisal since 2015.

The home was compliant with Deprivation of Liberty Safeguards, but not with the Mental Capacity Act 2005 (MCA). This was because people's ability to consent to care and treatment had not been assessed. Care staff knowledge of the MCA was poor.

People were happy with the food and drinks on offer at the home and told us they had a choice. Records showed people with specific nutritional needs were supported appropriately. People also had access to a range of healthcare professionals in order to help maintain their physical and mental health. The home tracked people's appointments and supported them to attend them, when necessary.

Interactions we observed between staff and people during the inspection were all positive. All staff, including the management team, knew people well as individuals. People and their relatives told us staff were kind and caring, and promoted people's independence.

Staff respected people's privacy by knocking on their bedroom doors prior to entering. We saw staff promoted people's dignity by supporting them with their personal care and grooming, if they needed it.

Records showed, and people confirmed, they were involved in the design of their care plans. Most people had chosen to sign their care plans and we saw they were reviewed with them on a regular basis.

People had access to advocacy services and had been referred to them when they needed independent support to make decisions.

Risk assessments and care plans were person-centred. Daily records plus bimonthly and annual reviews evidenced people were supported in accordance with them. The home had a transition process for prospective new admissions to the home.

People's care plans were not based upon a recovery model of mental health. We recommended the registered provider investigate current evidence-based practice around this in order to maximise people's mental health and independence.

People told us they had enough to do and most opted to pursue their own hobbies and interests. The home provided some activities and organised social events for people. We observed most people chose to go out during the day and returned to the home at mealtimes.

None of the people or relatives we spoke with had made a complaint about the home, but all said they would feel confident approaching a member of the management team to raise concerns if they needed to. Complaints received by the home had been investigated and responded to appropriately.

Feedback about the management team from people and their relatives was all positive. People, their relatives and staff completed biannual satisfaction surveys. Staff attended regular meetings and could share their views about the home.

The registered manager had failed to monitor most aspects of the service for safety and quality. This meant there was no analysis of accidents, incidents or complaints for trends, and issues with medicines administration and management had not been identified and addressed. Some incidents at the home had not been reported to CQC as statutory notifications.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014 and Care Quality Commission (Registration) Regulations 2009. 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 always safe.

Problems with medicines administration and management stemmed from the registered manager's lack of up to date training in this area.

Risks to people had been assessed and staff could describe how they kept people safe. The registered manager made regular checks on the building and utilities, with the exception of water temperatures to reduce Legionella risk.

People told us there were enough staff to meet their needs and our observations supported this. We found the home to be clean and free from unpleasant odours.

Is the service effective?

Requires Improvement

The service was not always effective.

The training matrix could not evidence staff had received the training they needed to meet people's needs. They had not received regular supervision or appraisal since 2015.

The home was depriving people of their liberty in accordance with the legislation. Assessments of people's capacity to consent to their care and treatment had not been made in line with the Mental Capacity Act 2005.

People enjoyed the food at the home and we saw they were offered choices. Four meals a day were provided, with drinks and snacks in between.

People told us, and records showed, they were supported to access other healthcare professionals in order to maintain their general health.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff at Elizabeth House were

kind and caring, and described the atmosphere as homely. We saw interactions between staff and people were supportive and friendly.

People were encouraged to maintain their dignity and independence by staff. We observed staff respected people's privacy.

People were involved in designing their care plans and setting their personal goals.

People had access to advocacy services if they needed independent help to make decisions.

Is the service responsive?

Requires Improvement

The service was responsive.

Care plans were detailed and person-centred but were not based on a recovery model of mental health. We recommended the registered provider investigate ways to make improvements.

People said they were happy with the activities on offer at the home and felt they had enough to do. We saw most people chose to go out during the day.

People and their relatives told us they would complain to the managers if they needed to. Complaints received in 2016 had been investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was not auditing various aspects of the service for safety and quality. Some statutory notifications had not been made as is required by the regulations.

People and their relatives had been given opportunities to feedback about the home at meetings and via questionnaires. Staff had regular meetings.

Feedback about the managers at the service was positive. Staff supported people in accordance with the home's philosophy of care.

Elizabeth House Care Home Adults

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 16 and 17 January 2017. The first day was unannounced. The inspection team consisted of one adult social care inspector.

We did not ask the registered provider to complete a Provider Information Return (PIR) prior to this inspection.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Portsmouth and the local authority safeguarding team. They did not report any concerns to us. After the inspection we also contacted three other healthcare professionals involved with people using the service plus the local community mental health and learning disabilities teams. Those that responded did not raise any concerns.

During the inspection we spoke with four people who used the service, two care workers, the registered manager, the deputy manager, the assistant manager and a cook. After the inspection we spoke with three people's relatives over the telephone.

As part of the inspection we looked at seven people's care files; this included their risk assessments and care plans. We also inspected three staff members' recruitment and supervision documents, the home's staff training records, seven people's medicines administration records, accident and incident forms, and various policies and procedures related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Elizabeth House. One person said, "I'm very comfortable and secure here", and a second commented, "They lock the door in the evening. The staff ask where we're going and when we're coming back. It's not a prison though." People's relatives also thought their family members were safe at the home. Comments included, "[My relative's] safer there than [they] were at the last place", "It gives me peace of mind", and, "It's a very caring place. I know [my relative's] in safe hands."

As part of this inspection we checked how medicines were managed and administered and whether people received their prescribed medicines on time. We saw the majority of people's tablets were supplied in blister packs by the pharmacy, with other tablets in boxes and liquid medicines in bottles. Blister packs are made up by pharmacies and contain the tablets each individual is prescribed at set times of the day; they are designed to make medicines administration easier and safer. The registered manager could explain how medicines were ordered and returned to pharmacy and records showed this was done correctly.

People and their relatives told us they were happy with the way medicines were managed at the home. One person said, "They help me with my medicines", and a relative commented, "[The registered manager] distributes the pills."

Medicines were locked in a cupboard in the home's dining room; there were no medicines requiring refrigeration at the time of this inspection. We noted the home did not check and record the temperature of the area where medicines were stored. Manufacturers recommend most medicines be stored at or below 25°C. This meant the home could not be sure medicines had been stored at the correct temperature. We spoke with the registered provider and recommended they seek advice around the safe storage of medicines.

There were no controlled drugs stored in the medicines cupboard at the time of this inspection. Controlled drugs include medicines such as morphine, whose use and storage is controlled by specific legislation. One person at Elizabeth House was managing their own medicines, which included a controlled drug. This was stored appropriately in their room, and a risk assessment had been undertaken with the person and one of their relatives to assess the risk versus benefit to the person of managing their own controlled drugs. This was a good example of the service promoting a person's independence with their medicines.

On the first day of inspection we observed the assistant manager had pre-potted each person's medicines and was distributing them to people in the dining room as they came down for breakfast. Each pot contained a small piece of card with the person's name on it and the assistant manager told us this is how they knew whose tablets were whose. Two people were prescribed a liquid laxative medicine which we saw did not contain a name card. The assistant manager signed people's medicine administration records (MARs) after all of the medicines had been distributed. We immediately raised concerns with the registered manager and assistant manager as 'potting up' of medicines is not considered good practice and care staff should record when people have taken medicines as soon as possible afterwards. We referred them to National Institute of Clinical Excellence guidelines on medicines administration in care homes. The

registered manager said they would review practice and implement changes straightaway.

On the second day of inspection we observed the assistant manager administering medicines to each person individually. They checked the contents of each person's blister pack against their MAR to make sure all of the tablets prescribed were included and then signed the MAR after they had given each person their medicines. We saw they spoke with people politely and respectfully, and answered any questions people had about their medicines. However, we noted the assistant manager did not observe each person taking their medicines and so could not be sure they had been taken. We also saw the assistant manager had taken all of the blister packs out of the medicines cupboard and left them unsupervised on a table in the dining room as they took people their medicines. Some blister packs had individual sheets of tablets taken from boxed medicines attached to them with elastic bands; medicines must always be kept in their original boxes with their prescription stickers so it's clear whose they are and how they should be taken. We asked the assistant manager why they did this; they told us, "It's so we don't forget."

Some people liked to receive their medicines in their rooms, so at the end of the medicines round the assistant manager put the blister packs away in the medicines cupboard and took medicines to people still in bed. On one such occasion we noted the medicine cupboard keys were left on a dining room table as they took medicines to a person on the second floor of the home. This meant people's medicines were not secure at all times. We raised this issue with the registered manager. He said he would speak with the assistant manager and ensure the medicine keys were kept securely in future.

We looked at seven people's MARs to see if people received their medicines as prescribed. We noted other medicines had been handwritten onto the printed MARs from the pharmacy by staff administering medicines at the home. Most of these medicines had been prescribed by mental health professionals, not by people's GPs, so they did not automatically appear on MARs generated by the pharmacy. Due to limited space on the MARs, extra medicines had been squeezed onto the bottom of other medicines records and most had not been signed by the member of staff adding the medicine or countersigned by another member of staff to confirm the instructions were correct, as is good practice. In some cases, clinical abbreviations and symbols had been used by the registered manager, which did not make it clear how the medicine should be administered.

We noted topical medicines, such as prescribed creams and lotions, had not been signed as applied on MARs and there were no body maps to show where creams should be applied. In addition, people prescribed medicines 'as required', such as Paracetamol for pain or Lorazepam for anxiety, had no medicines care plans to describe when the person needed to take this particular medicine. MARs showed these medicines had been given. For example one MAR showed a person had received Lorazepam four times in the three weeks prior to this inspection, although it was not recorded on the rear of the MAR what symptoms prompted the administration. This meant it was not clear if people had received their medicines as prescribed.

Issues with medicines were a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care files contained person-centred risk assessments for aspects of their physical and mental health. For example, we saw risk assessments for personal safety, drinking alcohol, moving and handling, and falls. People's care plans explained how risks to people should be managed. A healthcare professional involved with people using the service told us they thought, "Any potential risks (to people) seem managed well."

The risks to people presented by the building had been assessed annually, and we saw issues identified had been included on an action plan and then marked as actioned. The home had an up to date fire risk assessment and regular fire drills and training was coordinated by the registered manager. All the required checks had been undertaken on fire alarms, emergency lighting and fire extinguishers, as well as on utilities and the home's stair lift. One aspect the registered manager did not check was the home's water system in order to reduce the risk of Legionella. We directed the registered manager towards guidance from the Health and Safety Executive around water temperature and other checks which can lower the risk of a Legionella outbreak. He said he would implement a system of monitoring for this as soon as possible.

People told us there were enough staff deployed to meet their needs. One person said, "Oh yeah, there is enough staff", and a second commented, "If I need the staff they're always there." People's relatives agreed; one told us, "There's plenty of staff. They're very caring." We checked the home's rotas and made observations of staffing levels during the two days of inspection. The staff team at the home consisted of three care workers (including the assistant manager), a cook and the registered manager and deputy manager in the morning; and two care workers, a cook and the registered manager and deputy manager in the afternoon/evenings. One staff member was on duty at night, with the registered manager and deputy manager, who lived a short distance from the home, on call. The staff team was very stable, with most staff working at the home for several years. The registered manager told us staff holidays and sickness were always covered by existing staff and agency staff had never been used. Feedback from people and their relatives and our observations showed there were enough staff deployed at the home to meet people's needs.

We checked three staff members' personnel records to see whether the home's recruitment process was robust. Each staff member had been checked to ensure they were suitable to work with vulnerable people with either the Criminal Records Bureau (CRB) prior to December 2012, or Disclosure and Barring Service (DBS) after December 2012. It is up to employers to decide if and when to repeat these checks, but we did note one staff member's CRB check was dated 2004 and another's 2009. Records contained staff members' original application forms, which included a statement about their health, photographic identification, proof of address and proof of their right to work in the UK. One staff member's full employment history was not clearly recorded on their application form, although this was clarified during the inspection. We also found there were no records of prospective staff interviews recorded. The registered manager told us a recruitment tracking sheet would be developed to ensure each part of the recruitment process had been completed and could be evidenced in each staff member's personnel file.

Staff we spoke with could describe the ways in which the people living at Elizabeth House might be vulnerable, and all said they would report any safeguarding concerns appropriately. People told us they would tell staff if they were worried about anything. We found records of accidents and incidents, including safeguarding concerns, difficult to locate. This was because the forms used to document what had happened and how it had been managed were kept in people's care files, rather than in a central accident or incident file. Records we saw showed accidents and incidents had been recorded and investigated fully, and concerns notified to the local authority safeguarding team when required. However, there was no section on the form to record what measures had been put in place to minimise reoccurrences, or any other action taken to manage the incident. This meant it was not always possible to see if the home had taken preventative action in response to incidents and accidents. We discussed these issues with the registered manager and deputy manager; they could explain what action had been taken in each case to follow up each incident and accident. The registered manager said he would revise the format of the form and create a central accident and incident file, to make oversight easier.

Some of the incidents documented at the home concerned people who had displayed behaviours that may

challenge others as a result of their mental health conditions or learning disabilities. Records showed incidents had been managed appropriately and care staff could describe how they used distraction techniques when people became agitated. During the inspection we observed one person experiencing challenging behaviours; staff ensured other people were safe and managed the situation well until the person calmed down. When we checked the care plan of this person we saw issues with anger management were documented but there was no guidance as to how best to support the person when they became upset. The care plan for another person recorded on incident forms involving challenging behaviour similarly lacked detail. We fed this back to the registered manager. He said he would review behavioural care plans with people who needed them at their next review meetings to ensure they contained the detail staff needed to support people effectively.

People and their relatives told us they thought the home was clean, although the décor was somewhat dated. Comments included, "The house is clean", "It's clean but dated. The standard of hygiene is very good", "Perhaps the décor is a bit dated. It's adequate. It's not an unpleasant atmosphere at all", and, "The décor is old but it's clean." Some people told us they cleaned their own rooms, including making their beds and changing towels. One person said, "I keep my own room clean. I like my independence." We made observations around the home, including in communal areas, bathrooms, toilets, the kitchen and in people's rooms (with their permission). We found the home to be clean and odour-free.

Requires Improvement

Is the service effective?

Our findings

We asked people if they thought the staff at Elizabeth House had the skills and experience to support them effectively; they told us they did. One person commented, "They're very well trained." People's relatives agreed. Comments included, "[The assistant manager] is on the ball. The rest seem pretty competent", and, "They know how to look after [my relative]."

As with some other documentation at the home, training records had been handwritten by the registered manager and we did not find them easy to follow. A list of training covering the end of 2015 and all of 2016 showed most staff had attended training on health and safety, safeguarding, first aid and moving and handling. Certificates in staff personnel files showed some had attended infection control training in 2015, but it was not possible to establish when exactly all care staff had last received training on this, or on nutrition and food hygiene. One care worker's file showed they had received training in mental health, epilepsy, learning disabilities, diabetes and the Mental Capacity Act 2005, all of which were relevant for people at the home, but this had been over five years earlier.

With reference to the issues with medicines management and administration discussed earlier in this report, we asked the registered manager about medicines training and the competency checks made on staff at the home. The registered manager told us he had not attended medicines administration training for 20 years. The assistant manager, who started at the home in July 2015, had not received medicines administration training in their present role. The only other staff member who administered medicines had last had training in 2010. There were no records of any medicines competency checks made by the registered manager or the assistant manager, although both said they made them. This meant issues with medicines management and administration had been missed by the registered manager and this was a result of their lack of up to date training. We raised this issue with the registered manager. Shortly after the inspection he confirmed medicines management and administration training had been booked for all staff that had this role.

The home's training policy did not list which training courses care workers should undertake or how often they should be refreshed. The registered manager told us the core subjects, such as first aid, fire safety and safeguarding, should be updated every one to two years. He told us he would create a training matrix to make tracking staff training easier and after the inspection informed us that a range of training courses had been booked for all staff members.

The management team at the home were not aware of the Care Certificate. This is a set of standards introduced in 2015 by Skills for Care which the induction of staff new to care should cover. It is not mandatory but if not using the Care Certificate, staff inductions should cover the same subject matter in an equivalent depth. The registered manager told us new care staff at the home were enrolled onto a National Vocational Qualification in health and social care at level two, as part of their induction. This is a course is a higher level than the Care Certificate. The registered manager said he would investigate the Care Certificate and consider implementing it for new staff without care experience.

Care workers we spoke with told us they felt supported by the registered manager and deputy manager, and

could go to them if they had any issues. One told us, "I feel supported otherwise I wouldn't be here." However, records showed, and staff confirmed, they had not received supervision or an annual appraisal since 2015. Prior to this we saw supervisions were detailed and happened on a regular basis. The registered manager said he checked regularly with staff to see if they needed any support but had not arranged supervision meetings as he had been too busy. This meant care workers had not had access to regular supervision and annual appraisal for over a year.

Gaps in staff training and issues with access to supervision and appraisal were a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

Records showed people deprived of their liberty or thought to be being deprived of their liberty at the home had been assessed correctly, with applications made to the local authority for DoLS authorisations. However, people with mental health conditions known to affect their capacity had not been assessed for their ability to consent to their care and treatment. For example, two people living with dementia had no MCA assessments concerning their care and treatment. One of these people had signed a consent form to refuse safety checks at night, however, their capacity to make this decision had not been established. A care plan of one person with a DoLS in place stated they were able to manage their own money but not their medicines. We saw this decision had not involved a MCA assessment.

Care workers we spoke with could not correctly describe how the MCA affected the people at Elizabeth House or the process of assessment and best interest decision-making. One care worker said of a person living at the home, "I think I have the right to decide for [name] as [they haven't] got mental capacity." Another person's MCA/DoLS care plan stated, 'DoLS team (from the local authority) have provided consent for ongoing care and any treatment [name] may need.' This further demonstrated a misunderstanding of the correct process.

We discussed staff knowledge and procedures for MCA/DoLS compliance at Elizabeth House with the registered manager. He told us he would organise training and seek advice to make sure people were assessed appropriately in future.

The home was not compliant with the Mental Capacity Act 2005. This was a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback about the food served at the home was positive. One person told us, "They do a nice roast on a Sunday", and a second person said, "I enjoy the food. I can't complain." During the inspection we had a lunchtime meal with people at the home. We found the food to be hot, tasty and plentiful. The dining room was pleasant; tables were set with tablecloths and condiments were available. People told us there was a choice of foods on offer each day and if they did not like the food served, they could request an alternative. We saw food and drinks were on offer at set times throughout the day, with hot drinks and biscuits served in

between the meals of breakfast, lunch, tea and supper. People told us they could request food or drinks at other times during the day if they wanted to, and we noted jugs of juice were available all day in the dining room for people to help themselves.

We looked around the kitchen and spoke with the cook. They could describe each person's food likes, dislikes and preferences, and knew which people needed soft foods. We had noted in one person's care file that they needed a fortified diet in order to gain weight. The cook had a copy of the dietician's advice for this person and explained how they added calories to the person's food, using cream, butter and milk powder. The person's care records showed they were weighed weekly according to their nutrition care plan. This meant people's nutritional needs were met by the home.

Stock in the kitchen was adequate and the cook checked the temperatures of food storage equipment and food served on a daily basis. The most recent local authority food hygiene inspection in August 2016 had rated the home as the maximum five stars, which meant standards were high.

People told us, and records showed, they were supported to access a range of healthcare professionals to support their physical and mental health. One person said, "If I get a sneeze they say 'do you need a doctor?'", and then added, "They do more than care when I'm poorly." People's relatives were happy with the support their family members received to maintain their health. Comments included, "They take [my relative] to the doctors and to the hospital when [they] need to go", "They support [my relative] in meetings with [their] social worker", "They got all [my relative's] teeth sorted out for [them]. They've got a chiropodist and hairdressers that come to the home", and, "They keep in touch with [my relative's] psychiatrist and GP."

People's care files evidenced they had seen GPs, practice nurses, dentists, dieticians, psychiatrists, chiropodists and social workers. The registered manager told us, "We make sure people are registered with a GP and dentist." Appointments were noted on a table in the file containing people's daily records and written up in more detail in their individual care files. We saw these were discussed with people during bimonthly and annual reviews. Care files recorded how the home worked with mental health professionals to support people's mental health. The registered manager told us, "If there's a crisis we go to the social worker; they would do referrals to the psychiatrist." This meant people were supported to maintain their physical and mental health.

Good

Is the service caring?

Our findings

People and their relatives told us staff at Elizabeth House were kind and caring. Comments included, "They spoil [my relative] and think really highly of [them]", "They're very kind and understanding", "I get on with all the staff", and, "We banter together and have a laugh." A healthcare professional involved with people using the service told us, "The staff seem always polite and respectful to residents and aware of their needs."

People told us staff respected their privacy. One person said, "They always knock on my door", and a second person commented, "If they (staff) want to come in my room they always ask me first." We also observed care staff knocking on people's doors and waiting for them to respond prior to entering during the inspection. We saw people appeared well groomed and were dressed in tidy clothes which were appropriate for the time of year. People told us they could have a bath or shower whenever they chose; one person said, "I usually have a shower every day." The home laundered people's clothing; feedback we received about this aspect of the service was positive. This meant staff at the home respected people's privacy and promoted their dignity.

We observed interactions between staff and people at the home during the inspection. All interactions we saw were polite and respectful. Care workers could demonstrate they knew people well as individuals, by describing their likes, dislikes and personal histories. We also heard jokes and laughter exchanged between staff and people. People told us they liked the atmosphere at the home; one person said, "The residents are happy", and a second told us, "It feels homely." A healthcare professional involved with people using the service commented, "It is a caring service that provides a warm friendly family type environment."

People told us they were supported to remain independent and could make choices about how they lived at Elizabeth House. For example, they could decide when to get up or go to bed, and how to spend their time. We saw people's care plans included information about what they could do, as well as what support they needed, so care staff could encourage people to do those things they could manage for themselves. We noted the home included a smoking room for those people who chose to smoke cigarettes. People we spoke with who used it appreciated this facility; one told us, "I'm glad there is a smoke room." The registered manager told us he was keen to promote healthy living, including not smoking, but had provided the smoking room because Elizabeth House was home to the people who lived there.

People's care files evidenced they were involved in designing and reviewing their care plans. Meetings were held on a bimonthly basis to discuss people's needs and progress with goals, and we saw most people had chosen to sign their care plans. All files contained a detailed assessment document, which listed people's preferences for aspects such as food, activities and daily routines. Some also contained personal histories and we saw a good example of how this information had been used to personalise one person's mental health care plan. We asked the management team why all people did not have personal histories. The deputy manager discovered several people's personal histories had been archived mistakenly by administrative staff; they said each would be reviewed with people at their next care planning meeting to ensure information was used to personalise care as much as possible.

We asked the management team how they promoted equality and diversity within the home. The registered manager told us they reviewed people's existing documentation when they were assessed for a place at the home and spoke with individuals about their needs. The home supported people to attend church services and welcomed members of a particular church into the home on a regular basis as they visited a person there. None of the people living at the home had any dietary needs relating to their culture or religion at the time of this inspection, but the management team and cook could describe how foods and menus could be modified to suit any new admissions with dietary preferences.

The registered manager was aware of the referral process for advocacy service and could give examples of when he had referred people to advocates. Records showed some people had advocates who were involved with specific decision-making or had visited them at the home. Signs around the home advertised a local peer support group people could attend for help and advice. This meant people had access to independent support with decision-making if they needed it.

Elizabeth House did not routinely provide end of life care. The registered manager said the home would provide end of life care if he could be sure people's needs could be met and the right level of support was available from community nurses or GPs, if required. People's 'after death wishes' had been recorded as part of the assessment process on admission, but these constituted basic information about whether people wished to be buried or cremated, and if the latter, what they wanted to happen to their remains. No end of life care plans had been devised as none of the people was approaching the end of their life.

Requires Improvement

Is the service responsive?

Our findings

People told us care staff at Elizabeth House were responsive to their needs. One person said, "They're here when I need them." Relatives agreed. One told us, "They've had the most success with [my relative] than other services", and a second said, "They look after [my relative's] personal welfare really well and encourage [them] to engage with health services."

People's care files were organised and structured, which made it easy for us to find information. Each person had received a detailed initial assessment which identified the areas of support they needed. We saw these areas had then been risk assessed, if required, with care plans put in place to manage any risks. People also had care plans for aspects such as health and well-being, mental health, personal care, social activities and safety. People's involvement in designing and reviewing their care plans was clearly evidenced, as they included statements and opinions voiced by the person. One person told us they had written their own money management care plan and we saw this was included in their care file; they said of it, "It's going OK." Each care plan identified what the person could do themselves, what support they needed, and what their personal goal was in terms of each care aspect. Most people had chosen to sign their care plans. This meant people's care plans were person-centred and they were regularly consulted about their content.

Care staff evaluated people's care plans in daily records. We read a sample of these and found they evidenced people were being supported according to their care plans. People had care plan review meetings on a bimonthly basis; detailed records were made of these meetings, including progress with goals and the person's physical and mental well-being. People told us they attended these meetings; the registered manager said, "We work with the client. We ask their wishes and opinions." A healthcare professional involved with people using the service told us the registered manager and deputy manager, "Communicate well with professionals, providing updates and reports for reviews that are carried out regularly." An annual care planning meeting was also held at which people's healthcare appointments and other input from healthcare professionals was discussed. People could also share their feelings and voice their opinions. Minutes from these meetings were written from the perspective of the person and clearly described how they felt about their placement at Elizabeth House, and what their long-term goals were. We saw people had signed the minutes from these meetings to show they were an accurate record of discussions. This meant people were involved with the review of their care plans and goals.

We noted people's care plans did not include long-term goals for their recovery or rehabilitation. Even if it unlikely a person with a mental health condition will move on from a residential care setting, it is important for their care plans to focus on recovery and improvement in order to maximise their ability to become self-directing. The registered manager said they did not use 'recovery models' of mental health care because most people at Elizabeth House were older and viewed the home as their long-term placement. This meant that the provider may have missed opportunities to support people to become more autonomous regardless of their age or diagnosis.

We recommend the registered provider investigates current evidence-based practice around the use of

recovery models in mental health care so people are supported to maximise their independence, even if their long-term plan is to remain at Elizabeth House. We will check the provider's progress with this at the next inspection.

We asked the registered manager about the procedure for new admissions to Elizabeth House. He explained, "We ask people to come and visit us and spend time with us. They can meet the people who live here." He also said the management team would review information provided by social workers and conduct a detailed assessment; he told us, "We ask about continence, mobility and any behaviour issues." There was a transition process in place for people referred to the home as potential admissions. This consisted of half day visits for meals, and then overnight stays. When the person had made the decision to move in, there was then a 28 day trial period where the person could decide whether the home was for them. The registered manager said, "We try to have a good mix of residents. We try to ensure people will get on." This meant people were involved in the decision of whether or not to move to the home and a structured transition process was in place.

People we spoke with told us they preferred to arrange their own activities and decide how they wanted to spend their days. Comments included, "I go to church at the start of the week for a cup of tea and a chat", "I go to the pub", "I like to stay in my room. It's my choice", "I read and do crossword books. If I want to go shopping the staff will go with me", "I like my room and telly (television)", and, "You can have a chat to the staff if you need company." Relatives said of activities at the home, "They try to organise things, but [my relative] doesn't want to take part", and, "[My relative] visits our [family member]. [They] go to shops and tea shops around and about." During the inspection we noted most people went out between meals to pursue their own hobbies and interests. Various posters and leaflets around the home advertised local events and social activities people could take part in. One person told us, "I do get bored"; when we asked what they did when they felt bored, they told us they would tell the deputy manager who would then suggest activities they could do.

The home provided activities in the evenings when more people were in the building. These included board games, conversation, dominoes, films and reading magazines. One person told us, "We have a party for people's birthdays." Another person had a birthday during this inspection, and we saw the cook bought a cake which was offered to the person and others at the home to share. People gave positive feedback about the Christmas and New Year celebrations at the home. One person said, "I like Christmas when they put the tree up with decorations. We have parties." They also enjoyed the monthly karaoke session the registered manager organised at the home and went out for regular meals with staff. This meant people had access to a range of activities inside and outside the home.

Care staff at the home supported people to go on holiday if they wished by assisting them to make arrangements and accompanying them, if required. People were also encouraged to keep in touch with their families. One person told us they were accompanied by staff on regular visits to a family member in a different city; their relative said they really appreciated this and looked forward to seeing the care worker as well as their family member who lived in the home. Another relative told us, "If I arrange a social occasion I tell the home and they book a taxi to make sure [my relative] gets there." People told us their friends and relatives were free to visit at any time; relatives we spoke who visited the home said they were always made to feel welcome. This meant the home supported and encouraged people to see their friends and relatives.

People and their relatives told us they would complain to the registered manager or deputy manager if they were not happy about their care or some other issue at Elizabeth House. One person said, "If I had a complaint I'd go to [the deputy manager], [they] like me!", and a second person told us, "I'd tell [the registered manager] first obviously. I'm very confident they'd help me. I trust them that way." Comments

from relatives included, "I'd speak to [the registered manager] or [deputy manager]. They're available on the phone all the time", and, "I'd raise concerns if I needed to. They're approachable."

We saw people had a copy of the home's complaints policy in the care files they kept in their rooms. A poster explaining how to make a complaint to the local authority was also prominently displayed in a communal area. One person told us, "They'd (the registered manager and deputy manager) would help me to complain if it was about social services or something like that." We reviewed the complaints documented at the home in 2016. Records were detailed and evidenced each complaint had been thoroughly investigated and responded to appropriately. This meant people and relatives felt about to complain if they needed to and any concerns raised were dealt with correctly.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they thought Elizabeth House was well managed. One relative said, "It's always very organised and cosy when I go", a second told us, "It is well managed", and a third commented, "I'm quite satisfied with the care [my relative's] getting." A healthcare professional involved with people using the service told us, "They (the registered manager and deputy manager) always support the best interests of the service users and know their service users well", and added, "I have no concerns with the service provided."

People, relatives and staff at the home told us the registered manager and deputy manager, who also formed the registered provider partnership, were at the home every day. Care staff told us the managers were also on call 24 hours a day and could come to the home quickly, if needed, as they lived a short distance away. During the inspection, we observed the registered manager, deputy manager and assistant manager were visible in the home; they engaged with people in a relaxed but respectful way. It was clear they knew people well as individuals.

During the inspection the registered manager explained planned changes to the management team at the home. The registered manager said the deputy manager was going to apply to be the home's registered manager in summer 2017 so that he could take a step back from the day to day running of the home. The assistant manager was in the process of undertaking a National Vocational Qualification in management at level five, with the support of the registered manager and deputy manager. The longer term plan was for the assistant manager to become the registered manager when they had completed their qualification and the team agreed they were ready. This meant the registered provider was planning for the future of the home and the people living there in the longer term.

We checked to see how the registered manager and deputy manager monitored the home for safety and quality. We found that apart from a six-monthly health and safety risk assessment and audit, which included aspects of infection control, there were no other documented audits undertaken at the home. This meant there was no regular audit of medicines, complaints, accidents and incidents, or care plans. The registered manager said care plans were reviewed on a bimonthly basis, but this did not include oversight of the overall quality of care plans or daily records in order to identify areas for improvement. The registered manager showed us the home's audit file, which we saw was filled with blank audit templates; he told us, "We've got a nice audit file but we don't have time to fill them in." The management team said they would review the audit arrangements at the home and implement a system of regular audit as soon as possible.

Failure to audit the safety and quality of the service provided at the home was a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered managers and providers are required to notify the Care Quality Commission (CQC) about a range of incidents and circumstances. This includes deaths, actual or suspected abuse of a person using the service, incidents when the police were called to the home, and serious injuries. When we reviewed the accidents and incidents documented at the home we found some CQC notifications had been missed.

These included when the police had been called out for a person who had gone missing from the home, and incidents of abuse between people at the home. Each incident had been notified to the local authority safeguarding team as appropriate. We discussed the requirements for reporting with the management team at the home; the registered manager told us he would review CQC's guidance for registered providers and ensure notifications were made correctly in future.

Failure to make all appropriate statutory notifications to CQC was a breach of Regulation 18 (1) and (2) (e) (f) of the Care Quality Commission (Registration) Regulations 2009.

People told us they were given opportunities to feedback about the quality of the service they received at house meetings and by completing regular questionnaires. Residents' meetings at the home had not been regular in 2016. People told us they had been invited to them but the attendance from other residents was poor. The registered manager confirmed this, stating they tended to hold two meetings a year, mainly to discuss holidays and Christmas. However, the deputy manager told us, "We tried two or three times to revive residents' meetings. We will try again. It depends on the group dynamic."

The results of the most recent biannual survey, held the month prior to this inspection, had been compiled and analysed by the registered manager. Some feedback had led to actions for the management team and we saw these had been completed. For example, one person had complained about the way potatoes were served at the home, and had asked to have potatoes cooked in a certain way with all their main meals. When we spoke with the cook, they were aware of this request and we saw the person received potatoes cooked to their liking during the inspection. The information had also been shared with other staff via the care staff's communication book. Four people had fed back that they could not always understand the spoken English of some of the staff. The registered manager had responded by reassuring people that the staff involved had been enrolled on English courses to help improve their verbal communication with people at the home. Relatives also told us they had been invited to meetings at the home and had received questionnaires to feedback about the care their family members received. We also saw healthcare professionals had also been surveyed in 2016. This meant people, their relatives and healthcare professionals involved with people using the service were consulted about the quality of care provided by the home.

Regular staff meetings had been held at the home; staff also received regular satisfaction surveys. Minutes showed staff meetings included discussions around activities at the home, group reflection after incidents had occurred to identify any lessons learned, and people's holiday plans. Care workers told us they could feed back any issues at staff meetings and were asked by the registered manager and deputy manager for ideas for service improvement. One care worker told us, "We have meetings. I can say what I need to then." This meant staff had opportunities to share their opinions and ideas with the management team.

We noted each person at the home had been given copies of the home's 'philosophy of care' and their rights as a user of the service. The philosophy of care was also displayed prominently in a communal area of the home. We asked the registered manager how he ensured staff worked in accordance with the home's philosophy of care. He told us, "We show staff the way we do things. We talk to staff about how to maintain people's dignity. Privacy, dignity, independence and choice are all very important to us." We asked care workers about the home's philosophy of care and why they worked at Elizabeth House. One care worker told us, "As soon as I started here I knew I belonged. It's my second home. The residents are really close and bond with you. I just love my job." A second care worker said, "I've always liked to serve and care for people. It makes me feel good to help people. I love this job." Feedback from people and their relatives and observations we made during the inspection showed care workers and the management team demonstrated the home's philosophy of care as they supported people at the home.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified CQC of all relevant incidents and events as required by the regulations. Regulation 18 (1) and (2) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not compliant with the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We identified various issues with the administration and management of medicines. Regulation 12 (1) and (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failure to fully audit the safety and quality of the service provided at the home.

Regulation 17 (1) and (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training records could not evidence staff had received the training they needed to meet people's needs. There had been no staff supervision or appraisal since 2015. Regulation 18 (2) (a)