

Peaceform Limited

Eliza House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This comprehensive inspection took place on 15, 16 and 23 June 2017 and was unannounced. At the last inspection on 21 May 2015, the service was rated 'Good'.

At this inspection we found a number of concerns and breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Eliza House provides accommodation and support with personal care for up to 26 people some of whom were living with dementia. At the time of our inspection there were 26 people using the service.

The service did not have a registered manager, however the manager in place who took up the position in November 2016 had submitted an application to the Care Quality Commission (CQC), to become the registered manager of this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager completed a number of audits and checks to monitor the quality of the service. These included audits for medicine, care plans, fire checks, room checks, maintenance of the home and infection control. However, we found that these audits inadequate and failed to identify any of the issues that we identified as part of this inspection.

Health and safety, infection control and care plan audits were completed as per a tick box format and did not identify any of the issues we found. This included issues such as broken radiator covers, poor fabric and condition of the home, chemicals and toiletries left exposed in a bathroom and a broken bin which contained clinical waste.

Where external audits had been completed by the environmental health department for food hygiene ratings and the Clinical Commissioning Group (CCG) for medicines management, issues that had been highlighted had not been addressed. These issues remained and were identified again as part of this inspection.

The manager was unable to provide us with records in relation to staff supervision, appraisals, medicine competency assessments, safeguarding investigations, complaints, accidents and incidents and the results of previously completed satisfaction surveys as they were not available within the home.

Medicines were not managed safely. There were a number of concerns around the storage of controlled drugs, room temperature checks for the storage of medicines and incomplete paperwork confirming the safe and appropriate administration of covert medicines.

Scheduled activities did not always take place. People and relatives all told us that there was very little provision of activities taking place within the home and that activities listed on the activity timetable did not always take place. We saw very little interaction, activity or stimulation that was initiated by care staff that were on duty. People were taken to the lounge and positioned to watch television or listen to music. During the three inspection days, many people were seen to be in the same place throughout the day. People regularly gave feedback, ideas and suggestions at weekly residents meetings about activities that they would like to see organised. However, the home had failed to take action on this feedback.

Accidents and incidents were not recorded in a way which enabled the service to analyse and identify any trends or patterns so these could be reduced or mitigated against in order to keep people safe.

Where staff had completed training in topics such as medicine administration, we were unable to confirm that staff members competencies had been assessed once they had completed the training course to confirm that they were competent in the assessed area.

Care staff told us that they received regular supervision and felt supported in their role. Staff files contained supervision records that had been carried out since the new manager had been in post. However, we were unable to confirm whether staff had received regular supervisions since the last inspection. In addition there were no records of any completed appraisals for any staff members, some of whom had been employed by the service for a number of years.

Over the first two days of the inspection, the inspector and the expert by experience recorded a mixture of positive and negative observations of the lunchtime meal experience. Whilst it was observed that meals served were hot and people were seen to enjoy their meals and ate well, little consideration had been given to the setting and preparation of the dining room which would promote a positive mealtime experience.

Care plans did not always contain information about the person's likes and dislikes, choices and preferences.

People and relatives told us that they knew who to speak with if they had any concerns or issues to raise. However, we found that no complaints had been recorded since the last inspection in 2015. The manager, who had been in post since November 2016, was unable to confirm if there had been any complaints and where these had been recorded prior to his arrival. The manager told us that they had not received any complaints since November 2016.

All staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and seeking consent when supporting people with their care needs. We found that the service had appropriately submitted authorisation requests for people lacked capacity and who were possibly being deprived of their liberty. However, care plans did not always evidence that people or where appropriate their relatives had consented to the care and support they received.

Care staff demonstrated a good understanding of the terms safeguarding and whistleblowing and were able to describe the actions they would take if abuse was suspected.

Risks associated with people's care and support needs had been identified and these had been assessed, giving staff instructions and directions on how to safely manage those risks.

The provider demonstrated safe recruitment processes were in place to ensure that each person employed at the service was safe to work with vulnerable adults. This included criminal record checks, identification

verification, visa verification and reference requests confirming staff conduct in previous employment.

Care plans contained records of all visits and appointments made by a variety of healthcare professionals such as GPs, dentists, chiropodists and district nurses. Details of the visit and any actions to be taken had been recorded.

Throughout the inspection we observed some positive and caring interactions between people and staff. People were observed to be treated with dignity and respect.

Care staff demonstrated a sound awareness of supporting people from different backgrounds, varying religious and cultural backgrounds and supporting people who may identify as being lesbian, gay, bi-sexual or transgender.

People and relatives knew the manager and felt confident in approaching them. Staff were equally positive about the manager and found to him to be a supportive and good manager.

At this inspection we found breaches of Regulation 9, 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to unsafe medicine management, concerns related to health and safety, infection control and the condition of the fabric of the home, lack of activities, ineffective quality audit systems and lack of supervisions, appraisals and medicine competency assessments.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Medicines were not always managed and stored safely. Records were not available to confirm that staff competencies had been assessed to confirm competency when administering medicines.

Accidents and incidents were not always recorded and monitored to ensure people were kept safe and free from harm.

Concerns and issues were identified throughout the inspection which related to health and safety, infection control and the overall condition of the fabric of the home.

People and relatives told us that they felt safe with the care and support that they received. Risks associated with people's care and support needs had been identified and these had been assessed to keep people free from risk of harm.

The service had robust recruitment processes in place.

Requires Improvement ●

Is the service effective?

The service was not always effective. Care staff told us that they received regular supervisions and felt supported in their role. However, due to lack of documentary evidence we were unable to confirm whether staff had received regular supervisions since the last inspection. There were no records available confirming that staff had received an annual appraisal.

All staff demonstrated a good level of understanding of the MCA, DoLS and seeking consent when supporting people with their care needs. However, care plans did not always record that people or their relatives had consented to the care they received.

People were seen to enjoy their meals and ate well. However, little consideration had been given to the setting and preparation of the dining room which would promote a positive mealtime experience.

People had access to a variety of healthcare professionals and appropriate referrals had been made where a specific need had been identified.

Requires Improvement ●

Is the service caring?

The service was not always caring. Care plans were not person centred and did not always contain information about the person's likes and dislikes, choices and preferences.

Care plans did not always evidence that people had been involved in the planning or decision making process of how they wished for their care and support to be delivered.

Throughout the inspection we observed some positive and caring interactions between people and staff.

People told us and we observed that their privacy and dignity was respected at all times.

Care staff demonstrated a sound awareness of supporting people from different backgrounds, varying religious and cultural backgrounds.

Requires Improvement 

Is the service responsive?

The service was not always responsive. People and relatives told us that there was very little provision of activities taking place within the home.

We saw very little interaction, activity or stimulation that was initiated by care staff that were on duty. People were seen to be taken to the lounge and positioned to watch television or listen to music throughout the day.

Weekly resident meetings that were conducted recorded that people made a number of suggestions and gave ideas of possible activities that could be organised. However, there was no evidence available that these ideas and suggestions had been acted on.

Care plans were reviewed on a monthly basis and we saw some paperwork confirming that people and relatives had been involved in the care plan reviewing process. However, this was not the case for all of the care plans that we looked at.

People and relatives told us that they knew who to speak with if they had any concerns or issues to raise. However, we were unable to confirm whether the service had received any complaints since the last inspection and how these had been dealt with as there were no records available. The manager told us that they had not received any complaints since November 2016.

Requires Improvement 

Is the service well-led?

Inadequate 

The service was not well-led. The manager in post was awaiting the outcome of their application to the Care Quality Commission to become the registered manager.

On the third day of the inspection we had arranged with the provider to meet with them to complete the inspection process. However, the provider failed to arrive at the service with no contact or communication to the inspector informing them that they would be unable to attend as requested.

The manager completed a number of audits and checks to monitor the quality of the service. However, we found that these audits were not comprehensive and failed to identify any of the issues that we identified as part of this inspection.

Completed quality satisfaction surveys had not been analysed so that the service could learn and make the necessary improvements where required.

Throughout the inspection we were unable to view documentation covering the last two years since the last inspection in May 2015 as they were unavailable. Therefore we were unable to confirm whether the service had the appropriate systems and processes in place to confirm that staff were being supported appropriately and that the provision of care and support was monitored so that learning, development and improvements could take place.

Eliza House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 15, 16 and 23 June 2017 and was unannounced.

The inspection team consisted of one inspector, a pharmacist inspector and an expert by experience who spoke with people and relatives. An expert by experience is a person who has personal experience of using or caring for someone who has used or uses this type of care service.

Before the inspection we looked at information we had about the provider which included notifications about incidents affecting the safety and wellbeing of people using the service. We also looked at feedback that we had received from a variety of visiting healthcare professionals.

During the inspection we observed how staff interacted and supported people who used the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

During the visit we spoke with 13 people using the service, six relatives and seven staff members which included the area manager, manager, senior support workers, support workers and the chef. Some people were unable to communicate with us verbally and so we spent time throughout the day observing interactions between people and the care staff supporting them.

We looked at the care records of eight people who used the service and medicines administration record (MAR) charts and medicines supplies for 14 people. We also looked at the personnel and training files of seven care staff. Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies

and procedures.

Is the service safe?

Our findings

People and relatives confirmed that they felt safe living at Eliza House and with the care and support that they received from staff. One person when asked if they felt safe told us, "Yeah, I do." One relative stated, "I would say so." However, despite this positive feedback, there were some aspects of the service that were not safe.

We saw that the home was clean and free from any mal-odours. However, we identified concerns throughout the inspection which related to health and safety, infection control and the overall condition of the fabric of the home.

Prior to the inspection we received information from a visiting healthcare professional who had raised concerns with the home, in March and June 2017, about the condition of the radiators in two people's bedrooms. On the first day of the inspection we asked the manager to take us to the two affected bedrooms and found that the issue had not been addressed. The radiator metal casing was falling apart and could potentially expose the heat panel which could place people at risk of burns if left exposed. We asked the manager to address this issue immediately.

On the second day of the inspection we found that although the covers had been temporarily screwed together, some screws were sticking out which could cause harm to people if they were to slide their hand along the radiator. The manager told us that these issues had been highlighted to the provider with assurances from the provider that these radiators would be replaced. However, no timeframe was given to when this work would be completed.

In a further four bedrooms we found that the wooden radiator covers were broken with holes which exposed some areas of the radiator. Therefore, people could harm themselves if they were to put their hand through the hole by cutting themselves on the edges of the cover or by sustaining burns if they touched the heated radiator. In a third bedroom we found an armchair where the material covering was ripped with the foam exposed. In one of the toilets, in the entrance of the home, which was used by people, we found that the bin used to contain clinical waste was broken and staff were unable to use the foot pedal to operate the bin. This posed an infection control risk as staff were unable to prevent or reduce the spread of infection. In a fourth bedroom we found that the curtain hooks from which the curtains had been hung, were broken and looked in a state of disrepair.

In one bathroom on the first floor, we found open liquid medicines, chemicals and liquid toiletries. All these items were in easy reach to people especially those living with dementia who may not have understood what they were and mistaken them as something to drink or eat. The manager removed these items during the inspection.

The manager showed us monthly and weekly health and safety checks that were completed. Monthly health and safety audits completed since January 2017 had not identified any of the issues that we found even though it was confirmed that every bedroom had been checked for areas such as, 'Are heaters adequately

protected?' or 'Are all bins in place and emptied regularly?' Weekly 10 point health and safety checks were completed but again these had not identified any of the areas of concern noted above even though checks included areas such as, 'Are radiators safe to touch?' or 'Are chairs/stools solid, safe and hygienic?'

A maintenance book was in place which recorded all maintenance issues that needed to be addressed so that when the maintenance person visited they were provided a list of tasks that were needed to be carried out. On 25 May 2017, it was recorded 'All radiators to be checked in all bedrooms'. However, there was no confirmation of whether the radiators had been checked and if checked whether the concerns we noted had been identified. Furthermore, there was no recorded oversight by management to ensure that the checks had been completed appropriately.

In June 2016, the Environmental Health Agency had completed a food hygiene inspection and had rated the service 'three stars'. A number of recommendations had been made. However, some of these had not been addressed. One of the recommendations that had been made was to remove the net curtain in the kitchen as it posed a risk of infection. An action plan was not in place to address these recommendations and we found that this recommendation had not been addressed.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the third day of the inspection, seven days later, we observed that some improvements had been made, especially to the issues we had identified over the first two days of the inspection. This included the fixing of the radiator covers and the removal of the damaged armchair. However, we found that the bin in the toilet used for clinical waste was still broken and curtains remained in a state of disrepair. A clear plan had not been developed for how these remaining concerns were going to be addressed.

During this inspection we looked at how people were supported with their medicines and medicines storage. Senior carers administered medicines and used MAR charts to make records of this. Records provided assurance that people were receiving their medicines safely, consistently and as prescribed. The MAR charts were computer generated by the pharmacy that supplied the medicines. Most of the MAR charts had a photograph to assist with the identification of the person receiving medicines. We saw that records were made on the MAR charts to indicate the application of creams and ointments. However, the accompanying body maps were not completed correctly so it was not always clearly identified where the cream or ointments needed to be applied.

There were no controlled drugs (CDs) in use at the location at the time of the inspection. However, the CD cabinet that was available had not been secured to the wall and could easily be removed. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations.

We were told that there was one person receiving their medicines covertly at the time of the inspection. Covert medicine administration is when medicines are hidden in food or drink without the knowledge of the person. Whilst we saw a GP letter giving permission for this to happen, we did not see records of a best interest decision or advice around the use of covert medicines administration signed and agreed by the home staff, a pharmacist, and the next of kin. This meant that care workers were disguising the medicine in food without obtaining appropriate consent and without having received pharmacy advice on the best way to do this, which was unsafe.

Staff consistently recorded the ambient room temperature of the office where the medicines had been stored previously, and it was found to be hotter than the recommended 25°C. The recorded temperature on 15 June 2017 was recorded as 29.5°C. Staff had taken action by moving the medicines trolleys to the lounge area. However, the temperature of the lounge area was not being recorded. The service would be unaware of when high temperatures were recorded, the effects that this would have on medicines overall. Items were being stored in the fridge that should not have been there. One was a liquid enteral feed that had expired. The other was an injection that did not require fridge storage. Both items were given to staff at the home to dispose of.

Staff recorded the current fridge temperatures daily and they were all within the required range of 2 and 8°C. The minimum and maximum temperatures were not recorded. In addition, there was no evidence that the fridge thermometer had been reset. If abnormal temperatures had occurred, staff would be unaware of this and the impact of this on medicines stored in the fridge.

The local Clinical Commissioning Group had undertaken a medicines audit on 6 April 2017. As part of this audit concerns had been noted around temperature checks and high recorded temperatures in March 2017. Recommendations had been made to the service to consider alternative arrangements for the storage of medicines. However, this had not been acted upon.

We saw that protocols were available for medicines taken 'when required' which meant that care workers had guidance on when to offer them to people. One person had been given 'when required' medicine for agitation every night for four nights. However, the progress notes did not mention the person being agitated so it was not clear why this medicine had been given.

The manager told us that all care workers received medicines training, and completed a competency assessment before they could administer medicines. However, when we asked to see completed competency assessments these were not available. The manager told us that he was due to complete medicine competency assessments for all staff in the forthcoming weeks.

The manager had completed a quarterly medicines audit. However, these audits had not identified any of the issues we identified as part of this inspection.

All accidents and incidents were recorded. However, these were recorded concurrently across three different accident books. The system to record incidents was confusing and it was difficult to analyse the information about all recorded accidents. Staff were also required to complete accident incident forms which detailed the accident and the actions taken. However, the filing of these was disorganised. No analysis had been completed to identify any trends or patterns in order to reduce or prevent a re-occurrence or learn from accidents and incidents.

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

We observed a morning drug round during this inspection. Water was offered to people to assist with medicines administration. The care worker documented on the MAR chart immediately after each individual person had received their medicines to prove medicines were administered.

All medicines were stored in locked medicines trolleys. Only relevant staff had key access. Staff had a system for checking all the medicines received each month to ensure that none were missing. We saw that for liquid medicines, the date of opening was annotated on the label. Medicines were disposed of appropriately and

staff kept records of this activity.

Care plans identified and detailed risk associated with people's health and support needs. These included risks associated with epilepsy, eating and drinking, challenging behaviours, use of bed rails, falls and diabetes. Risk assessments detailed the identified hazard, the control measures in place, and the control measures required to reduce or mitigate the risk in order to keep people safe from harm. However, information contained within the care plans was not always consistent with the associated risk assessments. Where detailed information and guidance was available within the main body of the care plan, this had not always been transferred on to the risk assessment. In addition where risks had been identified within the care plan, an appropriate risk assessment had not always been completed. We brought this to the attention of the manager who was in the process of reviewing all care plans to ensure that they were up to date and reflective of people's needs and requirements. The manager assured us that these issues would be addressed as part of their on-going review and update.

The service carried out dependency level and needs assessments for all people living at Eliza House. These were reviewed on a monthly basis. However, the results of these assessments did not determine staffing levels within the home. Staffing levels were determined based on observations and had been set historically. The manager told us that there were four staff on duty in the morning, three staff in the afternoon and two waking night staff. The manager stated that staffing levels could be increased if it was observed that people's level of needs had increased. People, relatives and staff confirmed that there were sufficient staff available. Throughout the inspection we observed there to be sufficient staff available. However, concerns were noted about the deployment of staff especially as there was little observed activity and stimulation initiated by staff throughout the duration of the inspection. Staff were seen to be standing around in particular areas of the lounge or walking around various areas of the home. This has been further reported on under 'Responsive'.

Care staff demonstrated a good understanding of safeguarding and whistleblowing and were able to describe the actions they would take if abuse was suspected and the professionals they could contact to report their concerns. Comments from staff included, "We need to report any concerns because they are vulnerable adults" and "If I witness any concerns I would take notes and speak to the manager." Training records confirmed that all staff had received safeguarding training which was refreshed on a two yearly basis.

The provider had a safeguarding policy in place which gave information about the different types of abuse as well as the procedures that were to be followed if abuse was suspected. However, although the policy had been reviewed recently, the immediate contact details for the manager still referred to a previous manager and those for CQC referred to the previous care regulator, replaced by the CQC in 2009. This was brought to the attention of the provider to update.

We looked at seven staff files and saw that the service had safe systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK.

Maintenance records for the home included annual, monthly and weekly fire checks, call bell checks, monthly water temperature checks and equipment checks. These had been completed in a timely manner and no issues had been identified.

Is the service effective?

Our findings

People were unable to comment on whether they felt staff were adequately trained and skilled to deliver effective care and support. This was because most people living at Eliza House were living with dementia and were unable to understand the question that was being asked. One person told us, "Staff okay. Quite satisfied with treatment." Relatives that we spoke with were satisfied with the quality of care and support that was delivered. Comments made when asked if relatives felt staff were appropriately trained included, "I would say so" and "I'm not sure if staff are trained in dementia."

We looked at training records for seven staff members which confirmed that staff received a five day induction before commencing work, as well as regular training in topics such as moving and handling, safeguarding adults, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), dementia and health and safety. Care staff were also required to complete all relevant training modules to achieve the care certificate and we saw records confirming that staff were in the process of completing this. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support. We spoke with care staff about the training and their knowledge base around specific topics to assess the effectiveness of the training that was delivered. Staff told us "I received an induction. A senior staff went through the care plans and I met the residents" and "We refresh our training on a regular basis."

However, where staff had completed training in topics such as medicines administration, we were unable to confirm that staff member's competency had been assessed once they had completed the training course. The manager told us that previously completed competency assessments were not held at the home but were held at the provider's head office. However, on the third day of the inspection we were told by the manager that the provider had informed them that this was not the case and that all assessments should be available within the home. The home and the provider were therefore unable to demonstrate that any competency assessments had been completed. The manager confirmed that he was due to assess competency especially in medicines administration within the next week after the inspection for all staff.

Staff files contained records of supervisions that had been carried out since the new manager had been in post. Previous supervision records had been kept in a central file which was seen to be disorganised. Following the inspection the manager did send supervision and appraisal records that had been completed since the previous inspection, however, these did not confirm that all staff had received regular supervision or an appraisal since the last inspection. Supervisions that had been completed covered areas such as review of performance, review of training, development and future goals.

We spoke with staff about supervisions and whether they felt supported in their role. Care staff feedback included, "I have had two since I started six months ago. We talk about myself, any changes and team work" and "I receive supervision once a month. They are helpful. If you have an issue you can raise it then." Most staff spoken to confirmed that had received an appraisal but nothing recently and one staff member stated, "I haven't had that, don't know about it."

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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. During this inspection we found that the service had appropriately submitted authorisation requests for people who lacked capacity and who were possibly being deprived of their liberty. Where authorisations had been granted this had been documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested within a timely manner.

Care plans evidenced that the service had assessed people's capacity and where people had been assessed as lacking capacity and decisions had been made in their best interests, a multi-disciplinary approach had been taken in order to reach the decision. We saw documentation for decisions that had been made for people such as a 'do not attempt cardiopulmonary resuscitation' (DNACPR) directive, where a person required bed rails or where a person required support with their personal care. However, the service had not given the appropriate consideration for people who were administered their medicines covertly. For one person we did not see records of a best interests decision in relation to the administration of covert medicines. This was brought to the attention of the manager during the inspection.

Care plans did not always evidence that people or where appropriate their relatives had consented to the care and support people received. Out of the eight care plans we looked at only three had been signed by a relative, one care plan had documented that consent to care had been discussed with the relative over the telephone and four had not been signed. We again brought this to the attention of the manager to address.

All staff demonstrated a good level of understanding of the MCA, DoLS and seeking consent when supporting people with their care needs. One staff member told us, "You can't assume people lack capacity. You have to ask for consent." Another staff member explained, "Where people cannot make their own decisions an appointed person can make decisions on their behalf. People may not remember things but if you give them a choice you will be surprised about the decisions that they can actually make."

Over the first two days of the inspection, we recorded a mixture of positive and negative observations of the lunchtime meal experience. Whilst it was observed that meals served were hot and people were seen to enjoy their meals and ate well, little consideration had been given to the setting and preparation of the dining room which would promote a positive mealtime experience. On the first day of the inspection we observed that tables were set whilst people were waiting for their meal. One staff member placed cutlery for each person but little consideration was given to how cutlery was placed and whether in the correct position to enable people to use. No condiments or sauces were made available on each table. The same staff member poured an orange juice for each person. People were not asked or given a choice of what type of drink they wanted. Feedback about these observations was given to the manager and the area manager.

Following the previous day's feedback, on the second day of the inspection, we observed that tables were being laid as people were arriving in the dining room. Salt and pepper had been placed on each table and we heard some people express surprise to this. Some people were observed requiring help to use the salt

and pepper containers which needed to be turned and twisted. Again food looked and smelt appetising. A choice of juices and water were given to people during the course of the meal. We observed some positive interactions between care staff and people which included people being supported to cut up their food and support with eating where required. Staff were also seen to be laughing and joking with people. However, one care worker who was delivering food and clearing tables, was observed to have very little interaction with people. One person asked for an ice cream for dessert and became very angry when it was refused. The care worker was observed explaining to the person that it was because their blood sugar levels were high and then joked with them, pacified them and served them an alternative which the person accepted.

People's feedback regarding meals was mixed and included comments such as, "Food is English and alright", "Food is great. Never not liked anything", "Food gets on my nerves. Same all the time. If you don't like it can get a sandwich if you ask", "Not great choice. They make it interesting to eat" and "Like most of the food. Supper very basic, much the same. 8pm you get tea and biscuits."

We spoke with the chef who explained that four-weekly rotational menus had been set by management. Every morning people were asked what they would like to eat for lunch and the evening meal and were given two options. The chef explained that if someone did not want to eat what they had chosen at the time of the meal, they were offered an alternative. A menu was displayed in the dining room with options and choices for each meal. However, some relatives we spoke with told us that people did not always get choice and that options listed on the menu were not always what was offered to people. One relative told us, "[Person] has not had the desserts that have been on the menu board and as far as I know [person] has never been asked about choice." A second relative stated, "I can see [person] is eating properly and loves the food but there is no choice, everybody gets the same." Care plans did not always list people's likes, dislikes, choices, preferences or religious requirements in relation to food and drink.

Drinks including tea, coffee, juices and water were available throughout the day and people had access to a fruit bowl and biscuits as and when they desired. People's weights were checked and monitored on a monthly basis. Where weight loss or excessive weight gain was noted we saw records confirming that the appropriate referrals had been made to help ensure that people's nutritional needs were met. Where people required professional input in relation to dietetic services or the speech and language therapists, we saw records of referrals that had been made. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a soft diet or low sugar intake diet.

Each person's care plan contained records of all visits and appointments made by a variety of healthcare professionals such as GP's, dentists, chiropodists and district nurses. Details of the visit and any actions to be taken had been recorded. Eliza House also had access to a local Care Home Assessment Team (CHAT), consisting of nurses, occupational therapists and geriatric consultants, who were available to support them home with acute illnesses so as to prevent any unnecessary hospital admission.

Is the service caring?

Our findings

Throughout the inspection we observed some positive and caring interactions between people and staff. We saw one care worker talking to people whilst filing their nails in a very warm and interactive way. People were complimentary about staff and made comments such as, "Staff alright. No problem with staff", "The staff are friendly" and "As homes go I'm looked after alright. I'm quite happy." Relative's feedback was also positive and included comments such as, "My [relative] is happy being here. Carers are kind and make an effort learning the language that my [relative] speaks", "Carers are caring" and "Staff always acknowledge you. Always helpful. Look after him quite well. Staff have a joke and a laugh."

We observed care staff treating people with dignity and respect. Care staff understood how to support people to ensure their privacy and dignity was respected and gave examples of how they did this. Examples from staff included, "When supporting with personal care we shut the door, pull back the curtains and ask them how they want to be supported" and "We make sure when supporting the with personal care they are covered with a towel." One person told us, "They [staff] knock on the door before they come into my room." People and relatives confirmed this and told us, "They ask before they do things" and "Whatever I want to do they let me." Care staff understood people's needs and preferences and likes and dislikes and were able to tell us about people's mannerisms and traits in personalities.

However, most care plans that we looked at were not person centred and did not identify people's likes, dislikes, preferences and wishes. The manager explained that all care plans were currently being reviewed and showed us two examples of care plans that had been reviewed which included some background and life history information about the person and also some detail about the timings they would like to wake up, when they would like to go to bed and whether they preferred a male or female care worker when they required support. In addition the manager was also compiling one page profiles for each person which gave a brief description of the person, their health conditions, the level of support they required and some life history information. The intention of this one page summary was to allow any new staff member to have a quick overview of the person they were supporting. The manager confirmed that out 26 care plans only eight or nine had been reviewed since they had taken up post.

Care plans did not always evidence that people had been involved in the planning or decision making process of how they wished for their care and support to be delivered. Two care plans that we looked at recorded information about reviews that had taken place which had involved relatives but had not recorded the views and wishes of people. However, throughout the inspection staff were observed to ask people about what they wanted and how they wished to be supported. This included asking people if they wanted to sit outside in the courtyard, whether they wanted support with their meal or if they required assistance when wanting to visit the toilet.

Care staff demonstrated a sound awareness of supporting people from different backgrounds, varying religious and cultural backgrounds and supporting people who may identify as being lesbian, gay, bi-sexual or transgender. Statements from staff included, "You have to respect the person. It doesn't matter" and "They are individuals. Treat everyone equally no matter what." Care plans provided information about

people's religious beliefs and cultural needs as well as their sexual orientation.

Staff understood the term person centred care and were able to explain what this meant for the people that they supported. One staff member told us, "Everybody is different. What suits someone may not suit someone else. We make the care plan to suit the person."

Is the service responsive?

Our findings

People and relatives all told us that there was very little provision of activities taking place within the home. Comments from people included, "I do some activities. Breakfast, then lunch and talk to friends. Not many activities and sometimes singer comes here and sings English songs", "I don't think there are any activities. I sit around and talk to people" and "They make you do what you don't want to do. They throw a big blue ball at you. They say catch, catch, catch. People don't want that do they?"

Feedback from relatives when asked whether activities were organised and delivered included, "There is not enough stimulation. Need more entertainment. One thing I don't agree with is that after tea there is nothing, just TV. There is something on the wall but they don't happen. Never seen anyone. Definitely one thing I would change is having more to do" and "Once a week painting takes place but there is nothing occupational. There is an activity timetable which states bingo but this has never happened. There are no trips out."

An activity timetable was displayed on a notice board in the main lounge which listed activities such as keep fit, art, bingo, sing along, musical reminiscence, ball game and puzzle time. However, most people and relatives told us that these activities never took place. Eliza House has two lounges, one where a television was positioned for those people choosing to sit and watch television and another lounge where people who like listening to music have the opportunity to do so.

During the first day of our inspection we saw very little interaction, activity or stimulation that was initiated by care staff that were on duty. People were always seen to be taken to the lounge and positioned to watch television or listen to music throughout the day. However, we did observe people being asked if they wanted to sit outside in the courtyard as the weather was warm and one staff member playing with a ball with some people in the television lounge. However, for most part of the day there was little or no activity or stimulation for people taking place. The television had been switched on, but no-one had been asked what they wanted to watch and we observed no-one actually watching the programme that had been set. On the third day of the inspection we observed the same to be happening again. We asked people if they knew what they were watching, whether they wanted to watch the programme on television and whether anyone had asked them what they wanted to watch. The responses we received included, "Not really!", "Don't know what is on television" and "Don't really want to watch that."

Residents meetings were held on a weekly basis and topics for discussion including outings, activities and some people's food preferences. Minutes for every meeting from 18 February 2017 until 17 June 2017 recorded people's ideas and suggestions for a variety of activities. People also expressed the desire to go out on outings. One person expressed the wish to have culturally appropriate meals and another two people had stated that they did not want to take part in the meeting or did not want to add anything as 'nothing changes' or 'nothing has been acted upon'. Following these meetings there was no record available of the actions that had been taken in response to the ideas and suggestions that had been given. The manager did state that some of the activities that had been suggested had been facilitated, but there was no record available to confirm this.

The manager explained that they were in the process of recruiting an activity co-ordinator but in the meantime one staff member per shift had been allocated the responsibility of delivering some form of activity in the morning and the afternoon. We did not observe this to be taking place.

We asked care staff about the activities that took place within the home and whether they as care staff were responsible for organising or delivering any activities. One care staff told us, "We do activities sometimes, but sometimes people are not interested." A second care staff stated, "One thing I would say is that we are not the best. We try. Sometimes we don't have enough staff. All we can do is talk to them, do their nails or take them for a 10 minute walk. I don't know what else I can do for them. Also if you have been doing personal care all morning you don't want to be jumping around." A third staff member said, "Sometimes we do ball games and sing along but it's definitely not enough."

Further to our feedback to the manager and the area manager, on the second day of the inspection, we saw that one care worker was sitting with a person completing a puzzle, another care worker providing people with a manicure and some people playing a game of dominoes. However, we observed some people sat in the television lounge were observed to spend a significant part of the day sat in the chair without any movement, stimulation or activity being offered.

On the first day of the inspection, we saw that people were generally left unattended and were either passively watching television or dozing off to sleep. Care staff only intermittently walked over to the lounge, took a look at every one and then walked away. From 2.05pm, the first form of interaction from a care staff member was at 2.25pm when one person asked for a glass of water. One person was observed to request a cup of tea twice from two different care staff both of whom acknowledged their request but did not provide the person with a drink and instead waited for a third care staff, delivering tea and coffee as part of the tea round to finally give them a cup of tea. When we returned to the lounge some time later we observed the same people sitting in the same positions as they had been earlier in the day.

The home reviewed care plans on a monthly basis. Paperwork confirmed that relatives had been involved in the reviewing process for two people. However, for the other six care plans that we looked at, it was not documented that people or their relatives had been involved. One relative told us they couldn't remember if they had been involved in the devising or reviewing of the care plan. A second relative also told us, "I have not seen the care plan and have not been involved." A third relative commented, "We have not been involved in a formal review as yet but the manager talks to us informally."

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

Staff completed daily records for each person living at Eliza House. Records detailed information about the person, if they had eaten well, if they had slept well and all health observations especially where a person had been noted to be unwell. Staff also held a handover session in the morning, afternoon and evening so that at every staff change per shift, staff were given relevant information in order to respond appropriately to people's identified needs.

A complaints procedure had been displayed at the entrance of the home and detailed the steps that should be taken if and when people, relatives or visitors had any issues or concerns to raise. People and relatives told us that they knew who to speak with if they had any concerns or issues to raise. Comments from relatives included, "If I had a complaint would take it to the manager", "If we have any complaints or concerns, the manager is always available" and "I can approach the manager about any concerns." We looked at the complaints folder that the service held for any complaints that had been received since the

last inspection. However, we found that no complaints had been recorded. The manager, who had been in post since November 2016, was unable to confirm if there had been any complaints and where these had been recorded prior to his arrival. The manager told us that they had not received any complaints since November 2016.

Is the service well-led?

Our findings

A manager had been appointed in November 2016 and had submitted an application to the CQC to become the registered manager. This application was currently under consideration.

During the inspection, due to the ill health of the manager, we had arranged with the provider to meet with us on the third day of the inspection to complete the inspection process and give feedback about our findings including any significant concerns noted during the inspection. However, the provider failed to arrive at the service with no contact or communication to the inspector informing them that they would be unable to attend as confirmed.

The manager completed a number of audits and checks to monitor the quality of the service. These included audits for medicines, care plans, fire checks, room checks, maintenance of the home and infection control. These audits were superficial, consisting of tick boxes only. Systems and processes available to oversee the running of the home and quality of care provision were inadequate and failed to identify any of the issues that we identified as part of this inspection. This included issues such as broken radiator covers, poor fabric and condition of the home, chemicals and toiletries left exposed in a bathroom and a broken bin which contained clinical waste.

Audits for infection control and maintenance of the home were completed by other staff members, some of whom were support workers. The manager told us that he had shown some of the support workers how to complete the audit but we were unable to confirm whether support workers had been appropriately trained and assessed as competent to undertake this task. Where this was the case, the manager had not overseen or checked the audit to ensure that it had been completed appropriately. Where certain issues had been identified, no further detail was available of how and when the issue had been addressed. The manager told us that he had shown staff members how to complete the audits and said they were assured that the staff were completing them appropriately.

The provider carried out audits of staff files, training records, supervision records, care plans, medication and safeguarding on 1 June 2017. A number of areas that needed to be addressed had been identified, such as content and level of detail contained within care plans and medicines management which were similar to the issues that we had identified. An action plan had not been devised detailing how and when the issues identified were going to be addressed. The area manager and manager told us that they had held discussions about the identified issues and said they were working together to address these.

Where issues had been identified by external professionals such as the environmental health department and the local Clinical Commissioning Group, the issues found and the recommendations that had been made relating to food hygiene and medicines management had not been acted upon and the same issues were identified as part of this inspection.

The service had a number of accident and incident recording books which staff were required to complete when an accident or incident occurred. We found recording to be disorganised and multiple books were in

use. The service did not hold appropriate records which comprehensively detailed each accident and incident and how many accidents and incidents had been recorded on a monthly basis. The manager did not hold any analysis of all recorded accidents and incidents so that any patterns or trends could be identified and improvements made so that future accidents or incidents could be prevented or identified risks mitigated against. The manager only completed a monthly overview that detailed the number of falls per month which was sent to the local Care Home Assessment Team (CHAT).

A safeguarding folder was available which contained details of each of safeguarding concerns at the service. However, the manager told us that no records had been completed outlining any investigations that had taken place as a result of the concerns that had been raised, what the findings had been and any learning or improvements that had taken place as a result of investigation.

Documentation covering the last two years could not be located by the manager. This included paperwork confirming staff supervisions, appraisals, complaints, satisfaction surveys, management audits and medicine competency assessments. Therefore, the service was unable to confirm whether they had the appropriate systems and processes in place to confirm that staff were being supported appropriately and that the provision of care and support was monitored so that learning, development and improvements to service provision could take place.

The manager told us that quality satisfaction surveys were given to people and relatives to complete on an annual basis. The manager confirmed that the process of asking people and relatives to complete these surveys commenced in January 2017 and although relatives had been sent the questionnaire, the service had not received any completed questionnaires from them. Records of surveys completed by people, some of whom had been supported to complete the questionnaires by staff, did not confirm the date of when they had been completed. Where concerns or issues had been identified, there was no record of what actions had been taken to make the required improvements. Concerns noted included, 'Loo needs fixing', 'I don't enjoy the food here' and 'I don't know where to complain'.

In addition, where people had made comments, given ideas and made suggestions as part of the weekly residents meeting, there was no record available of the actions that had been taken in response to the ideas and suggestions that had been given. The manager did state that some of the suggestions and ideas had been acted upon, but there was no record available to confirm this. An analysis had not been completed of the findings from the residents meetings or satisfaction surveys so that the service could learn and make the necessary improvements where required.

Following the third day of the inspection the manager sent us a number of historic supervision records for four individual staff members and group supervisions/training that had been held between 26 February 2016 and 4 August 2016 as well as an appraisal record for one staff member. We were also sent a medicines competency assessment for two staff members completed in 2015. Based on the records we received, the service still was unable to confirm that all staff received regular supervision and appraisals and whether medicine competencies had been assessed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives knew the manager and felt confident in approaching them. One person told us, "Manager very nice man. He helps me to get out." Another person said, "Spoken to manager he is a nice man. Staff were equally positive about the manager and found him to be a supportive and good manager. Comments from staff included, "The support I need he gives", "He is a good manager, he is fine" and "He is

quite good."

Staff told us and records confirmed that regular staff meetings took place. Agenda items included, safeguarding, residents and policy and procedures. Staff confirmed that meetings were helpful. Comments from staff included, "We can add topics for discussion to the agenda. We can give our opinions and we are listened to", "We discuss the way we work and can give ideas. The manager listens" and "Everyone expresses what they feel or what they need and the manager listens."

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider did not ensure that appropriate and sufficient activities were organised and provided to people which encouraged autonomy, stimulation, independence and involvement within the community.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Medicines were not always managed and stored safely.</p> <p>Accidents and incidents were not analysed for trends and patterns so as to prevent future re-occurrences and to protect people from harm.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The provider did not ensure that all areas of the home used by the service were clean, suitable for the purpose for which they were to be used and properly maintained.</p>

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues around the home that were identified as part of this inspection. Where issues were identified there were no action plans in place on how these issues were to be addressed and resolved.</p> <p>Poor recording and analysis of complaints, safeguarding, accident/incident and customer satisfaction surveys meant that the provider had no management oversight on the quality of care that the service was providing. As a result there were no processes or systems in place to enable the service to learn and improve.</p> <p>There was a lack of evidence that staff were supported to fulfil their roles and responsibilities through regular supervisions, appraisals and competency assessments.</p>

The enforcement action we took:

We issued a Warning Notice on 11 July 2017.