Elliott House Limited

Elliott House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Elliott House is a residential care home providing personal care to 46 older people at the time of the inspection. Some people living in the service had dementia. The service can support up to 65 people. The service was provided over 3 floors in one large adapted building. There was a secure area for people with dementia called Poppy wing on the ground floor.

People's experience of using this service and what we found
People were at risk of harm to their health and wellbeing and there were concerns about the management of the service.

People's safety had not been sufficiently protected. Risks to people's health, safety and well-being were not always mitigated. Where people expressed their emotions though behaviours there was a lack of information for staff on how best to support people and not all staff knew about people's risks. The environment was not safe for people. Trip hazards had not been addressed. People would not be safe in the event of a fire, there were items blocking exit routes. Items which could be harmful if accessed by people with dementia, such as razors, were accessible to people. Medicines were not well managed to ensure people received these safely and as prescribed by their doctor.

People were not kept safe from the risk of infection. The service was not clean. There were insufficient cleaning staff to keep it so. The provider was not able to evidence they had checked staff had received their covid-19 vaccinations or were exempt, as required. There was no evidence staff were regularly testing for covid-19 which increased the risk to people.

Incidents were not always reported, it was not clear what actions had been taken to reduce the risk of incidents occurring again. People were not protected from the risk of abuse as safeguarding concerns had not always been reported to the local authority or Care Quality Commission (CQC).

There were insufficient competent staff to provide people with safe and effective care. There were a significant number of agency staff and they had not all received an appropriate induction when they first started work at the service. Staff had not always been recruited safely to ensure they were suitable to work in care. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of provider oversight of the service. Checks on the quality of the service had not been effective to keep people safe. The provider had failed to address concerns found at the last inspection. Staff told us they did not feel listened to and were not happy in their role. The service worked in partnership with other health and social care professionals however their advice was not always followed.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (Published 15 May 2019). We identified four breaches of Regulation. Regulation 12 (Safe care and treatment), 9 (Person-centred care), 10 (Dignity and respect) and 17 (Good governance).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing levels and the management of the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. We reviewed the information we held about the service. Prior to the inspection no areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elliott House.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to people's health and safety, staffing levels, safe recruitment, , safeguarding, good governance and notifying CQC of events as required by law at this inspection.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Elliott House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of three inspectors.

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

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. This means provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We met with the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

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

During the inspection
We spoke with four people who used the service and one relative about their experience of the care provided. Some people were not able to speak with us so we observed people's care and the support provided by staff in the communal areas. We spoke with sixteen members of staff including the nominated individual, four interim managers, senior care workers, care workers, agency care workers, a cleaner and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We met with the nominated individual, the managers in relation to concerns we identified and the actions they planned to take to address these. We met with the local authority. We shared some concerns with the Kent Fire and Rescue Service. The provider informed us they had taken the decision to cease trading as a care home. People were supported to move to other services.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risks to people's health and wellbeing were not well managed. At the last inspection we found that risks to people were not always identified and effectively mitigated. At this inspection we identified a number of risks to people's health, safety and welfare which were not effectively mitigated. For example, one person had a history of behaving in a way that increased the risk of a fire. Appropriate actions had not been taken to address this risk. The person was also at risk from ligatures and there was no system in place to reduce this risk. Staff told us they did not know if the person had items that could be a ligature risk in their room. One staff said, "We leave [their] room alone, we don't go in there."
● A number of agency staff did not know people well and were unaware of the risks people had. Some people displayed emotions though behaviour that could be distressing to themselves. These included hitting, smearing faeces, self-harm and aggression towards staff. One staff told us no one had this type of risk. There was a lack of written guidance to support staff to learn about people's risks. There was not always information about what might trigger behaviours and what actions to take to keep people safe. For example, there had been incidents where one person was at risk from harm from behaviours involving body waste. This also presented a risk to other people. There was no guidance for staff in relation to this concern and what action they should take to mitigate this risk.
● A number of people living at the service were living with dementia. Staff had left thickening powder unattended next to a person. Thickening powder is used to make fluids thicker so that people with swallowing difficulties can drink safely. If the thickening powder is swallowed without fluid, it can form an obstruction and people would be at risk of choking. Items such as razors were stored in an unlocked draw in the bathroom and could be accessed by people without staff support.
● There were risks to people from the environment that had not been addressed. For example, one person had fallen whilst in their room and suffered minor injuries. The person's room contained a number of trip hazards such as wires and a ripped floor covering. Action had not been taken to address these concerns. There were risks to people and staff from being unable to evacuate quickly from the building if they needed to do so, for example in the event of a fire. There were numerous items blocking different fire escape routes

throughout the service. One person's walker was blocking the corridor to the fire exit. A hoist and clothes rail blocked another exit. The handle to the front door fell off as the inspector attempted to leave the building delaying their exit. A manager told us it was not the first time the handle had come off.
● There was not a robust system in place to assure the provider had checked that all staff had complied with the requirement to be vaccinated against covid-19, unless they were exempt. There were records that some staff had the vaccine. However, records were missing for other staff and there were no records available for agency staff.

The provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. The provider had failed to ensure they had met the requirements of Regulation 12(3) in regards to ensuring vaccination (or exemption) was a condition of staff deployment. This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There was insufficient competent staff to keep people safe. Managers told us that there should be 11 staff on duty during the day. On the day of the inspection there were ten care staff, two of whom were working their first shift and had not undertaken any induction to get to know the service or people. Night shift numbers had reduced from six staff to five. There was no dependency tool supporting this decision.
● Some staff told us there was not enough staff on duty to give people the care and support that they needed. One staff said, "We don't have time to do things. We barely have time to give people a drink, the ones who need help. It's just get up, give them food, toileting and start again. Would I want my nan here? No, I wouldn't." Another staff said, "I don't feel like people are safe here. It would be best for people to leave, even if I have no job."
● There were not sufficient numbers of staff who knew people and could meet their needs. A large number of staff had recently left the service, others were working their notice. Agency staff did not receive an induction or shadow shifts to get to know people and learn how to support them. Some agency staff told us they did not get the opportunity to review care plans or risk assessments before providing support to people.
● There was one cleaner. Due to the size of the service this was not sufficient to maintain appropriate standards of cleanliness. For example, carpets had not been hoovered, we found items such as tea bags on the floor and some toilets were stained.

The provider had failed to ensure sufficient numbers of suitably competent and experienced staff were deployed. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment checks were not robust. There was no evidence that safety checks were completed on agency staff to assure the provider they were safe to work in a care setting. Managers told us that overseas DBS checks had not been completed when staff had just moved into the country. The provider had failed to complete checks to ensure permeant staff were of a good character to work with people. For example, full work histories had not been taken for staff.

The provider had failed to ensure safe recruitment procedures were established and operated effectively. This is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not managed safely.
● Liquid medicines had not always been dated to indicate when the medicine was open. Some medicines

can become less effective over time and need to be used within a certain time of opening. For example, one person's eye drops needed to used within 4 weeks of opening and there was no information for staff to indicate when the medicine had been opened.
● There was a lack of information for staff about people's medicines. A member of staff who administered medicines told us they did not know what some people's medicines were for, and there was a lack of information for staff to inform them. For example, one person's eye drops stated it was to be used 'in the effected eye'. There was no information for staff to inform them which eye this was.
● One person was using a pain patch. The pain patch needed to be rotated so that it was not put on the same area of the person's skin for three to four weeks to reduce the risk of skin reactions. There was a body map in place to assist staff with this. However, there were no instructions for staff on how often to rotate the patch and the patch had not been properly rotated.
● Stocks of medicines were not well managed. There was a large amount of some medicines in stock in one cupboard, they were all mixed up together. We found some medicines in this cupboard were out of date.
● Some people were prescribed creams such as emollients to keep their skin healthy. These were all mixed together and stored in one basket in a bathroom. Staff told us they used people's creams for people they were not prescribed for.

The provider had failed to ensure there was proper and safe management of medicines. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was not clean. Areas of the service smelt offensive and there was faeces on a chair in one person's room. A laundry bag containing soiled washing was left open on the landing where it could be accessed by people. The walls of one lift was covered in carpet which was dirty and frayed. One staff member told us the lift was "an infection control nightmare". People were not always provided with their own hoist slings to reduce the risk of transfer of infection.
● We were not assured that the provider was using PPE (personal protection equipment) effectively and safely. Staff frequently wore face masks under their noses throughout the day. Discarded PPE was found on the floor and in uncovered bins.
● We were not assured that the provider was accessing testing for people using the service and staff. We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We asked to see evidence of covid-19 testing for staff but managers were unable to provide this. Some staff told us they were not using PCR tests regularly.
● We were not assured that the provider's infection prevention and control policy was up to date. Where staff were at greater risk of complications from covid-19 there were no risk assessments in place to address these risks.

The provider had failed to ensure there were systems in place to prevent, detect and control the spread of, infections. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors were asked to undertake a lateral flow test before visiting. However, the lack of staff testing meant there was an increased risk of visitors catching covid-19.
● We were assured the provider was facilitating visits for people living in the service in accordance with the current guidance.

Learning lessons when things go wrong

● There was not an effective system to record and monitor incidents to reduce the risk of re-occurrence. Prior to the inspection on 05 November 2021 an incident had been reported to the local authority by staff at the service. The incident related to an event where one person had allegedly hit another. Staff told us about another recent incident where the person had hit a member of staff. We asked to see the incident reports for the person, the inspector was told there were no records of incidents for this person and none were provided to us. One staff said, "No we didn't always document when someone was hit, we should have."

● Guidance for staff was not always in place after incidents had occurred to reduce the risk of events re-occurring. One person expressed emotion though behaviours that could cause harm to themselves, other people and staff. Following a number of incidents, the person was referred for mental health support. However, no support plan was put in place in relation to this to guide staff on how to reduce the risk. The notes from the mental health assessment stated staff were to continue checking the person every half hour. There was no evidence this was happening.

The provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● People were not well protected from the risk of abuse. There were a number of incidents which had not been reported to the local safeguarding authority when they needed to be. Opportunities to work with the local authority safeguarding team to reduce risks to people had been missed. Some staff told us about other safeguarding incidents they had witnessed but told us they had not recorded or reported these concerns.

● Staff did not always have the knowledge they needed to raise concerns. Some staff knew how to raise concerns about possible abuse. However, other staff did not know how to raise concerns outside of the service. Some staff did not know how to blow the whistle or escalate safeguarding concerns, if they needed to do so.

The provider had failed to ensure systems and processes were operated effectively to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the services provided and the risks relating to the health, safety and welfare of people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- At the last inspection there was not a robust system in place to monitor the safety and quality of service people received. At this inspection we found the same concern. For example, quality checks had failed to identify medicines were out of date, ensure standards of cleanliness were maintained, and risks to people were not well managed. Audits were not always in place. There were no recent audits of medicines and no audits for infection control. There were no risk assessments for potential hazards in the service. For example, in the dining room there was a portable heater, that was very hot to touch creating a scalding risk. There was no risk assessment in place for the heater, for example for people who were at risk of falling and burning themselves. We highlighted this to the managers who removed the heater.
- The service has been rated Requires Improvement in all domains at the last inspection. The standards of care had deteriorated to Inadequate. At the last inspection we reported a breach of Regulation 9 in the Responsive domain as sufficient consideration had not been given to activities for people living with dementia. The provider sent us an action plan detailing how they were planning to address this. However, the plan had not been effective, and the issue had not improved. During the inspection there were no activities for people and people were not being engaged or stimulated. One person said, "There isn't much to do here and I just sleep all the time."
- The culture at the service had not been improved and continued to lead to people not being treated with dignity and respect. At our last inspection we identified a breach of Regulation 10 in the Caring domain. We did not inspect the caring domain at this inspection. However, we found the same concerns. For example, staff walked into a bathroom without knocking whilst a person was receiving personal care. They stood in

the doorway and talked to staff whilst holding the door open, so the person was on view. One staff loudly asked another person if they needed the toilet. The person was upset by this and said, "Don't shout it to everyone."

● A number of permanent staff had recently left. Moral was not good amongst some of the remaining staff. One staff said, "We are over worked, we are not being listened to. Our opinions are not been taken into account." Other staff comments included, "I don't think it's particularly great here. We don't know where this service is going so how do the residents know? They are very uneasy about what's going to happen." And, "I am just finding I am just so tired, I'm trying to do everything and I can't do it."

● There was a lack of clear oversight and provider leadership at the service. The registered manager had left the service the week before the inspection. There were four interim managers in place. The provider and the managers had met to discuss concerns at the service. However, there were no records of what concerns were discussed and no robust action plan in place to address any concerns. One person said, "I have no idea who the manager is, I never see them, they never pop up and say who they are."

● Record keeping at the service was poor. For example, care plans and risk assessments were not accurate or up to date. One person had a choking risk assessment that detailed they were at low risk of choking. However, their speech and language assessment detailed that they needed thickened fluids which was not included in their care plan. Records of incidents were not complete. There was no information on what action had been taken following some incidents. A number of incidents records stated the action was to inform a senior. However, they did not record what action was taken to reduce the risk or whether relevant parties were informed.

● Staff told us some incidents had not been recorded. Therefore, we could not be assured that the provider had complied with the requirements under the duty of candour. Incidents were not always analysed for trends to identify patterns and take action to reduce these. For example, there was no analysis of incidents of behaviour that occurred between people.

● Staff had made some referrals to health care professionals when people's needs changed, However, recommendations made by professionals were not implemented. For example, when someone was at high risk of harm professionals stated that 30-minute checks be completed on the person. We found no evidence of this happening.

The provider had failed to assess, monitor and improve the quality and safety of the services provided and the risks relating to the health, safety and welfare of people. The provider had failed to maintain accurate, complete and contemporaneous records. This is a continued breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● CQC had not been informed in a timely manner about incidents and safeguarding's that had occurred at the service as required to do so by law. For example, CQC had not been notified when there were safeguarding incidents between people.

The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event.

The enforcement action we took:

We took enforcement action against the provider to cancel the registration of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. The provider had failed to ensure there was proper and safe management of medicines. The provider had failed to ensure there were systems in place to prevent, detect and control the spread of infections. The provider had failed to ensure they had met the requirements of Regulation 12(3) in regards to ensuring vaccination (or exemption) was a condition of staff deployment.

The enforcement action we took:

We took enforcement action against the provider to cancel the registration of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were operated effectively to investigate any allegation of abuse.

The enforcement action we took:

We took enforcement action against the provider to cancel the registration of the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services provided and the risks relating to the health, safety and welfare of people. The provider had failed to maintain accurate, complete and contemporaneous records.

The enforcement action we took:

We took enforcement action against the provider to cancel the registration of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe recruitment procedures were established and operated effectively.

The enforcement action we took:

We took enforcement action against the provider to cancel the registration of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably competent and experienced staff were deployed.

The enforcement action we took:

We took enforcement action against the provider to cancel the registration of the service.