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Elliott House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on 28 and 29 April 2015 and was unannounced.

Elliot House Care Home provides accommodation for up to 71 people who need support with their personal care. The service provides support for older people and people living with dementia. The service is a large, converted property. Accommodation is arranged over three floors. A shaft lift is available to assist people to get to the upper floors. The service has single and double bedrooms, which people can choose to share. There were 51 people living at the service at the time of our inspection.

A registered manager had not been working at the service since November 2014. Before our inspection we had received an application from the registered manager to cancel their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run. A new manager began working at the service on 3 March 2015 but was not registered with CQC

Summary of findings

We last inspected Elliott House Care Home in August 2014. At that inspection we found the provider and registered manager had taken action to meet regulations that they were not meeting at our inspections in October 2013 and January 2014.

The service lacked leadership and direction. An acting manager had been working at the service since March 2015. There was a lack of leadership and oversight by the provider and acting manager and this had impacted on all areas of the service. Many staff had resigned and the remaining staff were demotivated and did not feel supported by the provider or acting manager. They felt the acting manager was not approachable and some staff did not feel confident to raise concerns they had. Staff felt they were blamed for anything that went wrong at the service. Processes were not in operation to learn from mistakes and use this to continually improve the service.

A system to make sure there were enough staff available to meet peoples' needs at all times was not in operation. The acting manager had used agency staff to increase staffing levels the day before our inspection. The agency staff did not know people or their needs. The time of staff shifts had changed to make staff breaks easier to manage. The needs of people using the service had not been considered when this decision was made. Staff did not have time to spend with people and people received little interaction from staff during the day. Staff were unclear about their roles and responsibilities. The staff's view of their role was different from that of the acting manager.

Staff recruitment systems were in place and information about staff had been obtained to make sure staff did not pose a risk to people. Disclosure and Barring Service (DBS) criminal records checks had been completed.

Information had not been provided to people and their relatives about what was included in the fees they were paying for their care. People and their families had recently been asked to provide goods and services previously supplied by the provider at no additional cost. Relatives did not know if the agreement with the provider had changed or not as they did not have a copy of any agreement or contract.

Staff were not supported to provide quality good care. The provider and acting manager did not know what training staff had completed and what skills and experience they had. A training plan was not in place to keep staff skills and knowledge up to date. Staff did not have the opportunity to meet with a senior staff member on a regular basis to discuss their role and practice and any concerns they had. Agency staff were not accountable to anyone at the service for the care they provided.

Staff knew the possible signs of abuse; however they had not recognised when one person may be at risk and had not reported this to the local authority safeguarding team. Emergency plans were in place, but the acting manager and many staff did not know that they existed. Equipment and plans were not in place to evacuate the building in an emergency. Agency staff had not been told what they needed to do to keep people safe.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider and staff were unclear about their responsibilities under Deprivation of Liberty Safeguards (DoLS). The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. The acting manager did not know that DoLS authorisations were in place for at least five people. Care had not been planned to keep these people safe and to ensure restrictions were kept to a minimum. Systems were not in operation to obtain consent from people or those who were legally able to make decisions on their behalf. The provider had failed to act in accordance with the Mental Capacity Act 2005.

The care some people needed had not been assessed; other people's assessments had not been reviewed. Care had not been planned and reviewed to keep people safe and well and to meet their needs. This included changes needed when people were eating and drinking less. Agency staff did not know people and the care they required. Information and guidance was not provided to them to make sure they provided the care people needed in the way they preferred. People and their relatives had not been involved in planning and reviewing their care.

People did not always get the medicines they needed they needed them to keep them safe and well. The provider's medicines management policy and procedures was not in line with current legislation and guidance.

Summary of findings

Action was not taken to identify changes in people's health and obtain the care and treatment people needed to keep them as safe and well as possible. People who had lost significant amounts of weight had not been referred to their doctor or a dietician.

People told us that they did not particularly like the food and that it was often cold. Food was prepared to meet some people's specialist dietary needs. People had lost weight and they had not been referred to appropriate health care professionals for advice and support.

People were not offered choices in ways that they understood. Some staff listened to people and respond appropriately, other staff did not. People were not always treated with respect and their privacy and dignity was not maintained.

People were not supported to continue with interests and hobbies they enjoyed. People told us they were bored and wanted things to do and people to chat to.

People and their relatives had raised concerns and complaints about the service. These had not been logged or investigated and people had not received a satisfactory response.

The provider and acting manager were not aware of the shortfalls in the quality of the service we found at the inspection and had not completed regular checks of the quality of the service provided. The provider had not obtained information from people and staff about their experiences of the care.

Dining rooms were not big enough to accommodate the number of people using the service and people were cramped and at risk of knocking into other people or furniture. The environment had not been designed to make sure that people could find their way around easily. Some equipment provided, such as chairs, did not support people to remain independent and safe.

Records were kept about the care people received and about the day to day running of the service. Some records were not accurate and did not provide staff with the information they needed to assess people's needs and plan their care.

The registered provider had not notified the Care Quality Commission of significant events that happened at the service. During our inspection the provider made a commitment not to admit any new people into the service until the concerns around staff and their knowledge and skills had been resolved.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this provider is 'Inadequate'.

Summary of findings

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.

Staff knew the signs of abuse, but had not reported some potentially abusive incidents appropriately.

There were not enough staff with the right skills and experience to meet people's needs and provide their care safely.

Emergency plans were not in place. Premises and equipment did not help people to remain as independent as possible.

People did not always have the medicines they needed to keep them well.

Is the service effective?

Inadequate

The service was not effective.

People's ability to make decisions had not been assessed. People were deprived of their liberty but this had not always been assessed and authorised.

Staff had not been inducted and trained to meet people's needs. Staff were not supported to provide safe and appropriate care to people.

People did not have the support they needed with their health needs.

People told us they food was bland and hot food was often served cold.

Is the service caring?

Inadequate

The service was not consistently caring.

Some staff knew people well and were caring. Other staff did not know people's names and did not take time to listen to what people had to say.

People were not always treated with dignity and respect.

The routine of the service was rigid and not flexible to people's preferences.

Some staff did not maintain people's privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans had not been updated when people's needs changed.

People were not supported to take part in activities they enjoyed, inside and outside of the service.

The provider's complaints procedure was not followed. Complaints were not logged and people did not receive a satisfactory response.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The provider and acting manager did not have a clear set of values, including involvement, equality and safety for the service.

There was no leadership and staff were demotivated. Staff's view of their roles and responsibilities was different to the acting manager's.

Checks on the quality of the service had not been completed. People, their relatives and staff had not been asked about their experiences of the care.

Records about the care people received were not accurate and up to date.

Elliott House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 and 29 April 2015 and was unannounced. The inspection team consisted of three inspectors, a pharmacy inspector, a specialist professional advisor, whose specialism was in the care of people with dementia and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A pharmacy inspector was included in the inspection team as we had received some concerning information regarding the management of medicines.

We asked the provider to complete a Provider Information Return (PIR). We did not receive the completed PIR from the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. Before our inspection we spoke with people's relatives and whistleblowers who contacted us to share concerns they had. We also met with the local authority safeguarding team.

During our inspection we spoke with 15 people, four people's relatives and six staff. We looked at the care and support that people received. We looked at people's bedrooms, with their permission; we looked at care records and associated risk assessments for six people. We observed medicines being administered and inspected medicine administration records (MAR). We looked at management records including seven staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the support provided to people in the lounge of the dementia unit on the first day of the inspection and first floor lounge on the second day of our inspection. We used the Short Observational Framework for Inspection (SOFI) because many of the people receiving care at the service were living with dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We last inspected Elliott House Care Home in August 2014. At this time we found that the registered provider and manager had taken action to comply with the regulations.

Inadequate

Is the service safe?

Our findings

People did not always feel safe at the service. One person told us, "I am worried because all the staff are leaving." Another person said, "Staff come quickly if I press the buzzer."

The provider and acting manager did not have a process to help them decide how many staff were required to keep people safe and meet their needs. Before our inspection we received information from whistleblowers that the acting manager had reduced the number of staff providing care during the day and the night. A week before the inspection the acting manager contacted us stating that the service was, 'in dire straits' as many of the staff, including care and housekeeping staff, had resigned and were no longer working at the service. She told us that she previously reduced the number of staff working on each shift but planned to increase the number of staff the following week to cover the shortfalls. Agency staff were used to increase the number of staff working on each shift. The number of staff on each shift had been increased by either one or two staff. Staffing levels were not consistent across the week. Rotas for the week following our inspection had not been completed and staff did not know when they would be working next.

People had to wait for the care they needed. One person told us that on occasions they received their 7am medicine after 8am as a staff member with medicines administration training was not on duty at night. At lunchtime people had to wait for their meal as there were not enough staff to support people to the dining room, serve people and support people to eat. People who required support with their meals did not receive the supported they needed. People struggled to cut their meals up and staff left other people in the middle of their meal to support others. People sat for long periods of time in the dining room without their meal. One person asked staff, "Why am I here, have I had my meal? What am I waiting for?"

The acting manager had not considered people's needs or the layout of the building, when deciding how many staff to deploy at different times of the day. Previously morning shifts had started at 7:30am to support people to get up when they wanted. Afternoon shifts had ended at 9:00pm to support people to go to bed when they wished. The acting manager had changed the shift pattern from 8:00am to 8.00pm, and many staff were working 12 hour shifts. The change had been made so that staff breaks were shorter and could be managed more easily. People's needs and wishes had not been considered as part of the decision making process that led to the change.

Cover for staff sickness and vacancies was provided by other staff members on occasions, but more frequently by agency staff. Five agency staff had been working at the service for over a year and knew people well. Staff told us these agency staff worked as part of the team, took responsibility for tasks allocated to them and knew the routines of the service. Two of these agency staff no longer worked at the service and the amount of time the other three agency staff worked at the service had reduced. The acting manager told us that this decision was made by the agency based on the acting manager reducing the number of hours they commissioned.

Staff supplied by a different agency were working at the service at the time of our inspection. At least one agency staff member had not worked at the service before, others had only worked at the service once before. The acting manager did not know what qualifications, competencies, skills and experience they had. These staff had not received information about the people they were caring for or the routines of the service. One person told us, "It would be helpful if staff wore name badges so we know who is who. I suppose that would be difficult with a number of staff changes we have here." People's relatives told us before and during the inspection that they were very concerned that their relatives were not getting consistent care from staff who knew them well. They told us that consistency was very important to their relatives and helped them to feel safe and secure at the service.

Staff were allocated tasks to complete during each shift, such as assisting people to leave the dining room after breakfast. These tasks were not allocated based on staff competency and knowledge of people's needs. We observed one member of agency staff supporting two people to return to the first floor in the lift after lunch. One person was in the lift and was complaining that the second person's wheelchair was digging into their leg as they were moved into the lift behind them. The staff member lent over the person using the wheelchair to move the first person's zimmer frame. The person became very distressed. We asked the staff member to remove the person in the wheelchair from the lift as we were concerned about the safety of both people involved. The

Is the service safe?

staff member's actions had put both people at potential risk. We informed the acting manager of the incident during the inspection. The staff member did not know that it was not possible for one person with a zimmer frame, one person in a wheelchair and themselves to use the lift safely and did not recognise that this placed people at risk.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep people safe and meet their needs. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew the signs of abuse, such as bruising or a person being withdrawn. They knew how to raise their concerns with relevant people, such as the acting manager and the local authority safeguarding team. On occasions staff had not recognised that people were at risk of harm. A record in one person's care notes showed they had been 'hit' by another person who used the service. This had not been reported to the acting manager or to the local authority safeguarding team. The incident had not been investigated to make sure that both people were safe. Another person had complained to a staff member about the way they were being treated by staff on two occasions. This was not reported to the acting manager and no further action had been taken.

Staffs' understanding of safeguarding had not been checked to make sure they had the knowledge they required to keep people safe. The provider had failed to protect people from the risks of abuse. This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fire safety plans were in place for each person including how many staff were required to move them to another place of safety in the building. Plans were not in place to evacuate people from the building in the case of an emergency. Equipment was not available to move people downstairs when the lift could not be used, such as in the event of a fire. The acting manager did not know if staff had received fire safety training and had not taken action to assess staff's competence. We reported our concerns to the local fire and rescue authority.

Contingency plans were in place with the aim of keeping people safe in certain circumstances, such as if the phone was out of order. The provider had not reviewed the plans to make sure they remained current. The acting manager and other staff were not aware of these plans and did not know what arrangements were in place to keep people safe. Plans were not accessible to staff in an emergency. Staff could not find the emergency procedures folder during our inspection. There was a risk that action would not be taken to keep people as safe as possible because the acting manager and staff did not know what action was required of them.

A call bell system was fitted in people's bedrooms and in communal areas. People did not always have the call bell within their reach in their room and were unable to call staff if they needed them. Call bells in communal areas were not accessible to people as they were behind furniture or out of peoples' reach. There were periods when no staff were in the lounges with people. People relied on staff checking on them or other people alerting staff to their needs to keep them safe. A staff member working on a lower floor had to go to an upper floor to respond to a call bell. They told us that the agency staff member working on the upper floor was not responding to the call bells.

The provider did not have plans in operation to respond and manage major incidents and emergency situations such as fires and make sure people were safe and any risks to their care were minimised. This was a breach of Regulation 12(2)(i)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Moving and handling risk assessments were in place for people who needed support to stand and transfer. These had not been consistently followed. Staff were using a stand aid hoist to move one person. The person's risk assessment, last reviewed in January 2014, stated they could not weight bear. People need to be able to weight bear to safely use a stand aid hoist. The person was not weight bearing in the hoist and was slumped down in the sling in an uncomfortable position. Staff told us that the stand aid hoist was always used for the person. Agency staff did not know about people's mobility needs. We asked an agency staff member how a person they were working with moved around and were told "I don't know really, I haven't observed (them)." This was a breach of Regulation 12(2)(e)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not follow good practice when using hoists to move people. Staff moved the hoist with people in the attached sling, rather than moving the seat or wheelchair to meet the person. This made people sway about in the

hoist sling and some people cried out and appeared anxious. Staff prepared one person to be moved using the hoist by moving them in their chair and putting a sling behind them. They did not tell the person what they were doing before they moved them. Staff moved the hoist and attached the sling to it, they were unable to move the person as the hoist battery was flat. The hoist was then removed and the person was left waiting whist another working hoist was found. The person was concerned about what was happening.

Some people regularly refused personal care or became agitated while staff were providing their care. A risk assessment for one person refusing personal care had been reviewed in February 2014 but was not easily available to staff as it was stored in another part of the service. The risk assessment instructed staff to leave and return later or to try a different staff member. Staff were not aware of the instruction in the risk assessment and told us, "Different staff all do it differently."

Accidents involving people were recorded. Incidents were not recorded. Accidents had not been reviewed to look for patterns and trends so that care may be changed or adjusted or advice sought. One person had fallen three times in 10 days. Their GP had visited following one fall but a falls assessment and support from appropriate health care professionals had not been requested. A 'handover' system was in operation at the beginning and end of each shift. Staff were informed of changes in the way risks to people were managed at the handover. Handovers were also recorded so staff could catch up on changes following leave or days off.

The provider had failed to assessed and mitigate risks to people. Plans for managing risks were not available to staff and staff did not follow them. This was a breach of Regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance and refurbishment plans were not in place for the building, grounds or equipment. Maintenance staff were employed to complete day to day maintenance work, including checks of the building and equipment. Hot water temperatures at sinks were check regularly to make sure that people were not at risk of scalding. The temperature of hot water taps on baths was not checked. Staff told us they tested the temperature of baths with their elbow before people used them. This process was not reliable to manage the risk of people being scalded in the bath.

People could not use the garden without the support of staff or their relatives because it was not secure. The garden was not secure and people living with dementia did not use it. The acting manager had changed the areas staff and people used to smoke as people's relatives had complained about having to walk through smoky areas to use the garden with their relatives.

People were able to choose where they ate their meals, if there was enough space. Both dining room areas were very crowded with people bumping into each other and furniture. On the second day of our inspection one person wanted to eat their lunch in the large dining room with other people but there was no room for them. Staff sat the person in an armchair in the corridor outside of the dining room on their own to eat their meal. The person did not look comfortable.

All the lounges contained low level wicker chairs. People appeared to have difficulty getting out of these chairs on occasions. They were not designed for use by people who had difficulty standing and sitting. The covers were difficult to keep clean and plastic bags had been placed under the covers to protect the cushion underneath. The dining room chairs did not have arms on them, again some people had difficulty sitting and standing from these chairs unaided as they had nothing to hold on to.

The environment had not been designed to support people living with dementia to remain as independent as possible. Some people had pictures and names on their bedroom doors to help them, and staff, identify which was their bedroom, other people did not. Consideration had not been given to the décor of the premises to support people to safely find their way.

Dining rooms were not big enough to accommodate the number of people using the service. Some people could not find their way around the premises easily. Some equipment provided, such as chairs did not support people to remain independent and safe. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment systems protected people from staff who were not safe to work in a care service. Sufficiently detailed information about staff's previous employment had been obtained. Staff conduct in previous social care employment had been checked. Disclosure and Barring

Inadequate

Is the service safe?

Service (DBS) criminal records checks had been completed for staff. Information about applicant's physical and mental health had been requested. Other checks including the identity of staff had been completed.

Systems for ordering, checking orders received, disposal and administration of prescribed medicines were in place. Before our inspection we received information regarding five people, whose medicines were not given to them for a period of time varying from 11 days to 27 days. These medicines had been ordered, but action had not been taken to obtain the medicines when they were not received. There was a gap in the continuity of treatment as medicines were not received in time. Action had been taken on the advice of visiting health care professionals and people had been reviewed by their doctors to make sure they were safe and well. The local authority was completing a separate safeguarding investigation into the concerns about missed medicines.

On the second day of our inspection one person's pain relief medicine was not in the service. They were given a pain medicine out of the homely remedy supply at the service. Staff had not recognised that the person's medicine was out of stock and contacted the person's doctor to requested a prescription for this medicine. They took this action during our inspection.

Some staff knew the signs that people may be in pain and offered them pain relief. Senior care staff had a good understanding of safe medicine management. They were knowledgeable and able to explain the action they would take to manage medicines safely. In practice we noted poor management of medicines that placed people at risk of potential harm.

Until recently senior care staff had completed daily medicine checks to quickly identify any shortfalls in the management of medicines. Two members of staff told us separately that they were told not to complete these anymore. The acting manager said this was not the case. The result of this miscommunication was that concerns such as missing medicine supplies and poor record keeping were not identified on a daily basis and so action had not be taken to address the issues.

The provider's medicines management policy and procedures was not in line with current legislation and guidance. Action had not been taken to ensure people had the medicines they needed when they needed them to keep them safe and well. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People were offered choices by some staff in ways that they understood. Staff did not consistently respond to the choices people made. Some staff did not know people and did not listen or understand what people were telling them. People were able to choose where they spent their time and who with.

Some people were able to make decisions for themselves about all areas of their life. They were supported to do this by staff who knew them well, but not by agency staff who did not know them. Staff and people's relatives told us that other people were not able to make complex decisions for themselves and some people were unable to make simple decisions. Assessments of people's capacity to make individual decisions had not been completed. The provider did not have a system in place to assess people's ability to make specific decisions, when they needed to be made.

Some people were unable to express themselves verbally. Ways to help people to communicate had not been explored and staff did not demonstrate that they understood how to communicate effectively with people living with dementia. Guidance and information had not been provided to staff about how to engage with people. There was a risk that staff would not understand what the people were saying and that they would not be supported to make decisions when they were able.

Staff's understanding of the requirements of the Mental Capacity Act 2005 was not consistent. The acting manager did not know if staff had received training in relation to the Act and had not checked their understanding or application of the Act to make sure it was lawful. Staff were not clear about their responsibilities to assess people's capacity to make decisions. Some staff said they would rely on a senior staff member to do an assessment, whilst other staff said they would assess a person's capacity themselves by asking them some basic questions not related to the decision. Senior staff understood the legislation, but were not clear who would be responsible for assessing people's capacity to make decisions.

One general capacity assessment had been completed for most people in relation to making the decision to go out in the community. This had not been reviewed they were written in July 2014. There were no capacity assessments in relation to people who were living with dementia for whom staff said making everyday decisions was difficult. Many staff did not know who could lawfully make decisions on a person's behalf in the person's best interests. One person's relatives told us they had a legal authority to made decisions about their relative's care, in their relative's best interests, and had been involved in making some decisions. However, they had not been involved in making other important health care decisions, including if the person received a flu vaccination.

Some people had a 'Do not attempt cardio pulmonary resuscitation' (DNAR) orders in place. Three people had not been involved in making the decision about not being resuscitated because they lacked capacity. The decision had been made by their GP or hospital based doctor without the involvement of the person or their family. Capacity assessment had not been completed to show how the person's capacity had been assessed. Staff were unclear about who would be responsible for carrying out the assessment. The orders had been in place for over a year and had not been reviewed to make sure they remained relevant and still in line with people's wishes.

The provider did not have processes in place to make sure that care was only provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The service was not meeting the requirements of DoLS. The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. Staff were unclear about their responsibilities under DoLS. Assessments of the risk of people's liberty being restricted unlawfully had not been completed.

People were subject to continuous supervision and were not free to leave. Therefore their liberty was restricted. The acting manager and staff did not know if applications to deprive people of their liberty had been made to the local authority DoLS Office, to ensure the restrictions were legal.

Inadequate

Is the service effective?

Five people living in the dementia wing had DoLS authorisations in place; the acting manager was unaware of these. Care for people with a DoLS authorisation in place had not been planned to support them to be as independent as possible and remain safe. One authorisation had conditions requiring the staff to make sure that restrictions were not excessive. The acting manager and staff did not know that the authorisation had conditions on it and had not acted to ensure that restrictions were not excessive.

The provider had failed to act in accordance with the Mental Capacity Act 2005. The risk of people being unlawfully deprived of their liberty had not been assessed. Where people had a Deprivation of Liberty Safeguard authorisation in place the provider had not planned their care to manage the risks of excessive restrictions on their liberty. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff employed to work at Elliott House before 2015 had received an induction when they started work there to get to know the people and the care and support that they needed. The acting manager, deputy manager and other new staff including housekeeping staff had not completed an induction to ensure they knew and understood their roles and responsibilities. Agency staff had not completed an induction or received any information about people to make sure they knew the care and support people needed. The deputy manager told us, "We try to pair them up with Elliott House staff where we can." We found that this system was not working, for example on the middle floor one member of permanent staff was working with two agency staff who did not know people. It was not possible for the permanent staff member to pair up with both agency staff and so one agency staff member worked alone.

Three new housekeeping staff were working at the service during our inspection. They had been working at the service for one or two days. They had not completed an induction. The acting manager told us it was the responsibility of the head of housekeeping to complete the new staff's induction. The head of housekeeping was not working at the service at the time of our inspection and was due to start the following day. Housekeeping staff told us they had received brief information about health and safety and the use of cleaning chemicals, but did not have a schedule to work to and did not know what was required of them. One housekeeper told us 'I'm not 100 percent sure what I'm doing. We're all in a bit of a muddle as we are all new. We are finding our way about and doing what we can." Care staff had not completed an induction that followed the Skills for Care, Care Certificate standards to make sure new staff were prepared for their role.

The provider did not have a system in place to ensure staff received the training they needed to perform their duties. There was no training plan and the acting manager did not know what training staff had completed or when. Evidence of the training staff had completed, such as training certificates had not been maintained and the acting manager had requested that staff bring copies of any training certificates they had into the service. These were not in the service at the time of our inspection.

Assessments of staff competencies and skills to complete specific tasks had not been completed. The provider and acting manager did not know if staff had the competencies, skills and experience required to meet peoples' needs.

The acting manager had not followed the provider's procedures to support staff, including supervisions. Staff told us they did not feel supported by the acting manager to deliver safe and effective care. Staff had not met with the provider or their management team regularly to talk about their role and the people they provided care and support to. Development plans were not in place to support staff to develop their skills, knowledge and experience. Staff were not supported to identify areas where their practice required improvement. Steps had not been taken by the provider to support staff to develop the attitudes and behaviours they needed to complete their role.

Staff were supported, skilled and assessed as competent to carry out their roles. Staff had not received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not been consistently supported to maintain good health. One person told us, "If we need to see a doctor for something, it is days before he appears. It is difficult to see a doctor." People were not supported to see health care professionals such as their GP as soon as they needed them. One person had informed night staff that they had a sore eye in the middle of the night. They

reported their sore eye to staff again the following morning. No action was taken until the following day when an appointment was made for a doctor to visit them. There was a delay of over 24 hours between the person reporting their concerns to staff and their GP being contacted.

One person had lost their dentures in February 2015. Appointments were made for them to see a dentist, but these were cancelled by staff for different reasons. The person saw the dentist at the end of April 2015. They were awaiting their new dentures at the time of our inspection. The missing dentures meant that the person was unable to manage their usual choice of meals and so they had to have softer foods. Their risk assessment and care plan had not been reviewed and amended to reflect their change in needs. On the day of the inspection the person was struggling to eat gammon at lunchtime. They asked a member of agency staff for some additional cheese sauce to soften the meal. The agency staff walked away and then came back a few minutes later and removed the person's meal and threw it away without saying anything. The person did not eat the meal, but ate a dessert. Staff had not reported that the person was struggling to eat to the cook. The person's food intake was not being monitored and records stated they were 'eating and drinking well.' The person had lost weight since the loss of their dentures.

People's day to day health needs were not met. Three people who needed glasses or a hearing aid had not been supported to wear these. Staff told us "The agency staff don't know these things, so we have to go back and do it all." One person had lost two pairs of glasses, which had been missing for two weeks. Staff said they just keep looking for the people's glasses when they go missing and people were "always losing their glasses." Action had not been taken to obtain a new pair of glasses for the person so they could see properly.

An optician visited occasionally to check people's sight. Staff informed people who had requested a doctor, when their GP was coming. One person who had been in hospital was advised to see their GP on their return to the service and this had happened.

One person was asleep during the morning of the inspection. Care records showed they were regularly asleep during the day, only waking to eat and drink. Their GP had reviewed their medication in July 2014 and reduced the dose as it was making the person drowsy. Staff did not know if the person's drowsiness had been investigated further and had not requested a further GP review.

People's skin health had been assessed and pressure relieving equipment was available to people who needed it. Some people needed to change their position regularly to keep their skin healthy. People were not consistently supported to be repositioned as required. One person's care plan stated they should be repositioned every two hours. The person spent the morning sitting in armchair and was not moved until after lunch. Staff had recorded that they repositioned the person during this time. They later confirmed to us this had not happened and that they had made an error in the records. The person was at risk of skin damage and this risk was increased by the lack of support to be regularly repositioned.

The provider had failed to make sure that people received appropriate care and treatment to meet their needs. This was a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not enjoy the food at the service. One person said, "The food is very bland. All the food here tastes the same". People asked staff for salt and pepper for their meals at lunchtime. Another person said, "So much food is wasted because it is not very nice and the meat is always tough, which means it is either cheap or not cooked well". Everyone we spoke with complained that food was served cold. One person commented, "I can't understand why they have to serve cold food, there is no need for it". One cook had recently left the service. A second cook was covering their work but did not know who would cook the meals when they had a day off. One person said, "Someone said the cook left last week, but if today is anything to go by, this one doesn't seem any better. Something ought to be done about it".

People's weight was recorded. People's weights were not monitored to identify any weight loss. One person did not eat their meal on the second day of the inspection. Staff recorded the person was 'eating and drinking well' on that day. In March 2015 staff identified that the person had lost a significant amount of weight over five months and recorded that they needed to be referred to a dietician. This did not happen and the person had lost a further 5.6kg. Other people had also lost weight. One person, who was at

risk of losing weight, had been prescribed a nutritional supplement. A food and fluid intake chart was in place to monitor the person's food and fluid intake. This had not been completed consistently which meant that the person's intake could not be monitored effectively and they continued to be at risk.

People who had difficulty swallowing or were at risk of choking were offered soft or pureed food. Foods were pureed separately and presented in an appetising way. People were able to taste the separate flavours of each food. Agency staff did not know who needed a soft or pureed diet and people were given food which was not suitable for their needs. One person who needed a puree diet was given a pudding containing pieces of fruit by an agency staff member, this put the person at risk.

People were offered a choice of food at each meal. If people did not like the choices offered the cook prepared an alternative of their choice. Most people chose the main menu choice each day. There was no choice of pudding.

Some of the meals were homemade such as cakes at tea time. People were offered regular drinks. Jugs of squash were available to people who could help themselves and at lunch time. Staff encouraged people to drink and hot drinks were offered to people mid-morning.

The cook understood the different diets people needed to keep them healthy. Low sugar varieties of the puddings were on offer, such as sugar free jelly and cakes. Some people needed food 'fortified' with additional calories as they were at risk of losing weight. Foods such as custard and mash potatoes were fortified with butter, eggs and cream for people who needed them. Meals were prepared to meet people's dietary preferences, such as vegetarian.

People's nutrition and hydration needs had not been regularly assessed and reviewed and action had not been taken to respond to people's changing needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People and their relatives told us that some staff were "very caring" and "kind". Staff who had worked at the service for a while knew people well, their likes and dislikes, their preferred names and how they liked things done. Some agency staff did not know people's names, or how they preferred their care to be provided. We observed staff and people in the lounges and dining rooms, some staff spoke and joked with people individually and people laughed and smiled back.

Some agency staff did not take time to listen to people and to check their understanding of what they had said. One person reached out towards a staff member standing near them. The staff member held their hand for a moment, but did not go down to their level to make eye contact or speak with them. The staff member then let go of the person's hand and walked away without saying anything. An agency staff member poured a person a glass of water. The person said they did not want water. The staff member offered the person orange or blackcurrant squash. The person kept saying they could not hear what the staff member was saying. The staff member walked away leaving the person with the water.

Some staff were indifferent to people and concentrated on completing tasks rather than caring for people. Agency staff did not chat to people while supporting them at lunchtime, they stood over people waiting for them to finish eating and cleared people's plates without talking to them. Other staff treated people with kindness and compassion. People appeared relaxed in the company of these staff, and told us they were "lovely". Staff reassured one person who said they were frightened. Staff said, "Don't worry, there is nothing to be frightened about, let's make a nice cup of tea and have a chat." They then spent time with the person chatting.

Some people and their relatives had been asked for information about their life before they moved into the service. Two people's relatives told us that they had provided information about people's lives. This information had not been used to plan people's care and was not accessible to staff. People had not been supported to express their views about the care and support they received and had not been given the opportunity to share their views about staff with the provider.

Staff told us they had previously worked to a flexible routine, which responded to changes in people's needs and to their requests. Staff told us the routine of the service was no longer flexible but was rigidly designed to meet people's basic care needs. Two staff told us at 11:20am, "We have to take all these people to the toilet by 12 o'clock. Some people need two staff to help them." There were twelve people in the lounge who staff planned to support to the toilet in 40 minutes. Staff rushed from one task to the next and did not have time to spend time with people. One staff member told us, "We are not carers anymore, I feel like a robot".

People were not always treated with dignity and respect. Some staff asked people quietly about personal matters, such as using the toilet, other staff did not. Several agency staff told people in loud voices in front of other people and visitor's, "I'm going to take you to the toilet. We are going to the toilet." Some people did not have privacy. Screens were not used to maintain people's privacy and dignity when they were being hoisted in lounges. Some staff did not knock on people's bedroom doors before entering their room.

Personal, confidential information about people and their care and health needs was kept in communal records. The acting manager had not considered how the confidentiality of one person could be maintained when visitors, such as health care professionals or family members viewed another person's records. People's personal information was accessible to other people and visitors to the service.

Staff sat next to people while supporting them to eat a meal. Some staff chatted to people as they helped them, other staff did not. People were not provided with information about what they were eating and were not asked if they would like any support. One agency staff member was sat between two people who needed support to eat. Another agency staff member asked if they needed any help. They responded "No, I'll do them both". This was not respectful and the people did not get the individual support and attention they needed to eat their meal.

Some staff showed genuine affection for people and people responded in a similar way. One staff member described to a person clearly and discreetly what they wanted the person to do, saying, "Come with me to the toilet as I have your cream to put on." The person responded by kissing the staff member and rubbing their hand saying it was cold.

Inadequate

Is the service caring?

Staff gave people their medicines in a caring manner and engaged with people whilst they took their medicines. However, staff did not always consider people's dignity when giving them their medicines. One person was given their eye drops while they were eating their lunch, in the crowded dining room. The person appeared use to this and happily tilted their head back for the eye drops.

Information was not provided in ways that people, including those living with dementia, could easy understand, such as large print and pictures. A calendar board was displayed in the hall way, this showed the wrong day and date. Some clocks had stopped and other showed the wrong time, making it difficult for people to know what time of the day it was. A menu typed in small print was on display hall way. The cook told us it was not the same menu as the one they had provided that day.

Some staff knew where people liked to spend their time and respected their choices. Other staff did not. Agency staff moved people in their wheelchairs around the service without speaking with them. People were placed in the lounges in their wheelchairs without being asked if that suited them.

There were no restriction on people's family and friends visiting the service. People and their relatives told us that they visited often.

People were not treated with dignity and respect at all times. This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People had not been offered the opportunity to look at their care plan and did not know if their care plan reflected their preferences.

Assessments of people's needs had been completed before they were offered a service. When people had specific interests these had been identified in their assessment, but the information had not been shared with staff to make sure they knew how to support people's interests. One person's pre-admission assessment stated they enjoyed watching sport on the television, but there was no care plan in place to inform staff what the person liked to watch and when and if they needed support to do so.

Further assessments of people's needs, such as assessments of their skin health and dietary needs had been completed once people began to use the service. These assessments had not been reviewed to ensure that any changes in people's needs were identified and the information used to plan people's care. Detailed assessments had not been completed for people who had moved into the service recently. Action had not been taken to find out about what these people were able to do for themselves and what support they needed from staff to keep them safe and healthy. One person's relative told us they and their relative had not been involved in developing the person's care plan and had not seen it. Another person's relatives told us their relative had been at the service for several years, but they had not seen their care plan for over a year and the person's needs had changed.

People's care plans had not been reviewed, to make sure they remained current. Care plans had been written by senior care staff for people who had recently moved into the service The acting manager did not know if care plans had been written for these people and did not know if they provided guidenace to staff about how to meet all their needs. People who were able, told staff what support they required and how they would like this to be done. Other people who had difficulty communicating their needs and preferences were not involved in planning their care.

People were not always happy with the support they received from staff. Most people accepted what staff did for them, however others refused the care and support offered to them. Care plans did not detail how to make sure people were offered support again after they had refused it.

Care plans included guidance for staff about how to provide people's care. One person's plan instructed staff to encourage the person to wear the correct footwear so that they did not fall and also to take a rest during the day as they were prone to falls when they were tired. Staff were unclear about where people's care plans were located and what they should be referring to, for guidance about how to provide peoples' care. Staff were not sure about what footwear the person should wear and that they should take rests during the day. Three staff told us that the care plans they had previously used were no longer in use as they were in the process of being updated by the new manager. They said a new record keeping system was in place to report on the care provided, but that they did not have current care plans to refer to. Staff worked from information recorded in daily notes, verbal information from other staff and their previous knowledge, if any, of the person.

Care was not provided consistently. Most people's plans stated they should be offered a weekly bath or shower, this did not happen. Staff told us that baths were carried out on a daily allocation basis and usually people had a bath every few weeks. One staff member said, "I just bath who I am told on allocation." One person's plan stated that they liked a shower once or twice a week. They had two baths between August 2014 and April 2015 and no showers. Staff told us that the person was, "encouraged to have a bath, but really they prefer a shower". Another staff said "X hates a bath, X prefers showers."

Peoples' care plans were not regularly reviewed to ensure they remained current. Action had not been taken when people's needs had changed to amend their care plan and inform the staff about the changes. Systems were not in place to review the care people had received to identify risks and changes quickly.

People using the service and the person who is lawfully acting on their behalf, were not involved in an assessment of their needs and preferences. Assessments had not been reviewed regularly and whenever needed throughout the person's care. Care plans were not updated with any changes in people's needs. This was a breach of Regulation 9(1)(a)(b)(c)(3)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

People had little opportunity to follow their interests or to take part in social or physical activities. People's relatives told us that people needed more stimulation and engagement from staff. They told us that simulation was essential to their relatives staying active and well.

No activities or social contact were available for some people and there was a risk that they were isolated or lonely. One person told us, "It is so boring. I wish they could find someone who would have a game of cards or draughts with me. Even in prison there are recreational activities, why not here?" People did not have the opportunity to go out unless they had family or friends to support them. Activities were not available for people to participate in when they wanted to, people relied completely on staff to keep them occupied and stimulated. Some staff did not have time to spend with people. Agency staff did not speak with people when they had the time to do so. We observed two agency staff sitting in the upstairs lounge with people for approximately 15 minutes. The staff did not speak to the people, everyone sat in silence.

The majority of people spent their time in the lounges with the television on. One person told us, "There is nothing to do. The television is on but the programmes are not interesting for us. The staff never ask us what we want to watch". Many people spent their time doing nothing. An activities coordinator worked at the service on two mornings a week and spent time singing with people in one lounge on the second day of our inspection. People in the dementia wing, the upstairs lounge and their bedrooms did not take part in the activity.

In the dementia wing lounge we observed that people spent the mornings looking around and watching staff walking through the lounge. One person had a doll which they kissed and cuddled and showed to the person sitting next to them. They let the person kiss the doll too and they had a 'conversation' between them. In the afternoon on the first day of our inspection, staff gave people instruments, such as bells and encouraged people to 'play' them in time with music on the radio. People were unable to do this and stopped participating. The staff member did not adjust or change the activity until another staff member began to play catch with people which they enjoyed.

People told us that they would like to vote in the upcoming general and local elections. Staff had not asked people if they would like to vote, arranged postal votes and people did not have polling cards. The acting manager had not considered that people wanted to vote. People had lost their right to vote in the general and local elections if they wanted to.

Participation in meaningful activities during the day promotes people's health and mental wellbeing. The registered provider had not supported people to be involved in their community as much or as little as they wished. The provider had not made sure that people were not left unnecessarily isolated. This was a breach of Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about how to make a complaint was displayed. In the dementia wing information was available in a way that people could easily understand. The provider and acting manager had not taken action to encourage and support people and their families to raise concerns, make complaints and give feedback about the service. People's relatives had made complaints to the provider and acting manager. These had not been recorded and action had not been taken to address people's complaints to their satisfaction.

A process to respond to complaints was in place; however the acting manager did not follow this. Staff recognised when people had made complaints about the service. Previously these had been recorded in the complaints log and had been followed up. The complaints log was no longer being used by staff. Staff had recorded complaints they received from people in the handover records, but were not confident that action had been taken to investigate and resolve people's concerns. The provider had not recognised that the acting manager was not following the policy or that people's complaints had not been addressed.

The registered provider had not established an effective system for identifying, receiving, recording, handling and responding to complaints by service users and others. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

An acting manager had been managing the service since the beginning of March 2015. They had replaced the registered manager who had not been working at the service since November 2014. The acting manager had not introduced herself to some people and their relatives. One person and their relative told us, "I understand there is a new manager here. We haven't met her yet and don't even know her name". The acting manager held two meetings to introduce herself to people's relatives on 31 March and 2 April 2015. People's relatives told us they had attended the meeting and had asked for a copy of the minutes but had not received them.

The acting manager had made a number of changes to the way the service operated. Changes were communicated to staff in memos. One staff member told us, "Nothing is negotiable; the manager has told staff if we don't like the changes we can leave." Staff did not know what the acting manager's vision for the service was and did not know why the changes had been made. Values such as involvement, compassion, independence and respect were not central to everything the acting manager did.

The provider and acting manager were not leading the staff team or managing the service on a day to day basis. Management roles and responsibilities had been taken on by a deputy manager and senior care staff in the absence of the registered manager. The deputy manager and several senior care staff had resigned since the beginning of March 2015. The remaining senior care staff, had been given an increased number of management tasks and responsibilities, including monitoring people's care and the day to day management of staff. The senior care staff did not have the time to complete all the duties required of them and to provide direct care to people. This meant that some tasks were not being completed, including following up medicine orders when they were not received.

Shifts were not planned to make sure that agency staff were supported by permanent staff to make sure people had the support they needed from staff who knew them. At lunchtime, people were supported by agency staff who did not know them and their needs while staff who knew people well completed paperwork in empty lounges away from people. Agency staff were not held accountable for the care and support they provided, such as supporting people to transfer safely, as they were not monitored or directed. The acting manager and deputy manager were not present in communal areas of the service during our inspection and did not show any leadership or support to staff.

Staff did not feel supported and appreciated by the acting manager and were required to make an appointment with the acting manager to discuss any concerns they had. Staff had not received positive feedback about their work. The poor standard of care provided by some agency staff went unchallenged. The provider and acting manager had not taken action to motivate staff to deliver a good quality service to people. Staff who had worked at Elliott House for a long time told us that they were motivated by the people they cared for but not by the provider or acting manager.

Staff had previously worked together as a team to support each other and provide the best care they could to people. Elliott House staff and agency staff were not working as a team and were not communicating with each other. Some agency staff did not listen and respond to the direction and requests of the permanent staff. One staff member asked a member of agency staff to assist a person to move to the dining room at tea time. The agency staff member did not respond to the request. The staff member asked the agency staff member several times and again received no response. A member of the provider's staff stopped what they were doing to assist the person to move to the dining room. This put additional pressure on staff and at times meant that people did not receive the care and support they needed.

The provider and acting manager did not have the required oversight and scrutiny to support the service. They had not taken action to monitor and challenge staff practice to make sure people received a good standard of care. Staff no longer had the confidence to question the practice of their colleagues. People's relatives and staff told us that the acting manager was not approachable or accessible and they had to make an appointment to speak to her. Staff told us that they did not tell the acting manager about situations that concerned them, including concerns about practice that might put people at risk of harm. They told us they were not confident the acting manager would listen to them and take action.

People and their relatives were not involved in the day to day running of the service. Systems were not in place to obtain the views of people, their relatives or staff to improve the quality of the service. People had not been

Inadequate

Is the service well-led?

asked for their views about the service they received or for suggestions about how the service could be improved. Staff had not been given an opportunity to tell the provider or acting manager their views about the quality of the service they delivered or make suggestions about changes and developments. Staff no longer felt involved in the development of the service and felt that their views were not valued.

Systems and processes were not in place to ensure that the service was of a consistently good quality. The provider and acting manager had not made it clear to staff what good quality care looked like and how it would be provided. They were not aware of the shortfalls in the quality of the service found at the inspection. Checks on the quality of the care people received had not been completed.

The daily medicine check did not include the actions taken to address any shortfalls found and was not used check if appropriate action had been taken. There was no process in place for the provider or acting manager to check for patterns in any errors or issues and to learn from this. The acting manager had not completed a medicines audit since they began working at the service in March 2015.

Staff were not supported by the provider or acting manager to keep up to date with changes in the law and recognised guidance. Staff were not aware of recent changes in health and social care law or the way that CQC inspected services. Some policies and guidelines for staff were available in the service, however the acting manager did not know what policies and guidelines were in place or how to use them.

The provider did not have systems and processes in operation to assess, monitor and improve the quality and safety of the service. Feedback on the service provided from relevant persons had not been obtained by the provider so they could use it to continually evaluate and improve the service. This was a breach of Regulation 17(2)(a)9e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate and complete records in respect of each person's care had not been maintained. Some people were at risk so staff needed to check on them regularly. Records of checks completed on people were kept. Some had not been completed and did not demonstrate that care had been provided. On one day of our inspection, nine records checked at 4:00pm showed that hourly checks had not been completed after 1:00pm. Other records were accurate showing the exact time night checks had been completed.

Records of what people had eaten were not accurate, and so could not be used to plan people's care. One person, who was at risk of losing weight, records said they had eaten well, when they had not eaten their lunch. People were at risk because decisions about their care were made based on inaccurate information.

Medicines administration records (MAR) contained gaps where staff had not signed to confirm that people had received their medicines. 'Post-it notes' were attached to MAR with gaps and were marked 'to sign'. These records should be signed at the time the medicine is given. There was a risk that the MAR charts were not correct and health care professionals, such as doctors would make care and treatment decisions based on inaccurate information.

The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of each service user, including of decisions taken in relation to their care. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had not received information from the registered provider about the service they were purchasing, such as what was included in the fee. People and their families had been asked to provide people's toiletries and extra incontinence products. These were previously provided by the service. People's relatives had been asked to escort their family member to health care appointments. This had previously been done by staff at no additional cost. Arrangements were not in place for people who did not have family members to help them with purchasing items from outside of the service. Staff had purchased toiletries out of their own money for people to make sure they had what they needed. One staff member told us that the service no longer provided razors and some ladies had grown facial hair. They told us that the ladies were embarrassed at having facial hair. Arrangements for people to pay for services such as hairdressing had changed. People and their relatives had not been told in advance about these changes and were unclear how to pay the bills.

Inadequate

Is the service well-led?

The registered provider had not provide a statement to people or those acting on their behalf with the terms and conditions of the services being provide, including the amount of the fees. This was a breach of Regulation 19 Care Quality Commissions Act (Registration) Regulations 2009.

The provider had not made sure that notifications were sent to CQC as required. Notifications are information we receive from the service when significant events happened at the service, like a death or a serious injury. We had not been informed that five people were the subject of DoLS authorisations.

The registered provider had not notified the Care Quality Commission of significant events that occurred at the service. This was a breach of Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009.