Peaceform Limited

Eliza House

Inspection report

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Date of inspection visit: 17 October 2014
Date of publication: 23/03/2015

Ratings

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

Overall summary

This inspection took place on 17 October 2014 and was unannounced. When we last visited the home on the 23 July 2014 we found the service was meeting the regulations we looked at.

Eliza House is a service for older people who are in need of personal care. Eliza House provided accommodation to a maximum of twenty-six people, many of whom were living with dementia.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from the risk of bullying and harassment because staff were not able to identify this form of abuse.

Not enough staff were available to meet people's needs as the registered manager had not assessed the level of staffing required. Staff were not always provided with support they needed to carry out their roles.

Summary of findings

The registered manager had not carried out regular audits of care plans and medicines administration to ensure that people were not risk from unsafe care as they had not identified the issues we found.

People were provided with a choice of food, and were supported to eat when required. People were supported effectively with their health needs. Medicines were managed safely.

Staff treated people with kindness and compassion, dignity and respect. They responded to people's needs promptly.

People using the service, relatives and staff were encouraged to give feedback on the service. There was an accessible complaints policy which the manager followed when complaints were made to ensure they were investigated and responded to appropriately.

At this inspection there were breaches of regulations in relation to safeguarding people from abuse, staffing and consent to care and treatment and quality assurance. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe. Staff did not always protect people from abuse as they did not recognise when people were being bullied or harassed.

There was not enough staff available to meet people's needs safely as the registered manager had not assessed the needs of people to determine the number of staff required.

Risk assessment were not reviewed so that changes in risks to people's safety were addressed.

People received their medicines safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective. The registered manager had not taken sufficient action to comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were not supported through regular supervision to meet the needs of people effectively.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People received a variety of meals and the support and assistance they needed from staff with eating and drinking, so their dietary needs were met.

People's healthcare needs were monitored. Health care professional were involved when people needed them.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported.

People and their representatives were supported to make informed decisions about their care and support.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans did not explain what staff needed to do when providing care to meet their needs.

People were not supported to engage in meaningful activities that reflected their interests.

People using the service and their relatives were encouraged to give feedback on the service and there was an effective complaints system in place.

Summary of findings

Is the service well-led?

The service was not always well-led. The provider did not have effective systems to check care plans and medicines as they had not carried out audits of these areas.

The culture of the service was open and transparent.

The registered manager checked that people were happy with the service they received.

Requires Improvement

Eliza House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 on17 October 2014 and was unannounced.

The inspection was carried out by an inspector 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.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. Before the inspection the provider completed a Provider Information Return (PIR). 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 spoke with the local safeguarding team, a chiropodist and a GP to obtain their views.

During the visit, we spoke with 10 people using the service, three visitors, four care staff and the registered manager. We spent time observing care and support in communal areas. We also looked at a sample of seven care records of people who used the service, five staff records and records related to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not always protected from the risk of bullying and harassment. People told us that they generally felt "safe" in the service, but they were not confident that they could share their concerns with staff and that these would be responded to. One person said, "I don't feel they would do anything even if you told them that there was a problem." We saw that staff did not intervene when people who use the service made inappropriate remarks to other people.

Staff were not able to identify abuse as they did not recognise bullying or potential harassment of people as a form of abuse. Staff had received training in safeguarding adults and knew how to report their concerns. However, staff could not explain how they would respond to people's behaviour in a way that avoided discrimination. This meant that people were not protected against the risk of abuse and discrimination. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives told us that there were not always enough staff available to meet their needs. One person said, "There's not enough of them. That's the trouble." A relative told us, that at times there wasn't, "enough staff around when people needed them." People told us and we observed that there was little opportunity for staff to spend time with people individually. At the start of lunch people sitting in the dining room waited for 15 minutes before staff arrived to give them their meal. There were times when no staff were present in either of the sitting rooms. For example, in the afternoon all available staff were supporting a game in one area of the home which left people in the other area without direct support. Professionals had told us that on some occasions when they visited the service they felt there were not enough staff available to meet people's needs. For example, professionals had to wait before staff became available to assist them with meeting people's needs or to give them the information they needed regarding people's care.

We looked at the staffing rota, this showed that four care staff were on duty in the morning and three in the afternoon and early evening. There were twenty-two people using the service at the time of the inspection. Care records showed that most people needed assistance with their personal care and other daily living needs. Some people needed the support of two staff to transfer using a hoist. People also had behaviour that could challenge the service which meant staff needed to be available to provide support to them quickly. We asked the manager if they carried out any assessment of the number of staff needed to respond to people's changing needs. They told us that no such assessment had been carried out. This meant there were not enough staff available to ensure the safety and welfare of people who use the service. This was a breach of Regulation 22of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safe recruitment procedures were in place that ensured staff were suitable to work with people. Staff had undergone the required checks before starting to work at the service The four staff files we looked at contained disclosure and barring checks, two references and confirmation of the staff's identity. We spoke with one member of staff who had recently been recruited to work at the service. They told us they had been through a detailed recruitment procedure that included an interview and the checking of references.

Risks to people were not identified as risk assessments were not regularly reviewed and updated. There were assessments covering common areas of potential risks, for example, falls and nutritional needs. These were not being reviewed monthly as was the provider's policy, and changes to the level of risk were not recorded and the actions to prevent risks to people from receiving care were not identified. Staff were not able to explain the risks that particular people might experience when care was being provided. People were at risk from unsafe care as risk assessments did not identified the action to be taken to prevent or reduce the likelihood of risks occurring. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's current medicines were recorded on Medication Administration Records (MARs) as well as medicines received into the home. All people had their allergy status recorded to prevent inappropriate prescribing. Medicines prescribed as a variable dose were all recorded accurately and there were no omissions in the recording or administration of medicines.

Protocols for homely remedies and 'as required' (PRN) were in place and recorded on the MAR charts and in the

Inadequate

Is the service safe?

associated care plans. Topical cream instructions were clearly written to show where cream was to be applied. This showed that medicines had been given to people as prescribed.

We saw evidence of regular review of medicines of the MAR charts and dosage changes were clearly documented. Copies of discharge letters from hospital were kept in people's care plans for ready access to refer to.

Requires Improvement

Is the service effective?

Our findings

People said they were able to make choices about some aspects of their care. However, we found that the registered manager had not taken sufficient action to comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The registered manager was about to apply to make DoLS applications for five people. When we looked at care records there were other people who needed an assessment of capacity regarding consent to their care and treatment. People had been refusing their medication, for example, medication for diabetes and no assessment had been made of their capacity to make the decision not to take the medication and whether this was in their best interest. Where people had behaviour that might challenge the service they had been taken in their bedrooms. Care plans did not show that a restriction to their liberty or if this was in their best interests.

While some staff had received training on the MCA they could not explain the process to be followed if they believed that people were not able to consent and make decisions about their care and treatment. People were at risk of receiving unsafe or inappropriate care and treatment as there had not been an assessment of their capacity to make decisions. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were not supported through regular supervision to meet the needs of people effectively. The registered manager told us that staff received supervision every two months in line with the provider's policy. However there was no record of recent supervisions in the five staff files we reviewed. The last recorded date on which staff had received supervision was June 2014. Staff said that they did not receive supervision regularly. People may be at risk of receiving unsafe care as staff were not being supported. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported by staff that had the necessary skills and knowledge to meet their needs. One person said, “Staff are exceptionally good.” Staff who had recently started to work at the home had completed a detailed induction. Training records showed that staff had completed all areas of mandatory training in line with the provider’s policy. Also staff had specific training on dementia and nutrition. Some care staff had completed a qualification in Health and Social Care. A training matrix was used to identify when staff needed training updated.

People told us they enjoyed their meals. One person said, "The meals have been really, really good." People had a choice of dishes for each meal. Some people were offered choices at lunch time if they didn’t want to eat or drink what they had originally requested. Another person told us, "You usually get the same thing, but if you don’t like it they’ll give you something else." At lunchtime staff were available to assist people to eat and drink when they needed support to do this. Staff supported people to take their time to enjoy their meals.

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. One person said, “The food is good.” The cook was able to explain the dietary needs of people who had diabetes or were on low or high fat diets.

People told us that they had been able to see their general practitioner when they wanted to. One person said that a number of healthcare professionals had been called in to see them, which included a GP, an optician, a nurse and a physiotherapist. One person told us that the support that staff had given them was instrumental in maintaining their mobility. The person said, “It’s marvellous what they have done for me.”

People’s healthcare needs were identified in their care records. Healthcare professionals said they were contacted with any concerns and staff followed the advice they gave. Healthcare professionals were all positive about the service and said staff were available to accompany them during their visits, took on board any changes in treatment and followed this through to ensure people received the care and treatment they required. There were records of GP visits in all the care records we reviewed and records of other contacts with health professionals such as chiropodists, and hospital specialists. This showed people’s healthcare needs were being identified and they were receiving the input from healthcare professionals they required.

Good

Is the service caring?

Our findings

People were treated with dignity and respect and had the privacy they needed, and one person told us, “I’m can spend time on my own when I choose.” We observed that staff knocked on people’s doors and waited to be invited in before entering. When people said they did not want staff to come in, staff respected that. Where people required support to eat, staff provided people with aprons to protect their clothing. Staff removed the aprons as soon as people finished their meals to help maintain their dignity.

People told us that they were treated with respect and staff responded to their views regarding how they wished their needs to be met. One person said, "They are looking after me." Another person told us, "As long as I am here and they are looking after me, I am happy." Staff provided care and support in a gentle and caring manner, listened to what people had to say and involved them in decisions regarding their care. We observed that staff asked people's permission before providing any care and support for them. People and relatives were able to discuss any issues that concerned them regarding how care was being provided with staff.

One person said, “All the staff that work here are pretty good.” Staff talked with people in a positive and caring manner and it was seen that some staff reinforced this with gentle physical contact such as stroking someone’s hand. It was also seen that staff noticed when things needed to be done to support people. For example, a walking frame had been pushed out of one person’s reach. Staff noticed this and put it back so it could be easily reached. On a number of occasions where people had fallen asleep and their head had dropped down, staff gently raised their head without waking them so it was better supported. One person had got their foot caught up around the legs of a table. Staff gently helped them to untangle it.

Meetings were held with people at which issues regarding the general running of the service were discussed. Minutes were written in a way that supported people who used the service to understand and participate in decisions. For example, people had made suggested options for the menu.

Requires Improvement

Is the service responsive?

Our findings

People's care was not always planned in response to their needs. The majority of the care plans we looked at were not detailed as they did not clearly identify and state the actions needed to respond to people's care needs. Where people's behaviour challenged the service (for example, shouting) no care plan gave guidance to how this could be responded to. We saw that staff responded to people's behaviour in an inconsistent manner. One occasion staff ignored them and another time they took the person to their bedroom.

An attempt had been made to monitor people's behaviour to identify if there were any reasons for the behaviour which challenged the service. This monitoring was not consistently carried out as it was only done for short periods of time and then it had been left uncompleted. This meant it was not possible to identify patterns of behaviour and to put in place effective interventions to address them.

People who were living with dementia did not have detailed care plans that reflected their life histories and interests. Care plans did not identify how people's dementia affected them and what needed to be done to support their well-being. Care plans regarding people's personal care needs were not individualised. For example, people's preferences regarding their care were not included in their care plans.

People were not supported to engage in meaningful activities that reflected their interests and supported their well-being. An activities plan was displayed on a notice board. The activities plan listed music therapy, reminiscence activities, cheese and wine tasting and visits from an entertainer being available throughout the week. The activities planned for the day were not carried out. Instead, two large group activities were provided, a quiz and an initial sound game. Both activities were unstructured and only involved a small number of people. In the afternoon there was a group of 14 people in the sitting room where the quiz was taking place, but only four people answered the quiz questions. Some people were woken to play the game. People became quickly disengaged with the activity, making comments about the appropriateness of the game. People's comments about the activity were, "We're going back to school" and "Stupid, isn't it." People were at risk as they were receiving care that responded to their individual needs and preferences. These issues showed that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Relatives and people were confident they could raise any concerns they might have, however minor, and they would be addressed. One person said, "If I didn't think I was getting good care I would say so." A copy of the complaints procedure was on display in the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the manager and inform the manager about this, so the situation could be addressed promptly. The complaint records showed that when issues had been raised these had been investigated and feedback given to the people concerned. Complaints were used as part of on going learning by the service and so that improvements could be made to the care and support people received.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have effective systems to monitor the quality of care and support people received. We asked the registered manager and provider if they carried out any monitoring of care plans and medicines administration, they were not able to show us and the audits of these areas. While the forms and procedure for these audits were in place they had not been carried out. This meant that none of the issues we had identified during the inspection had been identified by the provider's quality monitoring systems.

We had found that there were gaps in the planning of people's care particularly where they were living with dementia and had behaviour that might challenge the service. Care plans were not detailed regarding people's dementia care needs. The monitoring of people's behaviour had not been completed in enough detail to establish if there were any patterns of behaviour that could be identified. The registered manager was not aware that staff had not received regular supervision in line with the provider's own policy as no quality monitoring checks of this had been carried out. People may be at risk of receiving unsafe and inappropriate care as the provider did not have effective systems to monitor the quality of care being delivered to people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that there was an open and positive culture in the service. Staff, people and relatives told us that the service had a management team that was approachable and took action to address any concerns that they raised. One person told us, "I raised an issue with the manager. They sorted it out straight away." Staff were approachable and engaged positively with people and relatives.

The provider had a system to monitor and ascertain people's views of the quality of the care and support they received. An annual survey of the views of people, relatives and professionals had been carried out. The results of this were generally positive; people said that the service responded to their needs. Regular meetings were held with people to get their views on the service.

We reviewed the service's accident and incident records, and saw that each incident and accident was recorded with details about any action taken and learning for the service. Incidents and accidents had been reviewed by the registered manager and action was taken to make sure that any risks identified were addressed. The service's procedure was available for staff to refer to when necessary, and records showed this had been followed for all incidents and accidents recorded.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The registered persons had not taken appropriate steps to make sure there were sufficient staff to meet service user's needs. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The registered persons did not have suitable arrangements to ensure that service users were protected from abuse as reasonable steps had not been taken to identify possible abuse and prevent it from occurring. Regulation 11(1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered persons did not have suitable arrangements in place to make a decision regarding service user's capacity to make decisions and consent to their care and treatment. Regulation 18(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: The registered person did not take proper steps to ensure that service users were protected against the risks of receiving inappropriate care or treatment for their individual needs through the planning and delivery of care.

Regulation 9 (1) (b)(i)(ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The registered persons had not protected service users against the risks of inappropriate care and treatment as there was not an effective system to identify, assess and manage the risks. Regulation 10(1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered persons had not made suitable arrangements to ensure that staff were appropriately supported to enable them to deliver care to service users. Regulation 23(1)(a).