Welwyn Garden City Housing Association Limited

# Elizabeth House Residential Care Home

## Inspection report

Elizabeth Close
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01 November 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Elizabeth House is a purpose built care home and is registered to provide accommodation and personal care for up 60 older people some of whom live with dementia. At the time of our inspection 57 people were living at the home.

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

The inspection took place on 26 October and 01 November 2017. This inspection was in response to concerns we received from the local authority regarding unsafe care practises and a lack of managerial oversight in the home. This inspection focused on the Alexandra Unit which provides care to people living with dementia, as feedback suggested this was the area of the home where the concerns were identified by the local authority..

The inspector arrived on the morning of 26 October 2017 to inspect the service unannounced. On 01 November 2017 we met with the provider to seek assurances due to the nature of the concerns identified at this inspection. We have also referred our findings to the local authority commissioning and safeguarding team.

At our previous inspection on 09 February 2016 we found that people's medicines were not always managed safely, however, we rated the service overall good and asked the provider to make improvements in this area.  At this inspection we found that improvements had been made in relation to management of medicines, however we found that the service was not meeting the standards in relation to providing safe care and effective management and governance.

People told us they felt safe, however we found that people who required positioning to maintain their skin integrity did not receive this as required. Risks to people's safety and welfare were not consistently identified and responded to. Where people were at risk of harm, or had experienced harm these incidents were not consistently reported to local safeguarding authorities or investigated by management. People's medicines were managed well and they received their medicines as the prescriber intended.

People did not consistently receive care that was well led and robustly monitored. People's personal care records were not regularly reviewed, completed or updated when required. Audits of people's care records were not effectively reviewed to ensure actions were completed, and notifiable incidents were not consistently reported to CQC when required. Staff felt that the manager was not visible around the home and we found that leadership in the home was not sufficiently proactive to keep people safe. Notification that were required to be submitted to CQC regarding significant events had not been made.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Where people were at risk of harm, incidents were not investigated, monitored and the risks sufficiently mitigated to keep them safe.

People did not receive care in accordance with their care plan.

Staff were not always following the instructions of a health professional when providing care and support to people.

People were supported by sufficient numbers of staff.

People received their medicines in a safe manner as the prescriber intended.

### Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Systems were not effective in assessing and reviewing the quality of care people received to keep them safe.

Records relating to people`s care were not consistently developed or accurately maintained.

Leadership in the home was not effective. Staff were not provided with support through meetings or supervisions.

Notification that were required to be made to CQC were not made in a timely manner.

# Elizabeth House Residential 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 met 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 under the Care Act 2014.

This inspection took place on 26 October and 01 November 2017 and was unannounced. The inspection was carried out by one inspector.
Prior to the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. Prior to the inspection we also reviewed information received from the local authorities commissioning and safeguarding teams.

During the inspection we observed how staff offered support to people who used the service. We spoke with three people and one person's relative, and four staff members. We also spoke with the registered manager and the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to four people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living at Elizabeth House. One person told us, "It's lovely here I feel I am cocooned and at peace." A second person said, "I feel very safe and happy."

Staff spoken with were able to describe how they identified possible signs of abuse or harm to people. Staff were clear in how they reported incidents to their managers. One staff member said, "When we help them [people] we are looking for a mark or a bruise, or people's mood and behaviour. If something is not right for that person, then we record it, body map and report it." However, we found numerous incidents of bruising, skin tears and incidents involving people who presented with behaviours which were challenging at times that had not been reported.

Where incidents were reported to management, these had not been raised with either the local authority safeguarding team or CQC. For example, one person had been injured by another person causing a cut to the forehead and nose. This had been recorded in the daily records and on a body map; however the incident had not been reported to the authorities. A second example was for a person where staff noted bruising to the arms, a skin tear to the right leg, and redness to a pressure area. Although staff had documented this and referred for specialist review, they had not recognised that the person may be at risk of harm of abuse and they not reported this as an incident.

We became aware of one person receiving treatment for a pressure wound at the time of our inspection. The communication between the visiting professionals, staff and management of Elizabeth House, the GP and District Nursing service was not effective in responding to this person`s care. We found conflicting information recorded in the persons care plan regarding positioning frequency, and the registered manager told us they did not feel able to challenge the views of the GP when reviewing the persons care. We have raised our concerns in relation to each service with the local authorities safeguarding team for further investigation. Subsequent to the inspection, where this persons needs were again reviewed, their wound and general health improved significantly.

Risks to people's health and wellbeing were identified but not consistently responded to. Staff`s knowledge about risks associated with people`s daily living was not consistent. For example, one staff member was able to accurately describe why a person needed repositioning and the frequency of the turns and were aware of the recent changes to this regime. However, another staff member told us that this person had to be turned two hourly when in fact it was hourly. When we looked at this person`s care records we found that they had a pressure wound, and required hourly positioning. We spoke with staff on duty and they told us they turned the person hourly. As a result the person had not been repositioned as per the instructions given by a health professional to manage their deteriorating skin condition. We also found that on occasions staff had not turned the person for a long period of time. For example we saw that on one occasion the person was left for five hours to lay on their back without having the pressure relieved from their pressure areas. This meant that there was an increased risk that their wound would be aggravated and the healing process may be delayed because of the long time they spent in the same position. The provider immediately reviewed all those people in the home to ensure they were positioned appropriately and has reviewed these

people with the GP.

We found that one person had not eaten for an entire day. Although staff had offered this person their morning, lunch and evening meal they did not seek to find or offer a meal the person liked and would eat. We spoke with the cook who told us that they were able to provide a variety of snacks, meals and high calorific milkshakes to people if there was a need for it, however in this person`s case they were not informed by staff that the person was not eating. On the second day of inspection, with the intervention of the cook, we found that this person was eating their meals and in addition the cook had provided a number of milkshakes to them.

People who were unable to be weighed due to their health needs were not monitored for weight loss. Staff recorded that for these people, "Not weighed as palliative and not in [person`s] best interest." When we spoke with the manager they were not aware of alternative methods of monitoring weight loss such as measuring people`s arm circumference as an indicator of weight loss. This meant that if people lost weight this may have been undetected. We informed the registered manager and the provider about the people we identified from records that had lost a significant amount of weight and had not been referred for specialist support with their nutrition. Subsequent to the inspection the registered manager and the provider carried out a full review of people's weights and ensured those people who required referrals to health professionals or dieticians had this completed in a timely manner.

We found that where people required a food and fluid record to be maintained to monitor what they had drank, this was not sufficiently reviewed. For example, fluid charts did not contain a fluid target for people to aim for. Where fluids were recorded, we found that these were significantly lower for some people. We found a record which evidenced that on one day a person drank nothing which did not trigger staff to encourage further fluid intake. On the second day of the inspection we found that actions were taken and people at risk of dehydration had jugs of juice in their rooms and staff were actively encouraging them to drink.

We found that a person had demonstrated on several occasions challenging physical behaviours towards staff, relatives and other people living in the home. Although staff had sought the support of external health professionals they had not developed an appropriate assessment of the person`s needs or a behaviour support plan. Where the person's behaviour challenged, staff did not always report this to the managers. We saw that this person's behaviour continued without sufficient assessment of the risks to others or the person, and resulted in incidents where people were placed at risk of harm.

People did not receive care that was provided in a safe manner because staff did not consistently assess, monitor and review people's needs to ensure the risks to people were managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought there were enough staff to respond to them in a timely manner. One person said, "When I need help there is always someone I can call on to help me. I am happy with the number of staff about."

We observed throughout the inspection that staff were busy and pressured to meet people`s needs. However staff were seen to support people in an unrushed way, and were seen to take their time to talk to people and ensure they had everything they needed or wanted before they moved on to assist someone else. However we found that people's changing needs on this unit were not considered when planning staffing. For example, one person required a significant amount of two staff members' time to meet their needs. This meant that when staff were assisting this person there were less staff available to support others. When we asked the registered manager how they calculated staffing and how they responded to

people's changing needs they told us they did not routinely assess this. When we returned on the second day, we saw the registered manager had reviewed the staffing on this unit and brought in one additional staff member to support the team. To ensure that staffing reflects the needs of people living in the home, the registered manager must improve how they assess people's needs and staff the home accordingly.

At our previous inspection we found that people's medicines were not managed safely. At this inspection we found that action had been taken to make the required improvements. People's medication administration records (MAR) were completed when people were given their medicines. Medicines that were required to be given at specific times, for example pain relief, were given when needed. We checked the stocks of medicines held in loose packets and found that these tallied with the stocks entered on the MAR.

Requires Improvement

# Is the service well-led?

## Our findings

Systems in place to monitor the quality of care people received were not effective in identifying or remedying areas of concern. The registered manager did not receive regular supervision with their line manager. They told us that they had regular contact with their line manager through emails and discussions; however there was no formal review of the service or identifying where improvements were required. During the inspection the provider spoke with the registered manager and their line manager and told them, "I have not seen evidence of a meeting between you two for the last six months." However, where they had identified clearly that these formal meetings were not documented they had done little to address this or other areas. They told us, "I think we have an informal approach to governance."

The provider told us this was an area that they were developing and a service improvement plan would be put in place to address areas of concern and to identify where the quality of the care people received could be further improved.

The provider had sought the support of a consultant who visited the home four times in a month and who submitted a report to the board. They had also supported the provider with a `mock` inspection of the service in May this year, where they had identified a number of areas of concern. This included areas such as, complaints, care planning and managing challenging behaviour, call bell response times and visibility of management, particularly the registered manager. The provider had taken some actions, for example in providing training to staff about managing behaviours that challenged, however they were unable to provide us with a comprehensive action plan detailing how and by when they would have completed all the actions needed. The provider had emailed the registered manager and their manager in June asking for a response to the findings and detailing how improvements would be monitored. When we asked to see how the service was monitored, we found little evidence to support that this occurred.

Providers of health and social care services are required to maintain plans that they have for improving the standard of the services provided to people with a view to ensuring their health and welfare. Prior to our inspection, and in response to the local authority findings we asked the registered manager for a copy of this service development plan. We were told by the registered manager that they had not developed one.

Leadership in the home was not visible on the units or consistently effective in identifying, responding to and monitoring people's care. For example, the local authority identified there were gaps in people's care records, and reported this to the registered manager and the provider. When we visited four days later, we found that gaps continued to be present, and subsequently when we returned on 01 November we found that although there were some improvements, gaps were still present in people's repositioning records, food and fluid charts and care plans. The registered manager informed us prior to our second visit that these areas had been addressed and they were closely monitoring, however we found that this monitoring was not effective.

The provider and the registered manager had recently changed the management structure in the home. They changed the way that the care managers monitored and supervised the units in the home, by having

care managers assigned to people and not units. This meant that four different care managers were responsible for the oversight of the Alexander unit. This meant there was a lack of consistency in management oversight and getting to know people well. By not being based on the unit and being migrated from unit to unit, depending on where the people they were responsible for resided, their knowledge was not up to date regarding people's changing needs. This was demonstrated by one care manager who was not aware of the current positioning regime for a person with significant needs. Staff told us previously they were also key workers for people, which meant they were involved with reviewing people's care plans. One staff member said, "We were stopped from key working three or four months ago and care planning was given to the care manager and senior. Handover is now about who is up, had personal care, how much they've eaten or how they slept, but we don't talk about [person's] change to repositioning, so everything is much more difficult now."

We found on the Alexander Unit an agency staff member who was working alone with people. We found that they only worked in the home one time before. The provider was clear that this was against their policy. They said, "Why is there agency on Alexander Unit, you [Managers] know that we use our own staff over any agency staff." We spoke with the provider about the change in leadership on the units, and demonstrated where key issues had not been addressed, such as communication and use of inexperienced staff against their own policy. They immediately changed the care manager role so that Alexander Unit had one responsible care manager to ensure consistency, and undertook their own daily review of staffing in the home.

Staff told us that meetings were not held regularly and supervision sessions with their line manager to discuss their performance and development had not been held when needed. One staff member told us, "Team meetings are very rare; it was supposed to be once a month but never happens, nobody turns up, but it would be good to talk through our ideas or hear what going on."

We found that reporting to the provider by the registered manager was not consistent. For example they reported monthly falls, but did not report other incidents routinely.

People's care records were not accurately maintained. We saw that staff were completing people's daily records retrospectively. Staff recorded what people had eaten, or drank two hours after this was given and there was a risk that the information recorded was not accurate. Care plans that were necessary to support people's needs were not developed. For example people who were nearing the end of their life or who had behaviours that challenged. However for these people we saw that external health professionals supported people's clinical needs. People`s care plans were not sufficiently detailed to give staff support and guidance on how to support people. For example, moving and handling assessments recorded whether one or two staff were required to assist a person, but did not record the type of sling to use in case they needed a hoist to help them, or how to safely transfer a person considering anxieties or behaviours that may place them at risk of harm.

Subsequent to the inspection the provider has taken actions to introduce more robust monitoring of the service and people's care. In response to the feedback from CQC and the local authority they were collating feedback from staff, people and relatives regarding the service and planned to act upon those findings. The provider had also submitted to us a number of assurances regarding the safe delivery of care in Elizabeth House.

However, at the time of inspection, governance arrangements in Elizabeth House were not effective to ensure the risks to people's safety and welfare were identified, mitigated and monitored. Leadership within the home did not demonstrate positive and effective outcomes for people, and people's personal records

were not consistently developed or maintained. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that a number of incidents that required follow up, for example reviewing and developing a care plan, or reporting to the local authority had not happened. These were retrospectively submitted following the first day of the CQC inspection and local authority findings. However the registered manager had not effectively identified, reviewed and assessed people's injuries, incidents or falls and taken action to report these as required.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Notification of other incidents<br><br>Notification required to be sent to the Care Quality Commission of certain incidents were not sent as required. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Safe care and treatment<br>Regulation 12 (1) (2) (a) (b)<br>Care was not provided in a safe way for people. People did not receive care that was provided in a safe manner because staff did not consistently assess, monitor and review people's needs to ensure the risks to people were managed. Where risks were identified, actions were not consistently taken to ensure that people were kept safe by ensuring all actions that reasonably practicable to mitigate any such risks were carried out. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Good governance<br><br>Regulation 17 (1) (2) (a) (b) (c) (3) (a) (b)<br><br>Systems were not operated effectively. Systems did not effectively assess, monitor and seek to |

improve the quality and safety of the services provided. An accurate, complete and contemporaneous record in respect of each persons care and support needs was not maintained. When asked the provider was unable to provide CQC with a written quality improvement report that sets out how the service meets the required regulations.