Care Quality Commission

Shaw Healthcare Limited

Elizabeth House

Inspection report

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Ratings

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

Overall summary

The inspection took place on 12 and 13 November 2015 and was an unannounced inspection.

Elizabeth House provides accommodation and care for up to 60 people older people, most of whom have a diagnosis of dementia. The home is purpose built. It consists of six units, each equipped with a living and kitchen area. At the time of our visit there were 60 people living at the home.

The service has 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 harm because prompt action was not always taken to mitigate risks when changes occurred. Some changes in people's plan of care were not reliably acted upon by staff. Records were not always updated promptly and sometimes contained conflicting information. This put people at risk of receiving care that was inappropriate or unsafe.

Summary of findings

People received caring support from staff but had limited opportunity to engage socially or to receive support in pursuing individual interests. Although all staff told us they wished to spend more time with people, they told us, "There is no time to sit and chat". We found that some people, especially those cared for in their rooms, were at risk of isolation. **We have made a recommendation about reviewing staffing levels to ensure that staff are able to provide social stimulation to people.**

People felt safe. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. There were enough staff to keep people safe and to meet their physical needs. People received their medicines safely and at the right time.

Staff had received training to carry out their roles. They felt supported and told us that any issues they raised were addressed promptly.

People were treated with kindness and respect. They, and/or their relatives, had been involved in planning and reviewing their care. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, these decisions had not always been accurately recorded. This was discussed with the registered manager during our visit.

The registered manager had a system to monitor and review the quality of care delivered and was supported by two-monthly visits from a representative of the provider. People, their relatives and staff felt confident to raise issues or concerns with the registered manager. Where improvements had been identified, action plans were in place and used effectively.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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?

Requires improvement 

The service was not always safe.

People were not always protected from harm because prompt action had not been taken to mitigate risks or to reliably communicate changes in people's plan of care.

Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

There were enough staff to keep people safe.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Good 

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good 

The service was caring.

People enjoyed good relationships with the staff who supported them. Staff understood what was important to people.

People were involved in making decisions relating to their care and encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Some people were at risk of isolation because there were not always enough staff to provide regular social support.

People were given opportunities to share their views and felt they were listened to.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

Summary of findings

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

The registered manager was well-respected, approachable and proactive.

The registered manager and provider used a series of audits to monitor the delivery of care that people received and to make improvements.

Elizabeth 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 on 12 and 13 November 2015 and was unannounced.

Three inspectors and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed two previous inspection reports, a report from the fire and rescue service and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. This information enabled us to ensure we were addressing any potential areas of concern.

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 looked at care records for 16 people, medication administration records (MAR), monitoring records of people's food and fluid intake and weight. We also looked at eight staff files, staff training and supervision records, staff rotas, quality feedback surveys, accident records, audits and minutes of meetings.

During our inspection, we spoke with eight people using the service, five relatives, the registered manager, the deputy manager, five team leaders, 13 care staff, an activity coordinator, a district nurse, a member of the care home in-reach team from the local NHS Trust, the chef, a member of the housekeeping team and two administrators. Following the inspection, we contacted professionals to ask for their views and experiences. These included a nurse practitioner who made weekly visits to the home, an admissions avoidance nurse specialist and a social worker of one person who lived there. They consented to share their views in this report.

Elizabeth House was last inspected in September 2013 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

People were not protected from risks linked to their care and treatment because staff had not always taken prompt action in response to changes or concerns. When changes occurred this information was not always quickly communicated to staff or updated in the records. This meant that there was sometimes a delay in taking action to mitigate known risks.

Changes in people's care to manage risks to their health had not always been reliably communicated. In the review of one person's care dated 10 November 2015, it was noted that the person, 'Requires hourly turns and her skin integrity closely monitored'. Staff told us that the person needed assistance to reposition every three hours and the records confirmed that this frequency of support had been delivered. The increase to hourly repositioning, agreed two days earlier, had not been implemented. This put the person at risk because action to protect against skin breakdown had not been followed through. For a second person, a pressure area was noted on 6 November 2015. Advice had been sought for the GP and District Nurse but the care plan and risk assessments related to skin integrity had not been updated a week later to reflect this. This could mean that staff were unaware of the concern and would not be able to offer appropriate support to the person.

In some cases there was no evidence that staff had taken action in response to changes or concerns relating to people's health. Some people were monitored for bowel movements as they were at risk of constipation. These records showed gaps of up to eight days where people had reportedly not had a bowel movement. There was no evidence that action had been taken in response to this risk or that staff had noted this as a concern and checked with colleagues to see if the records were accurate. Some relatives told us that they felt a responsibility to highlight issues and remind staff. One said, "(Name of person using the service) has lost weight, but we raised this and asked for supplements. Their weight has now stabilised, but we had to notice and push".

Where changes had been agreed, these were not made clear throughout the care plan. We looked at the records for one person who was unable to change their position independently and was cared for in bed. In the 'Knowing me' document, used when a person goes into hospital to share key information about their needs and wishes, we read, 'I can independently turn in bed'. The care plan stated that the person no longer used a specialist nursing chair. In fact, one staff member told us that the person had a 'funny turn' last time they helped them to sit in it. However, in the person's personal evacuation plan which would be given to the fire and rescue service, it stated that the nursing chair would be used to evacuate the person. The lack of accurate records meant that people may receive care that was inappropriate or unsafe.

The guidance provided for staff was not always clear. For one person, staff had completed a falls risk assessment suggested by the falls prevention team. In addition, they had completed their own assessment which resulted in different information about this risk recorded in two places. It was not clear from the records how the person should be supported because one undated assessment recorded, 'It would be safer to use a wheelchair' but the person was seen to be using a three-wheeled walker. Another person's needs had been discussed with the older person's mental health service in relation to low mood and behaviours that might challenge. The care plan, however, contained no documented advice or guidance to support this area of need. Where people had diabetes, care plans recorded that the person, 'Must have a diabetic diet', but no further information as to what this meant in practice was offered. We found that staff had limited knowledge about diabetes care, though they were supported by district nurses who visited daily to check some people's blood sugar readings and administer insulin. The district nurse told us, "All diabetics are stable in here".

People were at risk because staff had not taken reasonably practicable action to mitigate the risks to people's health when their needs changed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager showed us a prototype of a new care plan format that was due to be introduced. Staff were positive about the new format. One team leader told us, that the new care plans were more person-centred and that there was more room to write details of people's care.

There were also positive examples of risks being assessed and managed. For one person who was at risk of falling, staff were instructed to check the person wore proper footwear and that their walking frame was in reach. The person was also checked every half an hour to monitor

Requires improvement

Is the service safe?

their whereabouts and safety. Staff had sought advice from the falls prevention team and occupational therapist and had worked with the GP to adjust the person's medicines. This was to avoid any medicines that made the person drowsy and therefore more at risk of falls. During our visit we observed staff assisting people to walk safely. A relative told us, "There's always someone here checking the rooms. I'm most impressed".

Where people used equipment, such as hoists or bed rails, these had been assessed to ensure that they were suitable for the person. This included details on the size of hoist and sling a person needed in order to be transferred safely. For bedrails it considered the risk of entrapment and whether the person might be placed at greater risk by trying to climb over the rails. Some people had sensor mats in place by their beds or chairs. These work by activating an alarm when stepped on, which alerts staff to the fact that the person is moving so that they can go to offer support. We observed staff supporting one person to get into their wheelchair to join an activity on the ground floor. They used a stand-aid hoist to help the person move to their wheelchair. This was done safely and throughout the procedure staff encouraged the person and explained what they were doing.

People felt safe at the home. One person said, "Yes, it's very good. I'm happy here". Another told us, "I feel safe here. I wouldn't live in a house, I'd be too lonely". Relatives had confidence in the vigilance of staff. One told us, "They all (staff) seem to be pretty on the ball to people's needs and wellbeing". One staff member said, "I like the manager and the staff and how residents are treated". Staff had received safeguarding training and had a good understanding of their responsibilities in relation to safeguarding people. The home's safeguarding policy had been discussed in staff meetings. This helped to make sure staff kept their knowledge fresh and up to date. They were able to describe the different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. They explained that they would report to the most senior person on duty at the time and if this was not appropriate they would go directly to the local safeguarding authority. One staff member told us, "I would report it (safeguarding concern) to the team leader. They immediately do something". Contact details for the safeguarding authority were readily available to staff and visitors through posters in the offices on each floor and on the general noticeboard.

Staff told us that they were able to meet people's needs safely but that the shifts were busy. One relative said, "(Name of person who lived at the home) is very well looked after. They are very good here. As soon as a bell rings here, everyone runs". While the staffing level enabled staff to meet people's physical needs, they had limited time to chat or offer social stimulation. One team leader said, "Another staff member on each floor would be lovely, the girls are rushed off their feet". Another told us, "If we had another person we could spend more time talking and sitting with residents to talk to them and give them a bit of attention". We have made a recommendation the Responsive domain about staff availability to meet people's social and emotional needs.

The home did not have a system to calculate how many care staff were needed to meet people's needs, rather they worked from a ratio based on the number of people accommodated. The registered manager explained that if a person's needs increased, they kept a 48 hour diary of their care. This was so they could make a case for additional funding from the local authority, or as supporting information to demonstrate that a person's needs would be better met in a home that offered nursing care. The registered manager was only able to increase the staffing level with approval from representatives of the provider. She explained that this had been granted in cases where a person was putting themselves or others at risk by behaving in a certain way or if a person was at the end of their life in order to provide one to one support. At the time of our visit, each of the three floors were staffed by one team leader and three support workers during the day. At night, there was one team leader for the home and two support workers on each floor. The rotas demonstrated that this staffing level had been maintained. One staff member said, "If we are short staffed they do get bank or agency where possible".

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Requires improvement

Is the service safe?

People received their medicines safely. Medicines were administered by the team leaders who attended annual training and underwent competency checks. The team leaders administered medicines to people in a discreet way and stayed with them until they had taken them. Some medicines had been requested in alternative forms, such as a liquid, to make it easier for people to swallow them. Some people had medicine prescribed 'as required' (PRN). There were clear instructions for staff describing when to use these medicines, the dose and the expected effect. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment.

Medication Administration Records (MAR) included a recent photograph and information on any allergies the person had. These were completed and demonstrated that people had received their medicines as prescribed. However, some signatures were missing for topical barrier creams. These were signed for by the support workers on a Topical Medication Administration Record (TMAR) as they assisted people to wash and dress or after they had used the toilet. Barrier creams are important as a preventative measure to avoid skin breakdown. The team leader told us that they would remind support workers at shift handover of the need to sign the TMAR to demonstrate that people were receiving the correct support.

Medicines were kept securely in a locked room and those requiring refrigeration were kept in a separate locked fridge. The room was clean and ordered. The temperature of both the room and the fridge were monitored and had been maintained within safe limits. Controlled drugs (drugs which are liable to abuse and misuse and are controlled by legislation), were stored securely in a separate locked cupboard fixed to the wall and were accurately recorded. Team leaders carried out monthly audits of medication, usually on a floor where they did not regularly work. This helped to ensure that people received their medicines safely and that practice was consistent throughout the home.

Good

Is the service effective?

Our findings

People were supported by staff who had been trained in their roles. The provider's mandatory training included courses in fire safety, health and safety, infection control, moving and handling, safeguarding and food hygiene. One staff member told us, "I have found all the training gave good knowledge". Another said, "We get the support when we need it and there is loads of training here". The provider had a system to monitor the completion of staff training and ensure that staff attended regular updates. At the time of our visit the completion rate for staff training was 99.7%.

Staff were happy with the training available to them and told us that there were lots of opportunities. They felt confident in their skills and explained that they could request additional training. Two staff had been trained as leads in infection control during May 2015 and were now able to offer support and guidance to their colleagues. Team leaders had the opportunity to apply for a place on a development programme starting in 2016. This course would cover management, communication, supervision and appraisal, performance management, rotas and supporting new staff. We saw that the registered manager had encouraged staff to enrol for diplomas in health and social care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The registered manager said, "The team are willing to learn, they enjoy training and learning new skills". At each staff meeting three of the provider's policies were reviewed. This helped staff to keep their knowledge updated. In October 2015 the policies around missing service users, disciplinary and service continuity had been reviewed and staff were required to answer questions as to the reason for the policy and the procedure they should follow.

Staff had received training to help them meet the needs of people who lived at Elizabeth House. As part of the induction programme, all staff received training in supporting people living with dementia. The deputy manager told us that this accounted for approximately one and half days of training. All team leaders had completed a course run by the provider entitled, 'Leading care that matters'. The registered manager and two team leaders had completed a yearlong course with 12 contact days run by a training provider specialised in dementia care. At the time of our visit the dementia in-reach team from the local NHS Trust had started to work in the home. Their support had been requested by the registered manager as a means of helping staff to improve their skills and the quality of the care delivered.

New staff completed a period of induction, which included shadowing of experienced staff. The provider's induction was structured to meet the requirements of the Care Certificate. This covers 15 standards of health and social care topics and is a nationally recognised qualification. When new agency staff worked in the home, they received a brief induction covering fire procedures, call bells, reporting incidents, safeguarding and emergency contacts. Their skills were checked by the home and copies of their profiles were retained detailing relevant skills, training and experience.

Staff were supported and felt that their work was recognised by the registered manager. Staff attended supervision with their line manager every two months and had an annual appraisal of their performance. One staff member told us, "It's nice to get feedback from the team leaders". Another said, "If I have any problems I can speak to my team leader". The registered manager also held monthly staff meetings. These provided an opportunity to share updates and to discuss any concerns. One staff member said, "It's a good place to work, I enjoy working here".

People were involved in decisions and asked for their consent before care was provided. We observed that staff explained the support they were offering to people. They spoke clearly and rephrased questions if necessary to ensure that the person had understood. One staff member said, "It's simple, just give them a choice, show them". Another told us, "If they say no, it means no". A third staff member explained how some people responded more positively to particular staff members, or that they had preferences such as to be bathed by older staff. They told us that if a person refused support, they would often suggest another staff member tried again a little later. One staff member summed it up as, "Try again, try with a different person".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people

make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that DoLS applications had been submitted for each person who lived at the home. The registered manger was able to explain why the applications had been made and demonstrated a good understanding of the legislation. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The home had received a decision on one application from the local authority. The requirements under the MCA and DoLS had been discussed in staff meetings and guidance had been shared with the team.

Staff understood how to protect people's rights when the lacked capacity to make decisions relating to their care and treatment. Staff had attended training in the MCA and DoLS. One told us, "We cannot assume that because they have dementia they cannot decide. Even if they make the wrong decision they have the right to make their own decision. We have to try and make it safe for them". We saw that a best interest meeting had been held in September 2015. The meeting involved the person's appointed Power of Attorney, their social worker and staff from the home. This decision was clearly recorded and demonstrated that staff had acted in accordance with the law.

There were also examples where the recording of best interest decisions was unclear. For example, the records indicated that a decision not to undertake any investigations into a bowel condition had been made by relatives who did not hold power of attorney for health and welfare decisions. On further investigation, this decision had been made in conjunction with the GP. We also found that assessments of people's capacity did not always include detail on how staff had supported person to understand the information. Under the heading, 'Identify practical support given to help person to make a decision' it was simply stated 'X is unable to make a decision'. We discussed this with the registered manager. She explained that new care plans were due to be introduced and that this would guide staff on how such decisions should be recorded. The deputy manager referred to the new care plans and said, "It's amazing. Everything has got best interests, there is a capacity assessment for each need" "I think it is really going to help them". Following our visit the registered manager sent a communication to team leaders, which was copied to us. We read, 'Please re-visit best interest documents and fully explain how the decision was obtained and decided; who was involved and how you came to that decision'.

There was a variety of food offered and people were supported to make choices about what, when and where they wanted to eat. People spoke positively about the meals. One told us the home had, "Good beds and good food". Another said that their breakfast was, '"Lovely, I had poached egg and bacon". Staff offered people a choice from the menu. They had laminated picture cards of each meal which helped some people to make a selection. We also saw staff showing people the options, for example by presenting two bowls of dessert for them to choose from. Alternatives were available if people preferred a simple dish such as omelette, jacket potato or salad. In addition, the kitchenette on each floor was stocked with snacks such as soups, crisps and cake which staff were able to serve at any time of day or night.

The chef had information regarding people's dietary likes and needs. For each person a dietary assessment had been completed. This included their preferences on food, portion size, eating environment along with any specific needs such as allergies, adapted utensils or modified textures to aid swallowing. The chef told us that they had received training on nutrition and diabetes and that a Speech and Language Therapist had visited to give advice on how to modify the texture of food. The meal time was a sociable occasion for many. One person told us that they ate, "In the communal place, we're all nattering together". Staff were attentive and asked people if they were enjoying what they had chosen. Where people needed assistance to eat or drink, staff sat with them and provided one to one support. This was done very calmly and at a pace led by the person. When one person didn't appear enthusiastic about eating, the staff member asked, "Would you like to get lunch or shall I save it for you?"

Good

Is the service effective?

Throughout the day we saw that staff encouraged people to drink. One person was felling unwell and struggled to drink from a glass. Staff tried offering sips of drink from a teaspoon which appeared to be effective. Staff were vigilant to ensure that people drank, we heard two staff discussing one person who had not been drinking well on the day we visited. Fluid charts were maintained to monitor the volume of fluid that people consumed. These were completed and totalled to show the overall intake. This enabled staff to take action or seek additional support if a person's fluid intake was consistently low.

People had access to healthcare. Staff had made referrals for people, including to the GP, chiropodist, optician and falls prevention team. The district nurses visited the home on a daily basis to administer insulin to some people. A nurse practitioner from the local GP surgery who visited the home weekly told us, "They're onto me like a flash if they are worried and they're very good at putting things in place that I've suggested".

The environment was suitably designed and adapted to support people living with dementia. The home was spread over three floors, each with two units for ten people. Each unit had its own small lounge and kitchen area which made it feel more homely. Dining chairs had arms which helped people to stand more easily. People were able to walk freely on each floor and there were handrails in the corridors to help those with limited mobility. Throughout the home there were interactive items displayed such as old sewing machines, typewriters or a wall of hats that people could take, feel or wear. Each unit had a decorative theme to help orientate people. Some of the themes encouraged people to think about their interests or past experiences. In one part of the home we saw postcards, flags, maps and pictures of other countries. To help people's visual perception, contrasting colours were used to differentiate between floors and doorways. There was also signage used to orient people to the bathroom, toilets and other key parts of the building.

Good

Is the service caring?

Our findings

People spoke warmly about the staff. One said, "I like it here" and told us, "Everyone is nice and friendly". Staff were kind and caring in the way they supported people. One staff member held a person's hand as she straightened out their collar and cardigan. Another staff member walked arm in arm with a person, both were smiling. When one person appeared distressed, a staff member took their hand and suggested they make a cup of tea together. The person went with the member of staff, observed her making the tea and became visibly more relaxed and calm. One relative had written in a card of thanks, 'They treated the residents as individuals, they were helpful to visitors, nothing was too much trouble for them'. Another wrote that staff, 'Went the extra mile' in their kindness and attention.

Staff spoke about their roles with commitment and enthusiasm. One said "I like it here, and love helping the residents. If you don't feel that way, you couldn't work here". Another told us, "They (the people who lived at the home) become like your family and you care for them as you would your own". One relative had written to staff following the death of their loved one saying, '(Name of person)'s last days were made so special. You were all so kind, you are all stars'.

People and often their relatives had been involved in planning their care. One relative told us, "I've been involved all the way along; I knew exactly what was going to happen". Information about people's families, interests and preferences had been sought when a person moved to the home and specific information, for example that one person liked the have their bathroom light left on at night, had been included in people's care plans. One relative said, "(Name of person) has not been a great one for getting up, she never has been. They (the staff) recognise that". Where people were unable to communicate verbally, details about how they expressed agreement or disagreement was clearly described. This included facial expressions and actions. Staff told us that the home operated a keyworker system. A team leader described the key worker role to us as, "Getting to know the person, going to hospital appointments, sorting wardrobes, clothes and family contact". There was limited evidence of this system in the care records. We saw that staff had been reminded of the importance of this role during a staff meeting in October 2015. They had been reminded that keyworkers should routinely be involved in care plan review meetings.

Throughout our visit we saw that staff involved people in decisions. We saw one staff member ask a person where they would like to eat their meal. There was no rush or pressure to decide where to eat and the person opted to stay in the armchair. One staff member said, "We let them make the decision". Staff prompted people and encouraged them to do things for themselves insofar as possible. For example, we saw a staff member assisting on person as they put their makeup on, others were given verbal support to encourage them to stand independently. One team-leader said, "We want people to keep their mobility and keep their independence".

People we spoke with told us that they were treated with respect. People were called by their preferred names. Staff asked permission before carrying out a task, for example during lunchtime staff asked if they may put an apron on people to protect their clothes. People were able to wash and dress in the privacy of their rooms as each bedroom had its own ensuite wet room.

Requires improvement

Is the service responsive?

Our findings

While staff were kind in their approach and engaged with people as they supported them with their care, we observed that people received limited social stimulation. They often appeared bored, disengaged and many were sleeping in their chairs. One person told us, "I'm not happy here. I'd like to see somebody to talk to on a regular basis". Care staff were busy meeting people's physical needs and had little time to spend chatting with people or engaging them in activities. One staff member said, "This floor is hard work and hectic. Some days there is no time for one to one". Another told us, "There is not time to walk them around the block or to do a puzzle". A third said, "My dream is to have more staff to do more things with residents".

The home employed activities staff from Monday to Saturday. On three days per week there were two activities staff, on the other three days there was one activities staff member supporting 60 people who lived at Elizabeth House. The activity programme included games such as bingo, arts and craft, a 'knit and natter' club, a 'Men's club' and seasonal events. We observed activity staff assisting one person to play pool and encouraging a small group to play a ball game; this game appeared to be greatly enjoyed. Artwork by people who lived at the home was displayed prominently throughout the building including paintings and knitted pieces from the 'Knit and Natter' group.

Records of people's activities were maintained by staff. It was not clear how information on people's individual interests had been used to inform the activities they participated in, though a staff member did tell us they were going to find a poetry book for one person who had expressed an interest in this. We observed some individual activity such as nail painting. We looked at the records of activities/social stimulation for one person who was cared for in their room. There had been no record in the previous month, the last record dated 14 October was that the person listened to music. Prior to that on 30 July it was recorded, 'One to one creamed hands and feet'. Although staff told us that not everything was written down, we discussed our concerns with the registered manager because we felt that some people were at risk of isolation. The registered manager told us that when two activity staff were on duty they felt people were supported emotionally and socially. This accounted for three days per week.

We recommend that the registered manager reviews the availability of staff to promote people's involvement in activities that interest them and to ensure that people's social and emotional needs are met.

When a person moved to the home they and their relatives were asked for information about their support needs and wishes. Care plans included details on how staff should assist people in areas including communication, eating and drinking, medication. There was also information specific health needs, for example for one person who had Parkinson's there were details of the symptoms, medicines prescribed and healthcare professionals involved in their care. While each section of the care plan had been signed as reviewed by staff on a monthly basis, the information was not always consistent and in some cases had not been updated when changes occurred. This meant that risks to people's health were not always promptly addressed which put them at risk of harm. We have made a breach of regulation in relation to this under the Safe domain.

There were also positive examples of staff taking action to respond to people's needs. One person had been regularly admitted to hospital due to blockages in their catheter. We saw that a protocol was in place detailing the steps to be taken before any admission. Another person had a detailed care plan in place entitled, 'verbal aggression'. This set out guidance for staff on how they should respond.

Staff were attentive to people in ensuring that their physical needs were met. We observed that they supported one person, as they were feeling unwell, who would usually manage to eat their lunch independently. They also offered the person soft food as the person agreed it would be easier for them to swallow with their sore throat. When the sun was shining in the eyes of one person, a staff member noticed this quickly and pulled the curtains to make them more comfortable. Staff told us that requests they made to the management, for example for a medicine review or to review a person's care needs as they may require nursing care, were quickly addressed. Staff told us they had a commitment to providing a good quality service for people who lived at the home. Staff confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. The discussion of handover demonstrated that the team

Requires improvement

Is the service responsive?

leaders had a good understanding of people, their needs, their histories and trying to engage with their relatives. They wanted to work with families and listen to their feedback.

People and their relatives told us that they felt confident to raise any concerns. One relative specifically told us that they had no concerns their relative living at the home would be disadvantaged if they raised any concerns. The home held residents' meetings where activities and the menu had been discussed. Relatives were invited to attend relatives' meetings and had also been asked for their views in a survey during September 2015. During the October 2015 relatives' meeting Alzheimer's Awareness Month had been discussed and information and support had been made available to relatives. During our visit one relative raised a concern with us that their mother had been made to go to bed earlier than she wished. They were happy for us to raise this with the registered manager. Following our visit the registered manager provided an update on her investigations into this concern, which included speaking with staff. We found that the registered manager listened appropriately to the concerns and took prompt action to investigate. A social worker told us, "The home have always addressed the family's concerns very openly and very quickly".

People understood how to complain. Information on the complaints process was displayed in the entrance to each unit of the home. This included details on who to contact if the complainant was not happy with the home's initial response. The registered manager audited complaints received and categorised according to topic, for example care/clinical treatment, staff competence or laundry. This helped to identify any patterns. Complaints received had been investigated by either the registered manager or area manager. With one exception, they had been responded to and concluded in line with the provider's policy. Following our visit, the registered manager confirmed that the one point outstanding, a letter concluding a complaint from September 2015, had been sent.

Good

Is the service well-led?

Our findings

People and relatives spoke positively about the home. They told us that they felt able to raise concerns and that there was an open culture. Some spoke of the calm atmosphere or spoke enthusiastically about the pet cat and rabbit. One relative said, "I'm amazed at the difference in (name of their relative). The relaxed atmosphere has made a huge difference". Another told us, "You can also come and make drinks for yourself whenever you want. It's so nice and relaxed".

The registered manager was proud of the community links the home had established. She told us about their activities and events in support of Alzheimer's Awareness Day, of involvement of local schools and youth organisations in visiting the home or in revamping the garden. The provider had a system of recognising achievement. The home had received a 'star' award under this scheme which was prominently displayed. They had also taken part in the National Dementia Care Award, with one person and one staff member nominated for awards.

The registered manager was well respected by the staff team. One said, "We feel very supported by management; I know if I had an issue I would be listened to and it would be sorted". Another said, "Aside from staffing levels I've never really had other issues. (The registered manager) manages to sort it". There were regular staff meetings which were used to share information and keep track of outstanding actions. It was evident from the minutes of the meeting that action was taken in response to issues raised by staff, for example new flannels and towels had been ordered for people. At each meeting, the minutes of the previous meeting were agreed and a plan was agreed to address any outstanding issues. The registered manager was quick to respond to points raised during our inspection. For example, a missing notification to tell us that a DoLS application had been approved was quickly sent and we received a copy of a memo sent to team leaders outlining our initial inspection feedback.

The quality of the service was monitored by a system of internal and provider audits. There was good evidence of the system identifying and driving improvements. We looked at the June and September quarterly audits overseen by the registered manager. These included audits of care plans, infection control, the environment, catering and medication. Most audits had been completed by team leaders who assessed the quality of the service on a floor where they did not generally work. The registered manager reviewed the audits and put in place an improvement plan. The registered manager told us that she conducted spot checks during the day and the night to ensure that the service was running safely and smoothly. She told us that she would start to document these checks as a part of the quality monitoring process. One staff member told us, "She's a good manager. She lets me know of changes and she does sort out any concerns".

On a monthly basis, the registered manager reviewed any accidents or incidents that had occurred in the home. There was evidence of action being taken, for example following several falls one person had been visited by a specialist Parkinson's nurse. We noted that the monthly adverse incident summary report did not include information about the location of incidents. We discussed this with the registered manager as the data was available on the individual incident reports and it might be useful in identifying patterns of incidents occurring at particular times of day.

A representative of the provider visited the service every two months. Each visit consisted of a review of three different regulations along with checks on staffing, safeguarding, pressure areas and complaints. Some data, for example, on any pressure injuries was sent monthly to the provider. This was reviewed by a clinical team who the registered manager told us made contact if they had concerns about the information received, and were able to offer advice. There were also six monthly visits by the provider's quality team. Following each audit an action plan had been drawn up. These had been annotated by the registered manager to show when actions had been completed. For example, in September, it was noted that some staff were due training updates. We checked the training records and saw that this had been addressed with all staff regarding fire training and that those overdue a moving and handling update had reduced from 12 to two. The representative of the provider also noted that some people's meals were interrupted by staff administering their medicines. This had been addressed with staff in the subsequent staff meeting.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Staff had not taken reasonably practicable action to mitigate the risks to people's health and safety.** Regulation 12 (2)(a)(b)