Elmcroft Care Home Limited

Elmcroft Care Home

Inspection report

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Date of inspection visit:
06 December 2022
13 December 2022
19 December 2022

Date of publication:
03 February 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Elmcroft Care Home is a residential care home providing personal and nursing care for up to 54 people. The service primarily provides support to older people and people with dementia. It is also registered to provide support to people with a physical disability, people with a learning disability and autistic people and younger adults. At the time of our inspection there were 42 people using the service.

The care home is in a rural location and has two separate units, called Blythe and GNU.

People's experience of using this service and what we found
Feedback from people and families was negative in relation to poor management. They gave us examples where people's individual needs were not met. They also told us some staff provided good care and recently there had been some improvements to the management of the service.

There had been significant management changes since our last inspection, and a new manager had just joined the service. Although the provider had detailed improvement plans and quality audits in place, these had not always been effective or implemented in a timely manner to ensure people received good quality care.

Morale among some staff was low. Senior staff did not always know what was happening across the service and did not communicate or organise staff effectively. Staffing were recruited safely, however improvements were needed in the oversight of agency staff. A revised timetable for staff training was helping ensure staff had the skills to support people safely and in line with their needs.

People did not consistently have a good quality of life. Staff did not always understand and meet people's needs in a person-centred manner, including around communication and end of life care.

Concerns about people's safety and complaints were not always managed well. The provider had focused on improving safety and practice around medicine management, risk assessment and care planning was improving. Maintenance and refurbishment works were helping minimise the risk of infection.

Staff did not consistently support people to have maximum choice and control of their lives and to support them in the least restrictive way possible and in their best interests. The policies and systems in the service were in place to support this practice but were not applied effectively.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The provider did not demonstrate an understanding of Right support, right care, right culture.

Right Support:
Staff and managers did not consistently support people to have a fulfilling and meaningful everyday life.

Right Care:
People's care, treatment and support plans were being amended to reflect their range of needs.

Right Culture:
The values, attitudes and behaviours of the management and staff did not demonstrate a consistently caring and open culture.

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

Rating at last inspection
The last rating for this service was good (published 5 May 2019).

At our last inspection we recommended the service looks at good practice guidance and environments for people with dementia. At this inspection we found the provider had invested in this area however there was still room to improve the care and environment for people with dementia.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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

We received concerns in relation to poor governance, safety and lack of person-centred care. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elmcroft Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to poor governance and lack of person-centred care at this inspection.

Please see the action we have told the provider to take at the end of this report.

We made a recommendation about Right support, right care, right culture.

Follow up
After the inspection we met with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will also request an action plan from the provider. We will work with the local authority and health professionals to monitor progress. We will continue to monitor information we

receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Elmcroft Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection team consisted of two inspectors, one who was a registered nurse 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. The Expert by Experience visited the service and made phone calls to relatives.

Service and service type
Elmcroft Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The service is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The last registered manager had left in 18/11/2021. A new manager had been in post for a couple of months and had submitted their

application to register before the publication of the report.

Notice of inspection
We carried out two unannounced visits to the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

The inspection
We spoke with fifteen people who used the service and used observation to understand people's experience of care. We met with two family members and three external professionals who were visiting the service. We had phone contact with ten family members for feedback about the service. We reviewed eight people's care records and medication administration records.

We spoke with the new manager, the administrator, reception staff, three nurses, the chef, the activity coordinator, six care staff and two domestic staff. We met with the nominated individual. A nominated individual is responsible for supervising the management of the service on behalf of the provider. We also met with the quality lead, medicine specialist, a consultant, the regional support manager, the associate operations director and the provider's maintenance manager.

We looked at three staff files. We also looked at a variety of records relating to the management of the service and quality assurance arrangements.

After our visit we continued to seek clarification from the provider for further information and to gain assurances about some of the concerns we found during our visit to the service.

We had email contact with five professionals who worked with the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• The safety of people was the main focus of the recent programme of improvements by the provider. With the support of external professionals, processes had started to improve. However poor communication between the staff team and between managers and care staff meant risk was not managed consistently.
• For example, on the first day of our inspection the lounge in the Blythe unit was not in use at 8am. The lights were off, and people remained in their rooms. Staff told us they had been instructed people could not use the lounge unless there was a member of staff sitting with them, irrespective of their needs and any assessed risk. The manager told us staff had misunderstood recent guidance. This issue had been sorted out by the second day of our inspection.
• Key staff told us they did not know who to contact in an emergency and they did not have the managers phone number. The manager disputed this and said staff had contacted them that weekend about a maintenance issue. However, they were not able to show us where their contact details were displayed. After our inspection, improved out of hours measures were put in place.
• We did not find people's safety had been impacted by the above examples. However, poor communication was impacting people's quality of life and the service management of potential risk.
• Processes in place to record accident and incidents were not always followed effectively. For example, it was difficult to review whether action had been taken and lessons learnt after a person had fallen. However, the provider had started to improve the reporting of accidents and incidents, such as introducing appropriate training and discussions in team meetings.
• As part of the programme of improvements at the service, care plans and risk assessments were being revised to ensure they were more person-centred. For example, care plans had been amended to ensure staff had improved guidance to support a person with a specific health condition.
• There were processes to monitor people's safety. People's weights were tracked monthly or as required and any concerns identified escalated for professional support including GP and dieticians. Two professionals we met at the service told us staff worked well with them to manage people's individual risk and needs.

Systems and processes to safeguard people from the risk of abuse
• Improvements were required in how the service managed safeguarding. This included the reporting of concerns, for example, a safeguarding had not been raised when a person had significant bruising following a fall.
• Individual staff told us they were committed to people's safety and to advocating on their behalf. Other staff told us they struggled to speak up, due to the poor culture and communication at the service.
• The provider had worked with the local authority to address these concerns. They had arranged refresher

training and discussed safeguarding in team meetings with staff. They had also arranged training to improve communication around people's safety. These improvements were key to ensuring there was an open culture and people were protected from abuse.

Staffing and recruitment
• Feedback from people about staffing was mixed. Some relatives and people told us there were not enough staff at weekends. One relative told us, "I feel staff need retraining when the buzzer is going, they need to know it means someone needs their help."
• At our visits we found there were enough care staff to keep people safe, though staffing issues impacted on people's wellbeing and unit organisation. There were vacancies for unit leads, so this task fell to the nurses, who were focused on nursing tasks rather than overseeing the running of the unit. There was a lack of staff focused on promoting activities and wellbeing.
• The service used agency staff regularly. The manager they told us they were using agency staff who had been in place for some time, to offer consistency of care. During our visit they were not able to find us the profiles or competency checks for agency staff. We were later sent agency profiles. However, we had concerns about the lack of oversight to the quality of care provided on any given day.
• Systems to develop staff skills were improving. We were concerned however, that staffing turnover meant key learning would lost. The training timetable targeted key areas of concern aimed at improving outcomes for people. A relative told us they were not sure staff were cleaning their family members teeth properly and the provider had arranged oral care training in early 2023.

Using medicines safely
• Improving the safety of medicine administration had been a key focus for the provider and external agencies. Progress had been slow over 2022, and concerns about poorly administered medicines were still being raised by health professionals in the November. By the time of our inspection, we found many areas had improved, though there was still a concern about the systems for oversight of medicine administration.
• Despite senior staff increasing their quality checks, on the day of our inspection the electronic records and medicine stocks did not tally. The provider told us they were aware of this issue and while the new electronic medicine system was being introduced, they were running a parallel paper system.
• Current risk was mitigated by the measures in place to resolve concerns around medicines. The provider had arranged for an internal medicine specialist to work at the service to improve practice. Other managers were focused on improving practice through competency assessments, retraining and revised guidance documents.
• Storage of medicines had improved significantly. The medication rooms had been renovated and new equipment purchased.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
• The service was improving processes and practice to ensure they worked within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty and any conditions related to DoLS authorisations were being met. The provider had reviewed all the mental capacity assessments and best interest assessments as part of their improvement programme and there

was refresher training on mental capacity.
• Our observations and discussions found staff understood mental capacity and people's rights to make decisions. Staff were able to tell us who had capacity and how to support people who were not able to make decisions.

Preventing and controlling infection
• We were somewhat assured that the provider was using PPE effectively and safely. Mask wearing was not consistent among staff. The provider had increased their spot checks and quality visits, which included checking staff were protecting people from the risk of infection.
• The provider was improving how they supported people living at the service to minimise the spread of infection and how they promoted safety through the layout and hygiene practices of the premises. There was ongoing investment in the physical environment. A relative told us, "They have replaced the flooring. It is kept lovely and clean now."
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
• Relatives and friends were able to visit people. Visiting arrangements had been discussed with people and their relatives. Senior staff had explained measures to keep everyone safe, while still enabling visits to take place.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not consistently met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• People's quality of life was inconsistent and depended on the staff on duty. On the morning of our first visit, staff in the Blythe unit told us they were stressed and there was minimal interaction with people. On the second day, the unit was warm and the atmosphere friendly, with a pro-active unit lead who promoted people's wellbeing.

• Mealtime experiences varied. In one dining room, we noted individual people had their practical needs met but there was no oversight to ensure the mealtime was an enjoyable shared event. Only three people ate at the table and they were all served at different times. A member of staff told us about a person who would have liked to eat at the table but had not been supported to do so.

• Relatives described how personal preferences were not accommodated. They said, "The cups staff give [Person] have got handles and they cannot cope as they can only grab cups without handles. I have told the home so many times", "Staff give [Person] cauliflower and green beans which they do not like, but staff still give them" and "I visited recently and [Persons'] clothes were dirty. I came on two days later and they were in the same clothes with more stains."

• For significant periods of time, some people's only contact was with staff who carried out tasks with them. The activity coordinator was stretched and although staff were courteous, some staff did not chat and engage with people when carrying out tasks. This increased the risk of people being lonely and isolated.

• During one of our observations, a person consistently told us they were cold and thirsty. Their care plan highlighted their need for social stimulation. Two members of staff provided a drink and a blanket, however when carrying out the tasks they did not sit and chat with the person or with others in the lounge.

• We had feedback that some staff were not gentle, were rushed and did not know about people's specific needs, especially during personal care. For example, a relative told us staff were not aware their family member bruised easily. Though actions were being taken to address these issues, people could not be sure of receiving care that was specific to their needs.

People were not always supported in a way that was personalised and met their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had arranged training in 'Soft hold and de-escalation' and 'Dignity in care' to address some of the concerns around how staff supported people receiving personal care.

• Although we had concerns with some of the care provided, we observed examples of person-centred care, in particular from established staff who knew people and their preferences well.

• The activity coordinator had been on specialist training and people benefitted from this. A person told us, "Care staff don't talk to me a lot. The activity person does come every day and talk about all sorts of things."
• There had been significant investment in revising people's care plans, and this was starting to improve the quality of the guidance to staff.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
• Some information was available in an accessible format; however, this was not always used. For example, we observed staff taking meal orders and they did not use pictures to help with meal choices, even though we were told by management these were in place.
• The provider's improvement plan reviewing and monitoring care plans and staff practice to ensure people's individual communication needs were being met.

Improving care quality in response to complaints or concerns
• The provider had a complaints process, which included a log summarising the complaints received. However, this did not capture all the informal complaints which had been raised with management. This meant valuable feedback was being lost and due to the management turnover, the provider could not be assured they were capturing and responding to complaints and feedback.
• Families told us the new manager had improved how their concerns were being managed. A relative told us, "I went and met the manager. We seem to be involved more and that is good."

End of life care and support
• Concerns around end of life care reflected the overall concerns around poor organisation and lack of person-centred care. People had end of life care plans; however, some lacked detail. A person's care plan stated the person had chosen not to discuss their end of life, but there was no record staff had involved their relatives in finding out about any specific instructions.
• The provider had arranged additional training, including specialist end of life training for staff. They were also revising end of life care plans.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• In a drive to improve safety, the provider had not focused on people's day-to-day wellbeing. A lack of oversight meant people's quality of life at Elmcroft Care Home was patchy. Staff and managers were not consistently supporting people to achieve good outcomes.
• Feedback was mixed, with relatives and people highlighting numerous concerns. A relative told us, "They need to change now in real time, they need urgent action and support to safeguard those in the home" and "They did have a relative's room where we could make a cup of tea but now it is filled with cardboard boxes. There is no dignity afforded."
• Staff were not clear about the vision for the service. They were not able to tell us who the provider representatives and consultants were. They told us it was confusing as new managers brought in different plans which kept changing. A member of staff told us, "There were plans for a second 'quiet' lounge in one of the units, but who knows what happened about that" and "There is no consistency, if it's confusing for us it must be awful for the people living here."
• Elmcroft Care Home supported three people with learning disabilities and autistic people. Two managers we spoke with were not able to demonstrate they kept up to date with best practice in this area, including the CQC guidance, "Right support, right care, right culture."

We recommend the provider and manager ensure there is a greater understanding of best practice and current guidance around providing care to people with learning disabilities and autistic people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• In November 2021, the local authority told us the provider had failed to meet the requirements of an action plan. A new manager was appointed and continued to work with the local authority to improve care. By November 2022 the manager had left, and concerns continued to escalate. Although improvements were starting to have an impact by the time of our inspection, the provider had not responded in a timely manner to ensure people received good quality, safe care.
• Management turnover and poor staff retention impacted on the quality of care. Relatives commented on the pressure on the new manager who did not have a deputy or effective unit leads. Relatives told us, "The manager is flying solo" and "The manager has just started, and they cannot do it all on their own."
• Roles were not clearly defined. We observed that individual tasks were assigned but lack of oversight meant the service did not run cohesively, such as clearly defining who was responsible for ensuring the

quality of care and experience on any given day.
• There were a number of audits in place, however they had failed to resolve the concerns we found at our inspection, in particular around people's quality of life. A member of staff discussed their concerns about some of the quality audits. They told us, "There is an inclusion timetable where staff record contact so it sounds like people get a lot of attention but how does the manager know whether it was a proper chat or just hello as staff run by."

The provider had not ensured effective processes were in place to assess, monitor and improve the quality and safety of the service (including the quality of the experience of people receiving the service). This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The manager and provider told us staffing issues had been exacerbated because some staff had left as they did not like some of the changes being brought in to drive improvements, such as organised break times. They told us they were actively recruiting to the vacant posts.
• People and relatives were cautiously positive about the changes since the new manager had arrived in the weeks leading up to the inspection. A relative said, "I've got mixed views, we've had problems in the past, but things have started to change with the new manager who is going in and doing spot checks."
• We found examples where staff were completing their tasks diligently, reflecting a commitment to their role, despite the difficulties at the service. A relative told us, "Staff come in and sometimes they don't know that I am here, and I hear them speak nicely to people."

Working in partnership with others
• The service worked closely and engaged well with external professionals. However, stakeholders told us partnership working was impacted by staff and management turnover. A health professional told us, "The biggest problem is the lack of consistency with staffing. Agency staff do not seem to get a meaningful handover, so they do not always know any specific instructions."
• Other professionals told us the service was working well with them to meet people's needs and make the necessary changes, such as improvement in medicine administration.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Communication was a key issue across the service. Some staff did not feel they were able to speak out safely and others told us they had limited opportunity to speak to senior staff on a regular basis.
• The staffing team was fragmented. On the day of our inspection, there was a handover between nursing staff, however care and domestic staff told us they did not feel involved or valued at the service. Nursing staff had specific concerns around their role and professional registration, which threatened their retention at the service. Following our inspection, the manager set up more regular meetings with staff to resolve the issues highlighted.
• Families told us communication and engagement with them had been poor but had started to improve since the arrival of the new manager at the end of 2022. Review meetings had been arranged with the new manager to ensure people and their representatives had been involved in care planning.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People were not always supported in a way that was personalised and met their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured effective processes were in place to assess, monitor and improve the quality and safety of the service (including the quality of the experience of people receiving the service). This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.