Elmcroft Care Home Limited

Elmcroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The Inspection took place on 5 April 2017.

Elmcroft Care Home provides accommodation, personal care and nursing care for up to 54 people. Some people have dementia related needs and require nursing care. The service consists of two units: the General Nursing Unit (GNU) and Blythe Unit. At the time of our inspection there were 38 people living at the service, 25 in the GNU and 13 in Blythe Unit.

A registered manager was in post at the service. 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.

When we last visited the service in 2015, we found the care in the GNU to be of a good quality and Blythe Unit was not occupied. At this inspection people living in the GNU continued to receive good quality care. However we had concerns regarding the experience of people living in Blythe unit which was now partially occupied.

People living in Blythe Unit had not been supported to settle into their new home in a positive way. The care they received was not person centred and stimulating. Staff did not know or treat people as individuals. Care plans had gaps and there was a focus on meeting physical needs, with insufficient information about people's mental health needs, life histories and preferences.

The registered manager had failed to pick up and resolve the concerns in Blythe unit and to address the lack of consistency across the service.

Staff, people and families were extremely positive about the registered manager. The manager promoted an open culture and relaxed atmosphere in the GNU but the layout of the service meant they were not as visible on Blythe unit. Complaints and concerns were investigated thoroughly.

The manager communicated very well with people, families, staff and professionals. There were measures in place to monitor the quality of the service. Whilst these had not resulted in the manager dealing with the specific issues we found in Blythe unit, we found that in other instances audits and checks had been used to drive improvements.

People were supported to maintain good physical health. Staff ensured people had enough to eat and drink. We made recommendations around supporting people with dementia with their nutrition and hydration needs, in line with best practice.

Across the service, staff focused on keeping people safe. There were effective processes to manage risk.

There were sufficient, safely recruited staff to meet people's needs. Medicines were administered safely by well qualified staff.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made diligently to the relevant local authority. Assessments and care plans within the GNU were complete and reflected people's needs and preferences. Staff knew people well and were caring and person centred in their approach.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Measures to keep people safe were effective.

People were supported by safely recruited staff. There were enough staff on duty to meet people's needs.

Medicines were administered safely and as prescribed.

Is the service effective?

Good

The service was effective.

People were supported to maintain good nutrition and hydration. We made a recommendation about supporting people with dementia to make better choices at meal times.

Staff had the skills to meet people's needs.

People were enabled to make their own choices about the care they received. Decisions made on people's behalf were done in their best interest.

Staff worked well with other professionals to promote people's health.

Is the service caring?

Good

The service was caring.

Staff showed compassion towards people and were not rushed when providing care.

Staff treated people with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People in the Blythe unit did not receive personalised, stimulating care and were lacking in information about people's

preferences and life histories. Staff met people's needs in a personalised way in the GNU and support plans were individualised.

Complaints and concerns were well investigated and responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The introduction of new people into the Blythe unit had not been done in a planned way which proactively promoted people's wellbeing. The service had a number of quality monitoring processes in place which while detailed had not addressed the lack of consistency across the service.

The manager was a good role model. Staff felt valued and morale was good. Poor practice was well managed.

People, families and staff were listened to and communicated with well and their feedback made a difference.

Elmcroft Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 5 April 2017and was unannounced.

The inspection team consisted of two inspectors and a specialist nursing advisor. The nursing advisor was used to check that people's health and care needs were met in a safe and effective way. Before the inspection we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We also reviewed safeguarding alerts and information received from a local authority.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service.

During our inspection we spoke with nine people and two relatives. We also spoke with the registered manager, regional manager, clinical lead, seven care staff and other office staff. We reviewed 10 care files, six staff recruitment files and other records relating to the management of the service. We also spoke with a health professional to find out their views of the service.

Good

Is the service safe?

Our findings

People and their families told us they felt safe at the service and felt able to talk to the staff if they were concerned or worried about anything. A person told us, "I tell the staff they sort anything out."

Staff understood how to protect people from harm and were aware of the signs that could alert them if someone was being abused. Staff knew how to report concerns and were confident that if they raised a safeguarding or whistle-blowing alert the management team would deal with their concerns promptly in order to keep people safe. Prior to our inspection we had noted that the manager carried out extremely detailed investigations into any safeguarding concern. This commitment to openness was mirrored in the statements from staff who told us, "I would report anything of concern and if I was still concerned I would contact social services or CQC" and, "I have never had to report anything but I would go straight to the manager and let them know."

There were effective measures in place to manage risk to people's safety which included detailed risk assessments and ongoing monitoring. For example, people's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for this purpose and guidance was in place about the equipment and care was required to minimise the risk.

Checks on people were proportionate, and not unduly restrictive. For instance, the manager told us that fluid checks used to be carried out on all the people at the service but now this was only done where people were thought to be at risk. We saw that a person who was felt to be at risk due to their complex health needs had welfare checks every 30 minutes to ensure they were safe. In addition, staff monitored their food and fluid intake and regularly carried out checks of their skin to monitor any vulnerable pressure areas.

Accidents and incidents were well documented; investigated and practical improvements were made. For example, a person had fallen and it was decided this was due to the positioning of their wheelchair in their bathroom. Staff now had clear instructions to ensure the wheelchair was stored safely.

Staff we spoke to demonstrated a good awareness of the risks to people and how they should be managed. The staff team gave examples of specific areas of risk and explained how they had worked with the individuals to help them understand the risks. A staff member described how they checked that a person who used a frame had a clear route around the service to ensure there were no trip hazards that might prevent them walking independently.

Environmental risk was well managed across the service. There were clear risk assessments in place, for example for managing electrical safety. Daily maintenance checks were thorough and picked up any outstanding concerns. Any equipment used by people, such as hoists or wheelchair were monitored to ensure they could be used safely. There were codes on all the doors, which were in place to keep people safe. However, each code had a different number which was unduly complicated and restrictive. We fed this back to the manager who said they would change this to one simple code so that people would not be unnecessarily restricted.

There were enough suitably skilled staff on duty to meet keep people safe. People told us, "When I call for staff someone always comes" and "Someone always comes when I press the buzzer sometimes they say they will come back in a few minutes but they always come straight away." We observed thought-out our inspection staff responding to call bells in a timely way and people were not having to wait to be supported to use the toilet or for a drink or something to eat. Staff were not rushed and spent time chatting to people as they walked around the home.

Systems were in place for the safe recruitment of suitable staff. Staff members described the appropriate checks that were undertaken before they could start working with people. These included references, identity checks and a Disclosure and Barring Service (DBS) checks. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use health and social care services. We saw records where these checks had been completed and recorded. Any gaps in employment had been investigated and documented. Recruitment of permanent staff was an on-going challenge but the manager told us they had introduced a number of initiatives to encourage new staff to join the service, in order to build a stable team. A member of staff told us they appreciated the focus on recruiting the right staff. They commented, "We have really good care staff and the right people are being recruited."

People received support to take their medicines safely and as prescribed. Guidance on medicines was clear and personalised. Staff were knowledgeable about medicines and the importance of their responsibility in this area. Each nurse coming on shift carried out a check on all of the medication administration record sheets (MARS) to check medicine had been administered accurately and signed for by the preceding nurse. They also checked that all the correct amount of medication was available. We looked at a selection of MARS and noted there were no omissions or gaps. There was a policy for giving out as and when required medicine, for example for pain relief, and it was being followed safely by staff.

Medication was securely stored and staff was able to clearly explain the medication signing in and out procedure. The clinical lead carried out audits every week on both the systems and looked for any omissions.

Good

Is the service effective?

Our findings

People received care and support from a competent and well-trained staff team. There was a high level of motivation and cohesion within the staff team in the GNU, however within the Blythe unit staff were not yet working as effectively as a team. Staff completed a wide selection of training which was both classroom based and online. There were measures in place to ensure there were no gaps in staff training. Care staff told us the qualified nurses also provided guidance and taught them about supporting people with specific health needs such as diabetes. A member of staff told us, "The nurses are always around to ask for help and advice any problems I just ask them."

Staff told us they completed an induction programme on commencing work at the service which included a mixture formal training and shadowing experienced staff. One newly recruited staff member said, "I had to do the mandatory training and the care certificate." The care certificate represents a set of standards which ensure care staff have a broad knowledge of good working practice within the care sector. Another new staff member told us senior staff were very supportive and stated, "I pop in the office and they support me with completing the care certificate."

Staff we spoke with during the inspection told us that they received regular supervision from senior staff and appraisals were carried out by the registered manager. Staff told us, "We have supervision and staff meetings, and appraisals carried out by the managers." and "I have had two (supervision meetings) already and haven't been here long, it is helpful as I can talk any problems through and ask for advice."

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. The provider was meeting the requirements of the DoLS. We noted the manager had applied to the relevant authority for DoLS authorisation where people lacked capacity and needed constant supervision to keep them safe.

Prior to our inspection the manager had contacted us to ensure they were correctly meeting their responsibilities under the MCA. They had carried out research and made detailed enquiries which demonstrated a commitment to upholding people's rights.

Staff received training in the Mental Capacity Act 2005 and DoLS. All of the staff we spoke with had a good

understanding of how to apply the principles of the act in practice to support people to make decisions. Staff understood the importance of assessing whether a person could make a decision and the steps they should take to support decision-making, for example, presenting information in a way that people could understand and giving people the time and the space to process information.

We observed lunch in both units. We saw tables were laid attractively and this was a sociable activity. People were given a choice of where they would like to sit and what they would like to drink. People sat in friendship groups and there were enough staff to promote a pleasant atmosphere. A person told us, "I like the food, there is plenty of it." There were two meal sittings and we were told people could choose what time they came for lunch. We observed one person ate slowly but were not hurried by staff to finish their meal before the later sitting.

People had made a choice about meal choices beforehand and we observed that staff sometimes served food to people without further communication about their chosen meals. We were told people could swap meals if they wished but we found staff did not pro-actively support this choice at meal times, in line with best practice. For instance, there were no picture menus or sample plates to support people with dementia to make meal choices.

We recommend the service seeks improved guidance on how to improve choice and decision making for people with dementia, in line with current best practice.

People's specialist nutritional needs were met. For example, people were given pureed food if required. The food was individually pureed therefore it had different colours and textures and still looked appetising. People received the support they needed to eat, and this was done skilfully. For example, we observed a person being supported to eat and the member of staff told them each time what food was on the spoon.

Throughout the day we observed a variety of snacks and drinks being offered which included bite size pieces of fruit, crisps, chocolate and sweets and in the afternoon people had a choice of different cakes.

Staff supported people to maintain good health and wellbeing. A care staff told us, "If I was ever concerned about someone's health, I would let the nursing staff know." Relatives said, "The nurses here are very good they are quick to pick up any problems with [relative] and staff always let us know."

We saw that staff were pro-active at making referrals to outsider professionals. For instance, one person had been referred to the memory clinic for an assessment. Staff were concerned another person was depressed and had asked the GP to review them. Staff were working well with other professionals to support the person, for instance they were completing various monitoring charts staff and professionals were better able to understand their health needs.

Good

Is the service caring?

Our findings

People we spoke to told us the staff were kind and caring. Comments included, "The staff are lovely so helpful, they are all good" and "The staff took me to my sisters funeral it was lovely of them I wouldn't have been able to go otherwise."

Within the GNU, staff knew people well. We observed a member of staff speaking kindly to a person when they became confused about what drink they wanted. A person had a pet and we observed a member of staff chatting with them about how they had turned a fan on in the bedroom as it had been a bit hot for the pet. However, people had only recently moved to Blythe unit and we found staff did not know people as well, so were not able to talk to them in such a personal way.

When staff spoke with us they were respectful in the way they referred to people. One member of staff said, "The best thing is making people smile it makes the job worthwhile." Staff spoke compassionately about the people they supported and wanted to promote people's welfare and well-being.

Whilst we found staff did not always use best practice when working with people with dementia we observed across the service that staff communicated well with people which meant they were involved in the care they received. We saw staff giving people time to respond to questions without rushing them. Staff ensured people had understood what they had said and maintained good eye contact for example, when staff were speaking to people who were in wheelchairs or in bed they got down to their level.. We observed at lunch time on the GNU people were chatting within friendship groups and when a member of staff interrupted the conversation they were respectful and apologetic.

We asked staff members how they supported people to maintain their independence. One staff member told us, "I encourage people as much as possible it is important even if they can only do small things" and "Some people just need a lot of time but they get there eventually you mustn't rush them."

We observed someone being transferred from their bed to wheelchair because they wanted to use the toilet independently. Two staff supported the person and showed competency and confidence throughout. The person they were supporting became tired and needed encouragement and the staff worked really hard to enable this person to be as independent as possible. The person's dignity was ensured at all times and they spoke to the person letting them know exactly what they were doing.

The staff we spoke with explained how they maintained the privacy and dignity of the people that they care for and told us that this was a fundamental part of their role. One staff member told us, "I make sure the curtains are closed and doors are shut." We observed staff cover a person up when their underwear was showing after they got up from lunch.

The manager had instilled an exceptional culture around confidentiality. In our communications with them outside of the inspection, we noted they had introduced stringent measures to ensure any personal information about people was sent to us in a secure way. This demonstrated a respect for the rights of

people to have their information stored and shared in a respectful, confidential way.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with were very positive about the care they received. One relative told us, "I can only say good things." Whilst we found that people living in the General Nursing Unit (GNU) received good quality of care, this was not consistent across the service and the care provided in Blythe Unit was not of the same standard. Whilst the people in this unit were safe and had their clinical needs met, the atmosphere was unstimulating and care was not person-centred.

The Blythe unit was not fully occupied on the day of our inspection. The manager told us this unit had not been opened for very long and staff were still in the process of assessing people's needs and getting to know them. We spoke with a health professional who visited the service around the same time as our inspection to find out their views of the service. Whilst they were positive about the care in the GNU they expressed concern regarding the inconsistency of care experienced by people living in Blythe unit.

We found a number of examples where people in Blythe unit did not receive personalised care. We spoke with two people in Blythe unit who were both in bed. Their bed linen was dirty and their clothes had food spilt on them from their breakfast. We saw another person had a radio on which was not tuned in properly. The person could not reach the radio themselves and was unable to ask staff to do so. We observed staff walk by their room but they did not stop and tune the radio which demonstrated a lack of attention to people's individual needs.

During lunch in the Blythe unit we observed one person was unable to reach for their food where staff had placed it and when we spoke with the person they asked us to give them their food as they were hungry. When we bought this to the attention of staff they told us the person was able to feed themselves but needed the food placed on their lap as they were unable to move however the person handing out meals had not been aware of this information.

We observed nine residents sat in the Blythe unit lounge in the morning. The television was on and did not see any activity or meaningful interactions taking place. Staff were sat at a table completing daily records. A staff member told us that the three people at risk of falling were sat in the lounge to ease observation. Whilst this meant they were safe, their support was not being met in a personalised way.

We were told by the manager that the activity coordinator had left and was being replaced. Despite this, people in the GNU were encouraged and supported to take part in activities and we heard chatting and laughter throughout the day. We observed people having their nails painted or a hand massage, as individual interaction took place with staff who knew the people well. A memory quiz took place in the main lounge, during which staff encouraged people to remember facts and memories from their past. Staff knew people well and had personalised care around their needs and preferences. For example, they had supported a married couple sensitively to enable them to spend more time together.

We saw recent photographs of activities which included a variety of activities inside and outside the service. There were examples of links with the local community as local primary school children had come to make

Easter bonnets with people and a local amateur dramatics society had put on a play. However, in Blyth unit we did not observe any activities taking place; staff told us they could only remember two activities within Blythe in the last week. Staff were not observed spending time with people and in contrast to the GNU we did not hear any banter or laughter.

A large proportion of people at the service had dementia. There were few objects around for the purpose of reminiscence. Corridors had not been designed to help people find the way back to rooms. Some rooms had a small box by the door where people could put mementos and personalised objects. We found these were rarely in use. Although caring, staff could not always describe how they specifically supported someone with dementia. After our visit, the manager told us they were working in consultation with people, families and organisations who could provide specialist advice to ensure the service adopted best practice in the area of dementia.

People had their needs assessed prior to moving into the service and care plans were in place to provide guidance to staff on how to support people. We found within Blythe unit that there had been a focus on completing essential physical health care plans to ensure people were safe but the mental health and social care plans had not been completed consistently. In the Blythe Unit peoples care plans less well ordered and did not always provide full and clear information to staff. We noted that a significant number of people on Blythe unit had a pre-existing mental health diagnosis, and staff did not have sufficient guidance on how to meet their needs.

Staff explained to us that records were not always complete because people had only recently moved into the unit. In addition we were told some people were in the unit for respite and these plans did not need to be so detailed. However there was no clear oversight of the gaps in the assessments and a plan to ensure these were completed, where necessary.

In contrast, people in the GNU had care plans which were of a good quality, and well ordered. They were personalised and individualised and had residents' preferences listed. There were snapshot forms which could go with a person, if, for example, they were admitted to hospital or for information for any visiting health or social care professional. Daily preferred routines were listed for personal care delivery, mobility and routines. For example one person's plan said, "I like to sit in my comfy chair during the morning and have a lie down in bed after lunch in the afternoon."

In this unit the mental well-being care plans were in place, though the quality of these plans were inconsistent. We observed staff struggling to support a person with particularly complex needs and noted their care plan was limited in practical advice of what to do in these instances. However, for another person with deteriorating health physical and mental health, assessments were thorough and there had been good communication with external organisations. Staff completed detailed daily records and all the charts we looked as such as food, fluid and movement charts were completed well and in a timely manner.

People and their families told us they didn't have any complaints about the service and that they felt comfortable approaching the manager and staff to raise informal concerns. One person said, "I don't need to complain, they do everything for me, this is a nice home." During our visit we were not aware of any specific complaints regarding the newly opened Blythe unit. We looked at concerns which had been raised with the service and saw that people received a detailed and personalised response from the manager. The service used complaints to make improvements to the service people received, for example concerns regarding specific staff were addressed swiftly.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in 2015 the service had been through a challenging period. The current manager had just arrived at the service and was instrumental in turning the service around. At this inspection we found the GNU continued to function effectively and people there were happy and well cared for. In relation to this unit, the manager had demonstrated positive and visible leadership. Due to the physical layout of the service, the management team and other key senior staff were all based around the GNU and so this unit benefitted from their positive input and oversight.

The concerns we had were primarily over the inconsistency of care, as we found the good practice in the GNU was not mirrored in Blythe unit. There did not appear to be any clear plans in place to effectively manage the increase in numbers in Blythe unit, for example there were no specific activities or measures to introduce people to their new neighbours. Likewise, whilst staff were meeting people's clinical needs, they were not being pro-actively encouraged to get to know people as individuals. We were not aware of efforts by senior staff to promote team building and identity within the unit. Feedback we received from professionals indicated a high use of agency staff to facilitate the opening of the unit, which had negatively affected the ability of staff to get to know people and work well as a team.

When the manager showed us around Blythe Unit during the morning of our visit, we met with a person who was still in bed. The manager helped the person put their hearing aid in, picked a tissue off the floor, and arranged for a member of staff to change the person's dirty shirt and support them to get up. Whilst this demonstrated the manager had high standards of care it also highlighted that basic checks on people's wellbeing were not carried out effectively in that unit.

We discussed this with the registered manager and the regional manager who showed us a new form being introduced to help ensure these basic checks on people's wellbeing were carried out across the service. We were advised after our inspection that this form was put in place immediately after our visit.

The registered manager was required to report regularly to the regional office which analysed trends over time. Senior representatives from the provider carried out monthly audits and an audit had been carried out one month prior to our visit. This audit was of a high quality and had picked up many of our concerns, for example it highlighted the gaps in care plans for newly arrived people. However, we found these gaps had not been completed in the month after the audit had taken place.

At the beginning of our inspection the manager had told us of their upcoming plans to fill Blythe unit. When we later discussed our concerns with the manager and area manager they acknowledged the need to ensure they only took on new people when they were able to meet their needs effectively. Whilst we were assured by this, we were concerned that the manager had not resolved the concerns prior to our inspection.

We were shown a log of compliments which the service had received, cataloguing the positive feedback from people. Much of the feedback pointed to the positive input from the manager. For example, one family member, "We found everything especially the staff to be excellent. I would have no hesitation in

recommending Elmcroft to anyone. The manager and his team are doing an excellent job."

Staff morale at the service was very good. Staff told us the service was well organised and they enjoyed working at the service. They said the management team had visible presence in the daily running of the service. They also told us that they were treated fairly, listened to and that they could approach them at any time if they had a problem. Staff told us, "The management are all great always around and nothing is too much trouble their door is always open," and "I love it here, it is very rewarding."

Staff told us everyone worked as part of a team. They said, "We all support each other everyone gets along it is a happy place to work" and "communication is really good in the home everyone talks and passes on information all the time." Particularly in the GNU and the reception area we saw an emphasis on informality and fun. For example, where there were photos of staff on duty, rather than institutionalised pictures, the photos showed a sense of humour. For example, one was of a housekeeping member of staff showed them folding up clothes.

The manager was very involved in the management of staff, for example, they carried out all annual appraisals. We saw from staff records and through our discussions with staff and the manager that poor practice was dealt with effectively. The manager was a good communicator and there were numerous formal and informal ways in which they ensured they received peoples' feedback and communicated any changes taking place at the service. We were shown minutes of effective relatives and residents meetings, and results of relative and staff surveys. There was a quarterly newsletter which was informative, for example it described the plans in place for a sensory garden.

Prior to our visit we noted that investigations into complaints and safeguarding were exceptionally well carried out. Our inspection confirmed the manager was passionate about resolving concerns when these were highlighted. When there had been concerns the manager learnt lessons and made improvements. For example, following an incident where there had been a delay in communicating an incident to family members, there was now a simple, yet effective checklist to ensure all steps were taken as required. We saw this in place for all incidents and the manager was now able to monitor that staff had communicated with the necessary people.