Care UK Community Partnerships Ltd

Ellesmere 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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6, 7 and 10 July 2017. The first day of the inspection was unannounced. We informed the manager we would be returning to complete the inspection on subsequent days.

At our previous inspection on 25 and 28 September 2015 we found the provider was meeting the regulations we inspected. We indicated that some areas of service delivery required improvement.

Ellesmere House provides accommodation for up to 70 people and is currently divided into four units. Two 15 bed units located on upper floors provide accommodation for people with nursing needs. A 20 bed unit on the first floor is allocated to frail older adults requiring nursing care and the lower ground floor provides residential care for people living with dementia. There were 70 people living in the home at the time of our inspection.

The manager was relatively new in post. She had begun the application process with the CQC to become the registered manager of the home. 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 told us they felt safe and comfortable with the staff providing care and support. Staff members wore uniforms and name badges making it clear what their role was within the home.

Although the provider had taken steps to ensure that risks to people's health and safety were being assessed and monitored, we found incidences where recording charts were not always being completed.

Assessments were completed to identify people's support needs and this information was used to develop their care plans. Care planning records demonstrated that people's capacity was assessed and documented in their care files.

The provider had systems in place to ensure people were protected from the risk of harm. Staff received safeguarding training and were familiar with the provider's policies and procedures in relation to safeguarding vulnerable adults and reporting any concerns. Staff understood the principles of the Mental Capacity Act 2005 (MCA) and promoted people's rights to make choices and decisions.

People were supported to maintain good health and had access to healthcare services and visiting practitioners when required.

People's medicines were stored safely. However, staff were not always observing that people had taken their medicines before signing medicines administration records (MAR).

Robust recruitment practices were in place to ensure people received care and support from staff who were suitably qualified and had the experience to carry out their duties effectively.

People's privacy and dignity was promoted and staff recognised the importance of encouraging people to maintain as much independence as they could.

Where people required support to eat and drink, staff provided people with appropriate support and encouragement.

The service advertised a programme of activities and we were shown pictures of past events and social occasions. However, activities were not always taking place according to the schedule.

People and their relatives told us they had been provided with information about how to make a complaint. Not everyone felt their complaints were listened to.

There were protocols in place to monitor the quality of the service. A range of audits, maintenance and fire checks were carried out on a regular basis. However, these systems were not always identifying and managing the shortfalls we found during the inspection process.

The provider had systems in place for gathering feedback, including visits by Healthwatch dignity champions, relative's surveys and care plan reviews. Daily handovers, supervision and meetings were used to reflect on the standard of care practice and discuss how the service could implement improvements where this was needed.

We have made one recommendation in relation to better communication.

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

Not all aspects of the service were safe.

Although the provider had taken steps to ensure that risks to people's health and safety were being assessed and monitored, we found incidences where recording charts were not always being completed.

Staff were not always observing people taking their medicines before signing medicines administration records (MAR).

The service had policies and procedures in place for safeguarding adults which were available and accessible to members of staff.

Is the service effective?

Good

The service was effective.

Staff promoted good hydration and provided appropriate assistance and encouragement to people requiring support to eat and drink.

People had access to health and social care practitioners as required and were supported to attend medical appointments when this was needed.

People and their relatives (where appropriate) were involved in making decisions about the care and support delivered.

Is the service caring?

Good

The service was caring.

We saw examples of staff providing kind and compassionate care. Staff maintained people's dignity and privacy.

Staff demonstrated a good understanding of the needs of people living with dementia, were interested in people's life histories and aware of their likes and dislikes.

People and their relatives described staff as "very, very good",

"kind", and "lovely."

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People didn't always feel listened to. Responses to queries and concerns were not always being managed promptly.

The service advertised a programme of activities. However, activities were not always taking place according to the schedule.

Most relatives felt the needs of their family members were being met by staff that were well trained and caring.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

There were protocols in place to monitor the quality of the service. However, these systems were not always identifying and managing the shortfalls we found during the inspection process.

The manager had been in post since May 2017 and was therefore relatively new to the service. She told us there were plans in place to improve areas of service delivery where this was required.

A deputy manager provided clinical leadership within the home and had a good understanding of people's lives, their backgrounds and their healthcare needs.

All staff members wore uniforms and name badges making it clear what their role was within the home. Staff were polite and welcoming.

Ellesmere 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 checked 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 6, 7 and 10 July 2017. The first day of the inspection was unannounced. The provider was informed that we would be returning to complete our inspection on subsequent days. The inspection team included one inspector on days one and three and two inspectors on day two.

Before the inspection took place we looked at information the Care Quality Commission (CQC) holds about the service including notifications of significant incidents reported to CQC since our last visit in September 2015.

During the inspection we spent time talking with people living at the home, their relatives and friends. Some of the people living at the service have dementia and other complex health conditions meaning we were not always able to gather their views or understand their direct experiences of life within the home. Because of this we spent time throughout our visit observing interaction between staff and people using the service.

We spoke with the manager and the deputy manager. We also spoke with four nurses, four care staff members, two lifestyle co-coordinators, a hostess, a receptionist and two members of the domestic team. We discussed people's care with a visiting GP and social worker. Following the inspection we discussed the management of the home with representatives from the local authority.

We looked at all the communal parts of the home and with people's agreement, looked at their bedrooms and bathrooms. We observed meals being served, reviewed how medicines were managed and administered and joined a clinical meeting. We reviewed nine care records, six staff files and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. Most of the relatives and family friends we spoke with were satisfied their family members were being well cared for in a safe environment. However, we found that risks to individuals were not always managed effectively to protect them from avoidable harm.

When people moved into the home, staff completed a range of risk assessments in relation to the environment, people's mobility and personal care support needs. Specific individual risks to people's health and well-being were being identified, for example; we saw that an assessment had been completed addressing the increased risk of isolation for one person who was receiving barrier nursing. Best practice guidelines were in place for people with diabetes and epilepsy and for people receiving nutrients, water and medication via a percutaneous endoscopic gastrostomy (PEG) tube. The provider's risk assessment policy stated that risk assessments should be updated as and when risks or significant changes occur or as a minimum on an annual basis. On the whole, we saw that this was being achieved and a brief update summary was being recorded.

Further risk assessments were completed for a number of people who had moved into the home with pre-existing pressure wounds or developed wounds whilst in the home. Where indicated, pressure relieving equipment was in place. Although the provider had taken steps to ensure that risks to people's health and safety were being assessed and monitored we found incidences where recording charts were not always being completed. For example, one person's two hourly turning charts showed a gap of several hours. Staff told us that the person in question had been turned but that they had not yet completed the paperwork.

Medicines were stored securely in locked medicine cupboards. Some but not all staff wore 'do not disturb' tabards in order to minimise the occurrence of any potential medicines administration errors. However, nurses were not always securing medicines trolleys to the wall after completing their rounds. We also observed staff leaving medicines for one person on their bedside table. We queried this with the nurse on duty and were told, "[They] like us to put it on the table. We go back and check. [They] will let us know if there are any problems." We returned to check whether these medicines had been taken and found one tablet had been left on a breakfast plate, one was sitting in a spoon and a third was caught up in this person's bedclothes.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled medicines were stored appropriately and controlled drug (CD) registers were signed and dated by two members of staff. Stock levels corresponded with recorded quantities. People's current medicines were recorded on medicines administration records (MAR) along with their allergy status in order to prevent any inappropriate prescribing. There were individual protocols in place for people prescribed 'as required' medicines (PRN). This meant that staff knew in what circumstances and at what dose, these medicines could be given, such as when people had irregular pain needs or observed changes in mood or sleeping patterns. Items requiring refrigeration were stored correctly and clearly marked with the opening date to

prevent staff continuing to administer expired items such as eye drops. Storage temperatures were monitored and recorded daily. Arrangements for the collection of surplus supplies were organised monthly.

People told us, "It feels safe", "I have all I need" and "I've got a buzzer here for the nurse." Other people we spoke with told us there were enough staff to meet their needs although staff response was sometimes slow at weekends. The manager told us recruitment of new staff was ongoing and that people living in the home were involved in the interviewing process. A May 2017 survey showed an improved level of satisfaction amongst relatives in regards to the availability of staff, with the home scoring 85%, up 10% from scores collated six months previously.

During the day a deputy manager provided clinical support to nursing and care staff across all floors. Additional staff were employed to provide one to one care where this type of individual support was required. A hostess who served drinks and refreshments was on duty four days a week and two lifestyle coordinators were employed to provide a range of activities seven days a week. Staff were easily identifiable and wore uniforms and badges displaying their names and roles.

Staff used hoisting equipment to lift and position people when they were unable to do this for themselves. We asked staff if they felt confident using the available equipment and were told, "We check sling sizes and that the battery is re-charged and working. We ask colleagues to help, gain people's consent and explain everything." Another member of staff told us they felt confident using lifting equipment and always checked for safety and hygiene before operating hoists.

Accident and incidents were reported and logged on a central database allowing a clear overview of any patterns, trends and action taken to prevent further incidents occurring. Where falls had occurred, appropriate steps had been taken to prevent repeat incidents. The deputy manager told us that a physiotherapist and a pharmacist were currently reviewing people's mobility and medicines as part of a joint project to address and minimise the risk of falls within the home.

The service notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations and registration requirements. We saw records demonstrating that where action was required the provider worked in conjunction with local authority safeguarding teams and the police (where appropriate) to manage these events.

The service had policies and procedures in place for safeguarding adults which were available and accessible to members of staff. Staff completed safeguarding training as part of their induction and this training was refreshed as required. Staff demonstrated a good understanding of safeguarding policies and procedures and knew who to contact if they suspected abuse or had other concerns about a person's welfare.

There were effective recruitment and selection processes in place. We saw documentation that recorded where appropriate identity and criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) and DBS applications were up to date. This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services.

Staff records contained application forms, job descriptions and employment contracts. Records showed that qualified nurses working in the home on a permanent basis had up to date registration with the Nursing and Midwifery Council (NMC). It is the responsibility of the provider to satisfy themselves that all agency and bank staff have also undergone similar checks and are safe to work with people living in the home.

The home environment was clean and free from odours. Staff and people visiting the service had access to hand gels to clean their hands. Staff were seen to be wearing gloves and aprons and following appropriate hand hygiene procedures. Staff told us they sometimes ran out of appropriate barrier nursing gloves and aprons and that this was a concern for them. The manager told us that in these incidences, they would procure items from the Chelsea and Westminster hospital situated next door to the home.

Good

Is the service effective?

Our findings

People were supported to maintain good health and had access to healthcare services and visiting practitioners when required. A GP visited the home twice weekly and more often if this was needed for people who were unwell or nearing the end of their lives. We spoke with a visiting GP who told us they thought clinical leadership within the home was good and that staff provided good care. We saw that people were seen by mental health professionals, tissue viability nurses, physiotherapists and speech and language therapists. Some visiting services such as chiropody were chargeable.

People and their family members (where appropriate) were involved in making decisions about the care and support delivered. People's care was reviewed regularly during weekly clinical meetings, GP visits and daily staff handovers. This meant staff were kept up to date about any changes to people's health and well-being. One relative we spoke with told us they would like more regular updates about their family member's progress.

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).

The provider was taking proper steps to ensure that people were protected against the risks of receiving care that was unsafe or inappropriate in relation to these safeguards. Staff had attended training which had covered aspects of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Relevant applications had been submitted to the local authority in relation to access in and out of the building, the use of bed rails and one to one supervision. Staff understood the reasons for these decisions and their potential impact on people's freedom. Care plans indicated where people had been assessed for a DoLS authorisation and the relevant capacity assessments had been completed in full.

People were able to eat their meals in communal dining room areas and in their own rooms. Where people required support to eat and drink independently, staff provided people with appropriate support and encouragement. We observed a hot cooked breakfast being served on the top floor of the home consisting of tea and coffee, toast, eggs, beans and sausages. We saw examples of compassionate and caring support being offered to people at mealtimes, where staff spoke gently to people, gave them plenty of time, were seated at the same level and able to converse in an appropriate fashion. Staff were aware of people's recommended dietary requirements such as pureed and soft food diets.

One person told us, "If I don't like something we can ask for something else" and another person commented, "I eat anything that's edible and I like washing the dishes." Other people we spoke with were not particularly enthusiastic about the food choices available to them and told us, "I don't always like the

food on offer", the food is "boring" and "the same menu every week." One person told us the provider didn't cater for different cultural preferences and said "Sometimes I can't eat at all because the food has got no taste."

The manager informed us there were plans in progress to improve the meals provided in the home. New chefs were being interviewed and part of this process would involve applicants producing sample menus to be tried and tested by people living in the home and staff. The manager told us that an increased budget would also allow chefs to produce meals that are nutritious, appetising and culturally appropriate for all of the people living in the home.

Staff promoted good hydration and we saw a range of chilled, sugar free flavoured drinks being offered to people at mealtimes and throughout the day. Fresh fruit was available at each of the nursing stations and tea and other refreshments were served between main meals.

The provider ensured induction programmes for new staff were meeting the requirements of the national standard of good practice. New staff completed an induction which included elements of the Skills for Care common induction standards, which have now been replaced by the Care Certificate. New staff were required to complete training in areas such as, moving and handling, dementia awareness, fire safety, infection control and mental health legislation.

New staff completed both classroom and e-learning and were required to shadow other members of staff before they began working with people on their own. Post induction, staff were required to complete ongoing job specific training such as, medicines management, wound management and care planning.

Good

Is the service caring?

Our findings

People told us, "Most of the staff are nice and help me with whatever I need" and "[Staff] are very, very good." Another person commented, "It's terrific. I think [staff] are wonderful. They are all charming." Another person described the home as "comfortable" and "spacious". Most relatives were complimentary about the care their family members received. One family friend told us they would recommend the home to others and another visitor told us, "It's lovely, it's changed, the staff are lovely."

We asked people if they felt their privacy and dignity was respected by the staff caring for them. One person we spoke with told us, "Staff look after my room. They make sure my bed is made, they wash me, they make sure the door is always closed and they pull the curtains. You have your own shower; you don't have to share anything. That's one thing I like about this place. Some of the carers put cream on my face and some of the night carers are very nice."

We were told that lifestyle coordinators spent one to one time with people learning about who they were as individuals and creating life stories. The manager told us this was a work in progress and had not yet been completed for all of the people living in the home. A member of staff told us, "It's good getting to know everyone. [People living in the home] tell you some lovely stories." Other staff members demonstrated a good awareness of people's likes and dislikes, hobbies and interests and spoke warmly about the people living in the home.

Staff organised parties for people's birthdays. One person told us, "They celebrated my birthday; There was a party and a cake. [Staff] were all very nice to me." Another person whose birthday it was on the day we visited had received a card from a relative. This person asked a member of staff if they could find their glasses so that they could read their card. We observed staff asking permission to enter this person's room and responding kindly to this person's needs.

There were systems in place to ensure people's end of life care was discussed and recorded where people felt ready to talk about this. Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place following appropriate discussions with them and/or their representatives and GPs. This meant people's preferences were known in advance so they were not subjected to unwanted interventions or admission to hospital at the end of their life, unless this was their choice.

Relatives and visitors were able to visit their family members at any time and were made to feel welcome. A relative told us they visited every day and always felt comfortable doing so.

Requires Improvement

Is the service responsive?

Our findings

Where possible, people's care and support was planned in partnership with them. People told us, "The care is alright", "[Staff] do a good job", "[Staff] know what they are doing" and "[Staff] are very kind." Most relatives felt the needs of their family members were being met by staff that were well trained and caring.

Prior to moving into the home, senior staff completed a detailed assessment of people's needs and expectations. Following admission to the home, staff undertook on-going assessments to best identify how people's needs should be met. Assessment information was used to develop a plan of care that provided sufficient information to guide staff and ensure consistent delivery of care. Staff maintained daily records about people's care, including how they were. We saw that support was responsive to people's changing needs and staff recognised how to adjust the care provided dependent on how people were feeling.

The service advertised a programme of activities and we were shown pictures of past events and social occasions. However, activities were not always taking place according to the schedule. Some people we spoke with were unaware of what activities were on offer. We spoke to a lifestyle coordinator who told us they visited people in their rooms, delivered a daily newspaper and stopped to have a chat.

On the first day of our visit we observed one person doing a jigsaw puzzle and another person doing some colouring. An arts and crafts session was due to take place in the afternoon. We were told this had been changed to a baking session. We discussed the low levels of activity within the home with the manager. She acknowledged that activities required more thought and better organisation and told us about future plans which would include music therapy, a resident's choir, pet therapy, spa days and tea parties.

A new cinema room had opened on the ground floor and we were told that people enjoyed their appointments with the visiting hairdresser who had their own allocated salon space within the home. New seating areas provided spaces for people to sit with family and friends and a well-designed garden provided outdoor seating when the weather permitted. Volunteers were also working in collaboration with the home to support people on a one to one basis. However, one person told us they felt lonely and commented "[Staff] come and bring me things but they don't come to chat." Another person told us, "It gets a bit boring at times." On the second day of our visit, we saw a birthday party in full swing. Performers sang, there was flag waving, wine and birthday cake was served and people appeared to be having a good time.

People we spoke with told us they knew how to make a complaint and to whom. However, one person told us, "They don't take much notice of you if you complain; they say oh yes I'll do it, go away and don't come back. I usually tell my [family member]." A relative told us their concerns were not responded to in a timely manner and we heard from a local authority representative that the manager didn't always respond to requests for information promptly.

We recommend the provider revises its communication methods and complaints procedures to ensure people are heard and responded to in a timely manner and where concerns have been raised, these are investigated fully, a satisfactory solution/outcome achieved and the relevant people informed.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since May 2017 and was therefore relatively new to the service. She was a registered nurse with many years' experience in NHS services and an active member of the Institute of Healthcare Managers. She was supported in her role by a deputy manager who was also a qualified and registered nurse. Both managers provided clinical leadership within the home.

There were protocols in place to monitor the quality of the service. However, these systems were not always effective. Shortfalls we found during the inspection process in relation to medicines management and people's health and safety had not been identified or addressed through the provider's quality control procedures.

Staff from across all departments attended a daily meeting where issues relating to maintenance, medicines, meals, visits from health and social care professionals, new arrivals and departures were discussed. This meant staff were kept up to date and informed about issues, concerns and any plan of action in place to address them.

The management team met regularly with service commissioners and healthcare professionals to discuss service improvement, referral processes, safeguarding, staffing issues, complaints and compliments.

A range of audits were conducted on a regular basis. Fire checks were carried out weekly and there were systems in place to identify the type of assistance people would require in a fire evacuation scenario. We saw a report dated December 2016 from the London Fire and Emergency Planning Authority stating that an inspection of the premises had been satisfactory.

The provider had systems in place for gathering feedback, including visits by Healthwatch dignity champions, relative's surveys and care plan reviews. Daily handovers, supervision and meetings were used to reflect on the standard of care practice and discuss how the service could implement improvements where this was needed.

We were provided with a tour of the building by the deputy manager at the start of our inspection and introduced to people living in the home and staff members. The deputy manager had a good understanding of people's lives, their backgrounds and healthcare needs.

We noted a calm and cheerful atmosphere throughout the home. Reception and administrative staff were welcoming and helpful. One member of reception staff told us, "Relatives might approach you with a problem. I make sure I give them all of my time, listen to what they have to say and follow up to see what has been done." Nursing and care staff were caring and responsive to people's needs. Domestic and cleaning staff were friendly and told us they had nothing bad to say about the management team.

One person told us, "We have very, very good staff and new managers with new ideas." Staff developed meaningful relationships with the people they cared for and had fostered good relationships with GPs, local

community nurses, physiotherapists and mental health teams. Healthcare professionals we spoke with were positive about the leadership provided by the managers and the clinical care delivered by the wider nursing team.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always providing care and treatment in a safe way for people using the service.