Care Quality Commission

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?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 5 and 6 March 2015. We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. We also identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance and as a result, issued a warning notice.

Following the inspection in March 2015, we asked the provider to send us an action plan by 15 July 2015 describing the actions they were going to take to meet the legal requirements and what they intended to achieve by their actions. We received the provider's action plan on 11 June 2015.

Due to the significant number of breaches we found during our previous visit, we undertook another full comprehensive inspection on 25 and 28 September 2015. We wanted to check that the provider had followed their plan of action and confirm the service now met legal requirements. The first day of the inspection was unannounced.

Summary of findings

Ellesmere House provides accommodation for people requiring nursing and personal care. The service can accommodate up to 50 people. The home is currently divided into three units. Two 15 bed units located on upper floors provide accommodation for people with nursing needs. A 20 bed unit on the lower ground floor is allocated to people living with dementia. The provider has submitted an application to add a new 20 bed unit which is currently being considered by our registration team. At the time of our inspection 41 people were using the service.

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

People's needs were assessed and care plans were developed to identify what care and support people required. Individual risk assessments had been completed for people living in the home and these were reviewed monthly in line with the provider's policies and procedures.

During our visit, we observed one incident of unsafe practice in relation to the moving and positioning technique of care staff and observed one incident where people's dignity was not being maintained or respected.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others.

Staff had received training in mental health legislation and senior staff understood when a DoLS application should be made and how to submit one. DoLS applications had been made in relation to a number of areas including access in and out of the building and continuous support and supervision.

Staff had previous experience of working in care settings. Most of the staff had completed training in dementia awareness and many had completed or were working towards completing training linked to the Qualification and Credit Framework (QCF) in health and social care. Staffing levels on the day of our visit were adequate to meet the needs of people living in the home.

We saw evidence that the home worked collaboratively with health and social care professionals to ensure people received specialist care and treatment. Specialist nurses, occupational therapists, dentists and podiatrists visited the home on a regular basis. The service maintained a diary detailing all healthcare appointments people were required to attend and had systems in place that ensured people were seen by the appropriate healthcare professionals at the appropriate time.

Staff demonstrated that they understood how to recognise the signs of abuse. Staff told us they would report any concerns to senior members of staff who would then assess the situation and report to the local authority's safeguarding team and the Care Quality Commission (CQC) as required.

The home organised a range of activities and employed two full-time and one part-time activities co-ordinators. Activities included church services, birthday parties, sing along sessions and games. Newspapers were delivered to people's rooms on a daily basis. People's participation in activities in and outside of the home was recorded in a daily record.

A pictorial menu board displayed meal choices although these were not always displaying the actual meals available on the day. Staff were not always ensuring that people who were served meals in the dining areas and in their rooms were in a suitable upright position (where appropriate), to reach their food and eat it without unnecessary difficulty. People's opinions as to the quantity, quality and choice of food on offer, were mostly positive.

We made two recommendations relating to staff training and people's dietary and nutritional needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Aspects of the service were not safe. We observed one incident of unsafe practice in relation to the moving and positioning technique of care staff.

Not all staff were familiar with fire evacuation policies and procedures.

Medicines were stored safely and information about people's known allergies was recorded accurately.

The home environment was clean and free from odours. The control and prevention of infections was well managed.

There were suitable recruitment procedures in place and sufficient numbers of suitably qualified, skilled and experienced staff on duty to safeguard people's health, safety and welfare.

Is the service effective?

Requires improvement

Aspects of the service were not effective. Improvements had been made to the way in which mealtimes were organised. However, we noted on three occasions that people struggled to reach their food.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training in mental health legislation which had covered aspects of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People's care plans were up to date and reviewed and contained the contact details of people's family members, GPs and other healthcare professionals and/or relevant representatives involved in people's care.

Staff had group and individual supervision which meant people were supported by staff who were trained to deliver care safely and to an appropriate standard.

Is the service caring?

Requires improvement

Aspects of the service were not caring. Staff were not always maintaining people's dignity and privacy.

Staff had completed training in dementia care and demonstrated a good understanding of the needs of people living with dementia and other complex health care needs.

People and their relatives used words such as "very kind", "friendly", and "dedicated" to describe staff.

Summary of findings

Is the service responsive?

Good

The service was responsive. The home completed assessments for all people newly referred to the service. Records were complete and contained an appropriate level of detail and had been initialled and dated.

We observed organised activities taking place during our visit which included a birthday tea party, a sing along session and a famous faces guessing game.

We saw that the provider had received and logged four written complaints since our last inspection in March 2015 and responded appropriately to people's concerns.

Is the service well-led?

Good

The service was well-led. We saw that quality monitoring was undertaken to assess compliance with local and national standards. Audits identified areas that required improvement. Recommendations and action points were being followed through systematically.

The service had a registered manager who was responsible for the day to day management of the service and was supported in her role by a deputy manager with clinical skills.

The registered manager told us that as part of their development plans, the service was working towards becoming a beacon site for the provider's new dementia strategy pilot programme. The programme aims to increase the quality of dementia care through training and support from dementia specialists and the creation of dementia champion roles for staff within the home.

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 visit 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.

We also needed to check that improvements had been made to meet legal requirements planned by the provider after our comprehensive inspection on 5 and 6 March 2015. We inspected the service against all of the five questions we ask about services: Is the service safe, effective, caring, responsive and well-led.

This inspection took place on 25 and 28 September 2015. The first day of the inspection was unannounced. The inspection team included an inspection manager, an inspector and a specialist advisor with experience in the care of older people. We were also assisted by an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses services, in this case services for older people and people with dementia.

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 March 2015.

During the inspection we spent time talking with 10 people living at the home and nine visiting relatives/friends. We spoke with the registered manager, a regional director, a governance lead and the deputy/clinical lead. We also spoke with four nurses, nine care staff members, two activity co-ordinators, a hostess, a housekeeper, two of the home's chefs and a member of the domestic team. We discussed people's care with a visiting dentist.

We looked at all the communal parts of the home and with people's agreement, looked at their bedrooms and bathrooms. 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

At our previous inspection in March 2015, people living in the home, relatives and staff members told us there weren't always enough staff on duty to meet people's needs. The registered manager told us that staffing levels had been increased since our last visit and said each nursing unit was now covered by a nurse, a senior care worker and two care staff members. The dementia unit was covered by a team leader and four care staff. The deputy manager provided clinical support to all three units. Additional staff were employed to provide 1:1 care where this type of individual support had been arranged. A hostess who served meals and drinks and supported care staff on the dementia unit with other tasks was on duty four days a week.

During the night, each floor was covered by two care staff with a team leader providing support on the dementia unit and a nurse providing support to all floors. People living in the home told us there were enough staff on duty to meet their needs and relatives told us they were happy with the current staffing levels. The service had two full-time and one part-time activities co-ordinators who provided a range of activities seven days a week. On the day of our visit, we saw sufficient numbers of suitably qualified, skilled and experienced staff on duty to safeguard people's health, safety and welfare. A relative told us, "There is always someone around to help, [staff] are amazing."

Where risks to people's health, safety and welfare were identified, appropriate management plans were developed to minimise them. We looked at nine care plans which showed individualised risk assessments were carried out addressing environmental issues and areas such as personal care, diet and nutrition and falls prevention. Care plans were reviewed and updated on a monthly basis and there was clear evidence that action had been taken when concerns were flagged with senior staff and other healthcare professionals.

At our previous inspection in March 2015, we found that staff were not always completing people's repositioning, fluid and nutrition charts on a daily basis. We found the provider had taken appropriate steps to ensure that risks to people's health and safety were being assessed and monitored appropriately. Charts were completed daily and checked by senior staff for accuracy and consistency.

During our visit we observed one incident of unsafe practice in relation to the moving and positioning technique of care staff. We notified senior staff on duty of our concerns who responded to the situation immediately. We later saw evidence that disciplinary procedures had been operated effectively and that this particular member of staff had been suspended from their duties, pending further investigations.

We had received a number of safeguarding notifications from the provider since our last visit in March 2015. We saw records demonstrating that these matters had been managed appropriately in conjunction with local authority safeguarding teams and the police where appropriate. Senior staff told us they had positive relationships with all of the local authorities they worked with and met with local authority representatives on a fortnightly basis to discuss all aspects of people's care and treatment. Improvement plans were in place with the name of staff members responsible for ensuring action points were completed on a timely basis.

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. We asked staff what they would do if they felt someone living at the home was being abused. Most staff demonstrated that they understood how to recognise the signs of abuse and told us they would report any concerns to senior members of staff who in turn would assess the situation and report to local authority safeguarding teams, the police (if indicated) and the Care Quality Commission (CQC) as required. However, one member of staff was unaware that verbal abuse also needed to be reported as a safeguarding concern.

The provider followed appropriate recruitment procedures and staff files we looked at contained copies of application forms, references, professional registration details and criminal record checks. A staff training matrix showed that most staff had completed training in dementia awareness. In addition to mandatory training covering areas such as fire safety, food hygiene and customer care, a number of staff had completed training linked to the Qualification and Credit Framework (QCF) in health and social care.

Medicines were stored securely in locked medicine cupboards within a secure treatment room. Medicines requiring cold storage were kept within a monitored

Requires improvement

Is the service safe?

refrigerator in the treatment room and storage temperatures were monitored and recorded daily. Controlled drugs were stored securely although we noted that arrangements for the collection of surplus supplies were not always being organised in a timely manner. Medicines were checked against medication identity records and medicines administration recording (MAR) sheets before being administered to people living in the home. People were offered water to take with their medicines, given the time to take them and observed before the relevant records were signed by a suitably qualified/trained member of staff. Eye drops were stored appropriately and labelled with the opening date. Where people required assistance with the application of topical creams, this was recorded in daily records. One person who was self-administering their medicines stored their medicines in a locked drawer and told us, "[Staff] come and check [my medicines] every week". There was an appropriate risk assessment in place for this person.

The provider had taken necessary steps to improve the home environment which was clean and free from odours. The control and prevention of infections was well managed. Staff and people visiting the service had access to hand gels. Staff were seen to be wearing gloves and aprons and following appropriate hand hygiene procedures. Staff wore uniforms and most had name badges. Shared toilet facilities were clean and free from clutter. The home continued to operate pest control measures to ensure the presence of mice was controlled. Domestic staff were observed to be adhering to the cleaning schedule. Infection control was monitored by the provider via an effective auditing system. Building works on the ground floor were ongoing and the registered manager told us the new 20 bed unit would be opening in November 2015.

There were systems in place to identify the type of assistance people would require in a fire evacuation scenario. Corridors and fire exits were kept free of hazards. People's doors were colour coded and corresponded with a central list of people's names kept in the registered manager's office and a fire evacuation folder. However, two staff members were unable to tell us what the colour codes represented. We also noted that emergency contact names and numbers in the fire evacuation folder were incorrect. Following the inspection, the registered manager emailed us copies of updated fire evacuation information.

Requires improvement

Is the service effective?

Our findings

Staff completed care needs assessments for all people newly referred to the service. The service had made notable improvements in the way in which they organised people's care documentation. Each care plan contained a large photograph of the person receiving care and included the contact details of people's family members, GPs, health care professionals and other relevant representatives. Clear information regarding advance care planning had been completed. One page profiles provided brief details of people's like and dislikes, past and present interests. We noted that not all one page profiles had been completed and were told by the registered manager that this was an ongoing project. Reviews of people's health and safety had been completed and were updated on a monthly basis in line with the provider's policies and procedures. Daily progress notes were completed and up to date.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found 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). The Mental Capacity Act 2005 (MCA) provides the legal framework to protect and support people who do not have the capacity to make specific decisions. The home was meeting the requirements of DoLS. Relevant applications had been submitted to the local authority in relation to access in and out of the building 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.

We noted improvements in the way in which mealtimes were organised. However, we observed on three occasions that people struggled to reach their food and had to ask staff to re-position people and/or tables to ensure people were in the optimum position for eating and drinking. We also noted that pop music was being played and televisions were left on during mealtimes. One relative commented, "More thought could be given to the type of music played in the lounge."

We observed staff supporting people to make choices about the food they wanted and offering assistance to those who required it. People were offered a choice of cold drinks and/or water. Staff supported people to eat their meals in an unhurried and relaxed manner. Kitchen staff were adhering to recommendation made by dietitians and speech and language therapists where pureed and soft diets had been recommended but were unaware that some people living in the home had diabetes and may have required a specific diet. We noted that on some days meals did not include any fresh vegetables.

Fresh fruit was available at each of the nursing stations and tea and other refreshments were served between main meals throughout the day. People's opinions as to the quantity, quality and choice of food on offer, were mostly positive. People had opportunities to discuss their food preferences with the chef and provide feedback on a monthly basis in 'meet the chef' sessions.

People were supported to maintain their health and had access to healthcare services. One person told us, "I'm able to attend all my appointments; they just wheel me over the road to the hospital." A multi-disciplinary approach was taken towards a person's care ensuring that people's health and well-being was managed appropriately and effectively. A range of healthcare professionals visited people in the home including GPs, specialist nurses, physiotherapists, occupational therapists and podiatrists. Visits were recorded in a central appointments diary ensuring that appointments were attended and followed up if required. We spoke with a visiting dentist during our visit who told us he had provided training to staff in oral hygiene and preventative care. Staff were aware of how to identify signs of deterioration in someone's health and wellbeing and people's relatives were kept informed of their progress.

People's names were displayed on the doors to their rooms and people were encouraged to furnish their rooms with their own belongings and personal touches. On the dementia unit, at the entrance to people's rooms, framed boxes contained pictures and objects that were meaningful to the people living there and helped to aid identification and memory. A large photo board contained colour pictures of people engaged in activities and art work was on display adding colour and decoration to the home environment. What had previously been a sensory room was now a tea room with chairs and tables laid with china

Requires improvement

Is the service effective?

cups and saucers, available for use by people living in the home, visitors and relatives. A relative told us, "I'm happy for my [family member] to be here. The staff are friendly, it's a modern place, [their] room is nice, and I can't fault it."

Staff were required to complete a three week induction which covered areas such as medicines administration and first aid awareness. Staff completed both classroom and e-learning and shadowed other members of staff before they began working with people on their own.

Staff had group and individual supervision which meant people were supported by staff who were trained to deliver care safely and to an appropriate standard. We saw records of supervision sessions where issues such as training and safeguarding had been discussed. A training matrix showed the training all staff were required to undertake to meet the needs of people they supported such as safeguarding, dementia awareness and infection control. Staff were encouraged to complete further continuous training to develop their skills and knowledge.

We recommend that the provider follow appropriate guidelines in relation to people's nutritional and health needs.

Requires improvement

Is the service caring?

Our findings

Staff developed caring relationships with people using the service and told us, "I love these people; they are part of our family." People and their relatives used words such as "very kind", "friendly", and "dedicated" to describe staff. We observed staff interacting with people living in the home during meal times and activity sessions. One person who preferred to stay in her room told us, "Staff are lovely, we're all friends. Sometimes they come in to chat."

Staff were able to explain and give examples of how they would maintain people's dignity, privacy and independence. One member of staff told us, "We shut doors and close curtains and ask people what they would like. We respect their choices." One person told us, "Staff always knock on my door if they want to come in" and another person said, "I have a shower at 7am every morning, I have women, no men." However, we observed one incident of where staff were not maintaining a person's dignity and reported this to senior staff who spoke with the staff member involved. Records were completed by staff to indicate when people had taken a shower and when personal care tasks had been completed.

We asked staff how they communicated with people who were non-verbal. Staff told us they observed facial expressions and other forms of body language. We noted in one person's care plan that English was not their first language and that interpreters were used for review meetings with healthcare professionals. However, there were no guidelines available for staff as to how to communicate effectively with this person to ensure that they could express their views and have their needs met other than a comment telling staff to use short sentences and speak slowly.

Relatives and friends were able to visit and take their family members out whenever they wished to. One relative told us they took their family member out at least once a week in a wheelchair provided by the home. We heard that other people attended church services and local events and that more plans were underway to organise trips to theatres and other places of interest. Some people indicated that they would like to have more choice around activities in and out of the home.

Staff had completed training in dementia care and demonstrated a good understanding of the needs of people living with dementia and other complex health care needs. Relatives comments included, "[Staff] are absolutely wonderful" and "there has been a change for the better, staff are more friendly, more caring."

During our last inspection in March 2015, we noted that staff were not always aware of or had failed to appreciate the importance of completing in full, documentation relating to end of life decisions. The provider had updated these records and documentation demonstrated that end of life plans had been discussed with people and their family representatives when and where appropriate. Documentation was clear, completed in full and signed appropriately. One person we spoke with regarding these matters told us they were happy with all the arrangements that had been put in place for their last days.

The home had communal lounge areas with televisions and comfortable seating on each floor. The large lounge on the dementia unit led on to a communal garden area currently under re-construction. However, people were still able to access the area and we saw people taking walks and sitting outside for short breaks during our visit.

A hairdresser visited the service and people were able to book an appointment in advance. Weekly manicure sessions were also available to those who chose to partake.

We recommend that staff training is refreshed for all staff in the area of care and dignity principles.

Good

Is the service responsive?

Our findings

During our previous visit we found people's care plans were inconsistently completed. We looked at care documentation relating to nine people living in the home. Records were complete and contained an appropriate level of detail and had been initialled and dated. We found some minor inconsistencies and noted that role titles were sometimes missing from the documentation we reviewed. Information relating to people's pressure wounds was correctly documented and re-positioning charts recorded people's skin integrity accurately. Air mattress settings were documented and checked on a regular basis.

When people were referred to the service, they were visited in their own homes or in hospital by a senior member of staff in order to complete an initial needs assessment. Where possible, people were involved in making decisions about their care and support needs. Where people were not able to make these decisions for themselves, family members (if appropriate) and/or health and social care professionals contributed to the development of care and support plans. The initial assessment process ensured that people's individual care and support needs could be met by the service before people moved into the home. Relatives told us that they were contacted by the home if there were any concerns regarding the health and welfare of their family members and felt involved in the care planning process.

The service now employed two full-time and one part-time activities co-ordinators who provided activities and organised events that people could join in with if they wished to. One person told us, "Staff are all very nice and very charming. If I want to join in with activities I can and if I don't, I don't. Nobody pushes me. It's very relaxed and I'm very happy with the attention and care."

An activities programme was displayed on noticeboards which listed activities such as baking sessions, art groups, movement to music and reminiscence activities. People's activity levels were recorded in a log book. On the day of our visit some people were watching television in the day room. There were sufficient comfortable chairs for the number of people attending. In the afternoon we saw people and their relatives participating in birthday festivities. All attending were encouraged to join in and we saw people singing and dancing and enjoying the tea and cakes prepared and served by staff. Relatives told us, "Things have generally got better since [named member of staff] came. Ten times better organised." Another relative told us, "I couldn't speak more highly of the home. They stimulate my [family member], they are always doing things, and they sit outside and I can come and visit whenever I like."

We saw copies of the complaints policy displayed within the home. The policy explained how to make a complaint and to whom. We saw that the provider had received and logged four written complaints since the last inspection in March 2015, relating to standards of care, food and building works. We saw that these issues and/or concerns had been resolved following a written response and/or review meetings and changes to care plans.

Comment cards were available throughout the home and we saw evidence that people were asked for their views on an individual basis about the care they received and how the service was run. People's views were gathered on a monthly basis when their care plans were updated. We were told meetings were held for relatives on a regular basis and saw meeting minutes that evidenced that these meetings were well attended. Relatives told us that communication between management and family members had greatly improved.

Good

Is the service well-led?

Our findings

The service had a registered manager who was supported in her role by a deputy manager with clinical skills. People living in the home were able to tell us who the registered manager was and staff told us the manager was "supportive" and that they were happy in their jobs.

At our previous inspection in March 2015, we found that quality assurance procedures were failing to ensure people's health, safety and welfare was protected and promoted. The service was now operating a range of effective auditing systems across all areas of service delivery. We looked at a range of audits covering areas such as, health and safety, medicines, tissue viability, staff supervision and support, documentation and nutrition. Action plans were detailed and there were clear lines of responsibility for the actioning and completion of any recommendations made.

Relationships with outside agencies and stakeholders continued to be well managed. We looked at comprehensive quality assurance records and were able to see that the provider had been open and transparent in examining service performance and identifying areas for improvement. Feedback from external stakeholders about the management of the service confirmed that this process continued to be undertaken to their satisfaction.

The provider tailored a range of methods to gain feedback from people and their relatives. These included surveys and feedback cards. People were consulted on an individual basis about which new activities were to be introduced, meal preferences and the care and support they received.

The home worked closely with people's GPs, specialist nurses and mental health clinicians and maintained collaborative partnerships with commissioning groups and local authorities.

Relatives and representatives were asked about their views about the care and treatment provided in the home. Relative's meetings were held every six weeks and we saw minutes had been recorded from these meetings. Relatives told us that communication between themselves and the management team had improved. People and their relatives told us they felt comfortable raising concerns or making a complaint.

There were processes in place for reporting accidents and incidents. We saw that accident analysis records had been completed and these records fed into the monthly service report completed by senior managers. Incidents were discussed during staff meetings and within staff supervision sessions.

The service had a whistleblowing policy which provided staff with guidance on how to voice their concerns within the company they were employed by. Not all staff were aware of the policy's existence despite this being provided to staff during their induction training.

The registered manager told us that staff meetings were held on a monthly basis. We read the minutes of the last two staff meetings held and saw that issues such as staff team working, the working culture and practice had been discussed. Staff told us they felt valued but that they would welcome more feedback from senior staff and more opportunities to shape the service.

The registered manager told us that as part of their development plans the service was planning to become a beacon site for the provider's new dementia strategy pilot programme. The programme aims to increase the quality of dementia care through training and support from dementia specialists and the creation of dementia champion roles for staff within the home.