Croftwood Care UK Limited

Elm House Residential Care Home

Inspection report

76 Pillory Street
Nantwich
Cheshire
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Elm House is a purpose-built building. It lies on a large plot of land, in Nantwich, near to shops and public transport facilities. It has three floors which are accessible via a lift. It is registered to provide accommodation and nursing care for up to 40 people.

At the time of our inspection there were 39 people living there. Many of these people were unable to give us verbal feedback about their views on the service but we observed them and their interactions with staff, during our inspection. We spoke with visitors to the home, so that we had their opinions to support our own observations.

The home requires 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. There was a registered manager in place.

We found that the home was a safe environment for people, who were supported by properly recruited staff who administered their medication correctly and who followed the policies and procedures of the provider. However, people told us that staffing levels were poor and we saw that the building was large and in two wings which, on two of the floors, were not connected. This could mean it was difficult for staff to support people it timely way.

People were treated without discrimination and their human rights were protected and promoted. Staff knew how to safeguard people from abuse and how to report any concerns about this or any other accident or incident.

We saw that all the staff treated people as individuals. The records we saw demonstrated that each care plan was individual to the person it was about. However, whilst the care plans were person centred, the daily records lacked detail as they just gave bland statements. People and their relatives told us they were involved in any reviews about their family member's care plans.

The building had been purpose-built and it was safe and well maintained.

Staff were well-trained and supervised and had the skills and knowledge to deliver effective support to people living in the home. Staff understood the Mental Capacity Act 2005 and worked with other agencies to ensure that people had the right support. People were enabled to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were treated with kindness and compassion and staff involved them in decision-making about their day-to-day lives. They promoted people's equality and diversity, gave explanations and information in a way

that people could understand and supported people's well-being and right to privacy.

The people who lived in Elm House could join in with various activities throughout each day.

We saw that the home worked well with other health and social care professionals to provide support to each individual person who lived in Elm House.

The service completed various quality checks and audits including questionnaires to people using it, their relative's and health and social care professionals.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they did not feel there were enough staff enough staff to meet their needs.

Staff were recruited using safe methods including criminal records checks and references.

Medication was administered safely and the home was maintained well.

Is the service effective?

Good

The service was effective.

The home followed the Mental Capacity Act 2005 and people's mental capacity assessments were carried out where appropriate.

Staff were trained and competent to support people's needs.

People's nutrition and hydration needs were supported and meals were cooked in-house from fresh ingredients.

Is the service caring?

Good

The service was caring.

The staff had a kind and respectful approach.

They involved people and communicated in a way that they could understand.

Staff promoted and ensured people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care was planned in a person-centred way and documents reflect that this.

A range of activities was provided people.

People knew how to complain.

Is the service well-led?

Good

The service was well led.

The registered manager was open and transparent.

Staff felt that they were well supported in their roles.

Quality assurance processes and audits ensure that the service continued to improve.

Elm House Residential 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 was 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 was an unannounced, comprehensive inspection. It was carried out by two adult social care inspectors, a specialist nurse adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience had experience of people who lived with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

We reviewed the information that we held on our systems, including any concerns or statutory notifications. Statutory notifications are information about important events which the service is required to send us by law. We also checked with the local authority and the local Healthwatch organisation to see if they had any concerns or information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We looked around the premises, observed the interactions between people living at the home, care delivery and activities provided at the home. As some people were unable to give us their views we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people living at the home, three visitors and eight staff who held various roles at the

home, including the registered manager, deputy manager and carers. We looked at a range of documentation including six people's care records.

We looked at overall medication storage and records, five staff recruitment files, accident and incident records, safeguarding records, health and safety records, complaints records. We also looked at audits and records relating to the quality checks undertaken by staff and other management records related to the running of the home.

Requires Improvement

Is the service safe?

Our findings

People and their visitors told us the home was safe and clean. They said that any risks were well managed, and their medicines were managed well. We saw that people who lived in the home were treated equally and without discrimination. One person told us, "I have a bell for safety or if I am worried". A relative said, "I know that she is looked after and safe here".

Although the registered manager told us they used a dependency tool to determine how many staff should be on duty, the feedback that we had from staff themselves, the people who lived in the home and their relatives was that there were not sufficient staff. One person told us, "The staff are marvellous; they are in short supply but they are very good".

The building was large and in two wings, which were not joined to each other on the first and second floors. We observed that this was difficult for staff to support people in a timely way. On the day of our inspection there were four care staff on duty and one care team leader. We saw during lunchtime, that two people needed support to eat and that another member of staff was undertaking a medication round. The fourth and fifth members of staff were working elsewhere in the home, supporting people who remained in their rooms. This meant that this staff member was distracted every time the doorbell rang and that they had to lock up the medication trolley to answer the door. Although we not see any issues during our inspection, we were concerned that two staff may be required at times to support some of the people at any time of the day or night. For example, staff might be needed to help people mobilise or to use the toilet. With the numbers of staff available, this could mean delays for other people. A relative told us, "There are not enough staff" and another relative said, "The staff do well with the pressures they work under".

One relative told us that they were concerned because staff were under pressure and subsequently left employment with the home. They told us, "There are changes in staff; they don't stay, they move on". We discussed this with the manager who told us that staffing numbers would be looked at again. The home has since confirmed that it has increased the numbers of night care staff to three. They also told us that nobody had ever raised any concerns to them.

We recommend that the home reviews its staffing levels in line with the layout of the property and people's assessed needs.

Staff were recruited safely and we saw in their recruitment records that, for example, application forms, criminal records checks, proof of the applicant's right to work in UK and references had been obtained and were recorded appropriately. The registered manager told us that a person who lived in the home who wanted to, could be involved in the interview process. The manager told us that they wanted to recruit, "The right person for the right people".

The home had systems and processes to safeguard people from abuse. There were safeguarding and whistleblowing policies and staff had been trained in safeguarding vulnerable people. They could demonstrate that they knew how to raise a safeguarding alert and there was information around the home

with contact numbers. We reviewed the home's safeguarding records and found that appropriate actions had been taken when concerns were raised. We noted that the home was meeting its obligation to notify CQC of incidents or concerns of this nature.

Personalised risk assessments had been completed for various aspects of people's care, such as moving and handling, pressure relief and mobility and were reviewed regularly. The risk assessments gave staff the information they needed to safely manage these risks.

Medication was correctly administered and recorded. However, we saw that the medication fridge needed a lock and that some temperature records showed gaps. We discussed this with the registered manager who assured us that this would be addressed. The medication administration records (MARs) we looked at had been appropriately completed and medication stocks were accurately accounted for. This included administering and recording, 'as required' (PRN) medication. We saw that relevant staff had received training on medication administration and there were policies and procedures in place to support them. Their competency to administer medication was assessed annually and the registered manager carried out monthly audits to ensure medication was being safely administered, stored and recorded.
The home was well-maintained and the safety of the environment was regularly checked by staff. The home had a variety of up-to-date safety certificates that demonstrated that utilities and services, such as gas and electric had been tested and maintained. We saw legionella checks had been appropriately carried out. Legionella is a water-borne bacteria often found in poorly maintained water systems.

Fire safety at the home was well-managed. This included a fire risk assessment; regular checks and maintenance of fire safety and firefighting equipment; personal emergency evacuation plans (PEEPs) for people living at the home; fire safety training and a business continuity plan in place to guide staff in the event of an emergency. A recent inspection from the local fire brigade had found that everything was in order.

We saw that accident and incident policies and procedures were in place and there was a system to record any accidents and incidents that had occurred. Appropriate action had been taken in response to those incidents that had occurred. We also noted that this information was reviewed to help identify any emerging patterns or trends that needed addressing.

During our inspection the home was visibly clean and free from unpleasant odours. We saw that there were effective infection control procedures in place. The staff we spoke with could tell us how they ensured they followed best practice guidance around infection prevention. We observed that staff used personal protective equipment (PPE) when necessary, such as when supporting people with personal care or serving food. This meant that staff and people were protected from the risk of infection being spread. One member of staff told us, "We make sure we use PPE and take this off before leaving the person's room, we keep the home clean and make sure we use the correct bags when handling soiled clothes". Housekeeping staff ensured that cleanliness was maintained.

Good

Is the service effective?

Our findings

People's needs were effectively assessed before they were supported by the service. This ensured that staff at the home had the skills and capacity to safely and effectively meet people's needs. The information from the assessment was developed to be more detailed in the care plans and risk assessments. People's needs in relation to equality and diversity were considered during the assessment process and included within the care plans, such as age, disability, preferences, cultural needs and religion.

People's care plans clearly identified each type of support need, the associated aim or outcome desired and information about how staff could support the person to achieve this. People told us that staff supported them to maintain their health and wellbeing, such as accessing relevant other health care professionals when necessary. For example, saw that referrals had been made to dieticians, geriatricians, opticians and dentists for people in the home.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met and found that it was. People's mental capacity had been appropriately assessed where required and appropriate DoLS applications made to the local authority. These were reviewed and updated as necessary.

All new staff completed a thorough induction programme at the start of their employment. This included a three-month probation period in which staff completed training, competency assessments, an introduction to policies and procedures and had regular supervisions with the registered manager before being signed off as a permanent member of staff. All new staff also completed the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives staff who are new to care the introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. Other staff were qualified to either level two or three of the national vocational qualification (NVQ).

All staff had received training relevant to their roles and the staff we spoke with gave positive feedback about training provided by the service. This included manual handling, safe handling of medications, safeguarding, mental capacity, infection control, equality and diversity and dementia awareness, stroke awareness and end of life care. Updated training had also been completed by most staff. One person said,

"The staff are definitely well trained".

Staff were well-supported with regular supervisions and annual appraisals. There were regular staff meetings which conveyed information and gave staff an opportunity to talk to management in a group setting. Staff told us that they felt supported in their roles and all other staff, including the registered manager and deputy manager, were approachable and helpful.

Most of the people we spoke with told us they enjoyed the food and drink at the home. One person told us, "I think the food is excellent!" Another said, "I can't complain about my food". We saw that meals were freshly prepared each day and people were given a choice of nutritious foods to help them to maintain a healthy and balanced diet. We sampled the food and found it to be tasty and hot. Relevant information regarding anyone who required special diets, such as diabetic, fortified or soft diets, was available in the kitchen for guidance. The kitchen had been awarded a rating of five, for their food hygiene standard, which is the highest attainable. Records showed that people were being supported to have enough to eat and drink and we saw that people that required assistance to eat and drink were given this support by staff. People were offered drinks frequently during the day and could ask for drinks if they wished to. We saw that people had jugs of juice or water in their rooms.
People had been able to personalise their rooms with their own pictures, items and furniture. Some of the people living at the home were living with dementia. People looked happy and relaxed in the home. At points in some of the corridors where they widened, there were mini lounges which were well used.

There were some dementia friendly adaptations at the home, such as good contrast in colour, between the flooring and the wall colouring of the communal corridors. However, some of the signage was small and often hidden, for example on the sliding doors to the bathrooms which when open a little, partially hid the sign. We discussed with the registered manager the latest dementia friendly environment research, which is now widely available. They agreed to look at this and implement it where possible.

The home used assistive technology where possible. This included sensors on exit fire doors, and various sensor items for people's rooms such as sensor mats.

Good

Is the service caring?

Our findings

People told us the staff were caring and friendly. One person commented, "The staff are marvellous". Another person told us, "They [staff] do a fantastic job". A relative told us, "I know she is cared for".

We observed caring interactions between staff and people living at the home throughout our inspection. For example, we saw one staff member stop to talk with somebody who looked confused about their surroundings. It was obvious in the way that staff spoke with this person that they knew them well and were experienced in supporting this person.

People and their relatives told us that staff respected and supported them to be as independent as possible. For example, people made their own choices about when to get up in the morning and when to go to bed at night and what to dress in. One person said, "I do whatever I want to. There's no problem".

We saw people moving throughout the home at various times. People could eat and drink when they wanted to and staff supported them to do this.

People and their relatives told us that staff respected their privacy and treated them with dignity and respect. We saw that staff knocked on people's room door and waited for them to answer before entering. We noted that staff used respectful and caring language when communicating with people.

We saw that, in the afternoon of our inspection, the family of one person were all gathered in a mini lounge having tea with their relative and were there for an extended visit. This location in the home gave them privacy from the main lounge and did not interrupt the quiz happening in the main lounge, at the time of their visit. They said this was, "Homely".

We found that staff knew the people they supported at the home and some positive and caring relationships had developed. Staff could tell us about some of the people they supported, including things they liked to eat, drink and do along with the type of care and support they needed. One person commented, "They are wonderful, all of them."

All staff had received training on equality and diversity. We saw from people's care plans and the staff we spoke with that the service treated people as individuals with individual needs. For example, the service considered people's personal histories and any religious and cultural preferences. The relatives we spoke with told us that the service provided care and support which reflected people's needs and preferences and that the staff groups approach was consistently non-discriminatory.

We saw that people's confidential information, such as care plans, was stored securely at the service's office and only people who required access could do so.

People had access to advocacy services where required. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. We spoke with the

manager who was aware of how to make referrals for advocacy support for people where required.

Good

Is the service responsive?

Our findings

The records we saw demonstrated that each care plan was individual to the person it was about.

People living at the home had person centred care plans and risk assessments. The care plans we looked at were regularly reviewed by staff and where possible and appropriate, the people, their relatives and other relevant health professionals were involved in the process of reviewing this information.

We found the information in people's care plans was clear and concise. This meant that staff who were new to the home or agency staff could quickly understand people's care and support needs. However, we saw that the information on the daily records was very brief and not person centred. They usually contained one short sentence which gave basic information but did not relate to a person-centred approach. We discussed this with the manager who told us that he would address this with the staff.

People's care plans gave staff clear information on how to support people with any communication needs, for example, ensuring people who wore hearing aids or glasses were supported to wear them. This demonstrated that the service was acting in line with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for providers of NHS and publicly-funded care to ensure people with a disability or sensory loss can access and understand information they are given. We also saw that information was available in other formats for people to use and read, such as pictorial, large print, other languages than English or Braille.

There was a part time activities coordinator (four days per week) and who arranged a variety of activities for the people who lived in Elm House. The activities we saw scheduled included arts and crafts, chair exercises, days out and quizzes. External activities or entertainment were brought in, such as PAT dogs (pets as therapy) visiting, or an entertainer. People told us that very much enjoyed the quiz shows on television and they said they often competed with each other in the lounge and shouted out the answers. Each person had a home-made birthday cake and a celebration for them on the day of their birthday. People told us that they were able to be escorted to church services, go on outings and trips and have pamper sessions such as nail care when people came into the home to provide services.

People were supported to make choices about what they did and how they spent their time. For example, we saw that people could stay in their rooms if they wished and one relative told us, "The home provides a hairdressing service every Friday but people can invite their own hairdresser into the home if this is their preference and there is one here today". We also found that staff assisted people to go out on trips organised by the home, such as to a candle factory or to afternoon tea at a nearby hotel, or to go out with their relatives.

The home had a complaints policy and procedure in place. We saw that people and their relatives were encouraged to make a complaint if they needed to and the details of how to do so were easily accessible. Most of the people we spoke with told us they have never had any need to make a complaint. A relative told us this, "We deal with issues as they come along and they are mainly resolved". Another relative told us, "I've

never had to complain but if I did I would speak to [Name]". We reviewed the home's complaints records and found that complaints were appropriately recorded and responded to in a timely manner.

Two people living at the home were receiving end of life care at the time of our inspection. Records showed that people were asked about their preferences and choices at the end of their life and this was clearly recorded in people's care records. We saw people's wishes on whether Cardiopulmonary Resuscitation (CPR) should be commenced in the event of them becoming unresponsive had been sought and documented appropriately on a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. We noted that the home had good links with other relevant health professionals to ensure people's end of life care needs were effectively met and noted that several staff had received end of life training.

Good

Is the service well-led?

Our findings

People we spoke with and their relatives felt the service was well-led. One person said, "[The management] are lovely, really nice".

The home required and 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. There was also a deputy manager who had day-to-day responsibility for managing Elm House.

The service had clear lines of accountability and there was a stable management team in place. We found both the registered manager and the deputy manager to be open and transparent. They were helpful and engaging and provided us with all the information that we requested. They shared the responsibility for covering each other and ensuring that the home ran smoothly, throughout the week.

Both managers visited the home throughout the whole week and at various times of the day and night. This meant that they had good oversight of the safety and quality of care being provided.

People and visitors to the home all knew who the managers were as they frequently moved around through the home and were a visible presence. Staff told us that the registered manager had an open-door policy which enabled them to share any urgent issues or concerns straight away. They told us that the managers were supportive. The staff felt there was good morale and teamwork at the home and that all staff supported each other when they needed help.

The service had good community links including attending community-based organisations such as schools and churches. People both visited these and students and members of the churches visited people who lived in the home.

Records showed that the registered manager held regular staff meetings. These meetings were documented and provided staff with the opportunity to receive and share any important information. Staff told us that they had appreciated these and that they were an opportunity for both staff and management to share information.

Residents meetings were held periodically. One person told us, "We have resident's meetings at times, in the lounge". We asked for the minutes of the residents meeting and were given those dated for July 2018. There was a monthly newsletter sent out to people who lived in the home which included news items about events that had happened or were coming up. It also reminded people that they could comment about the home either online or via a freepost card which was available in the reception area. We saw that the home gathered people's feedback about the service provided through inviting people living at the home to complete annual surveys. People relatives were also sent surveys annually. One relative told us, "I have filled in a satisfaction questionnaire so I was able to say that I am quite happy overall with this Home".

The registered manager had a range of regular audits in place to monitor, assess and improve the quality and safety of service being provided at the home. These ranged from environmental and health and safety checks to care plan audits.

The home had a range of policies and procedures in place that staff could access if they needed any guidance. These included policies on safeguarding, medication administration, whistleblowing, equality and diversity and complaints. We saw that these policies and procedures were up-to-date and regularly reviewed.

Registered providers are required to inform the Care Quality Commission (CQC) of certain incidents and events that happen within the service. We saw that the home had notified the CQC of all significant events which had occurred in line with their legal obligations. From April 2015, providers must clearly display their CQC ratings. The home also met its legal obligation to clearly display its most recent CQC rating at the home and on its website.