Alhambra Care Limited

Elm Lodge Residential Care Home

Inspection report

Cluntergate
Horbury
Wakefield
West Yorkshire
WF4 5DB

Tel: 01924262420

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Elm Lodge is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. The service can support up to 17 people.

Elm Lodge is a converted property. It has communal areas on the ground floor with bedrooms on both the ground and first floor.

People's experience of using this service and what we found
The premises and equipment were not clean. Risk assessments were in place, but these were not always an accurate reflection of people's needs. Not all staff had refreshed their fire training and the registered manager was unable to evidence all staff had attended a recent drill. Improvements were needed to ensure staff were always recruited safely. Staff had received medicines training and we observed a member of staff administering medicines to people safely. We have made recommendation about staffing at the home and the management of medicines.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

People and relatives told us staff were caring and kind. We saw staff were friendly and caring in their approach to people, but records did not evidence people were supported to bathe at regular intervals. Most staff involved people in making decisions, but this was not always consistently applied. Staff respected people's right to privacy and took steps to maintain their dignity.

Care plans and daily records lacked detail about peoples likes, preferences and how their care had been provided. We were unable to evidence people were provided with the opportunity to have meaningful social engagement or occupation. The registered provider had recently purchased a 'pod' for the garden to enable people to meet family in the garden. There was a system in place to manage complaints.

Systems of governance were ineffective. Quality monitoring systems had not highlighted or addressed where shortfalls in quality or consistency. Despite our findings, relatives were generally happy with the care provided and staff felt supported by the registered manager. Regular meetings were held with staff and people who lived at the home.

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

Rating at last inspection
The last rating for this service was good (published 13 December 2018).

Why we inspected
We received concerns in relation to infection control, person centred care and management oversight. As a result, we undertook a focused inspection to review the key questions of safe, caring, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key question. We therefore did not inspect the key question, effective. Ratings from previous comprehensive inspections for this key question was used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the relevant sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe.

We have identified breaches in relation to person centred care, safe care and treatment and good governance.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Elm Lodge Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

An Expert by Experience telephoned relatives of people who lived at Elm Lodge, 10 September 2020. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Elm Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
During the inspection, we visited Elm Lodge on 7 September 2020. We spoke with two people who lived at the home, we inspected the cleanliness of the premise and we observed staff's interactions with people. We also reviewed three files around staff recruitment.

We spoke with a total of six staff, including care staff, a domestic and a cook. We spoke with four staff on the day of the inspection and a further two staff, on the telephone, on 17 September 2020.
We also spoke with the registered manager on the telephone on 11 September 2020. An expert by experience spoke on the telephone with nine relatives of people who lived at the home. We also received feedback from an external health care professional.

We reviewed a range of records. This included eleven people's care records and a random sample of medication records. We also looked at a variety of records relating to the management of the service, including audits and action plans.

After the inspection
We requested further information from the registered manager and senior management team to validate the evidence found.

Requires Improvement

Is the service safe?

Our findings

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

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

Preventing and controlling infection
• The premises were not clean. In one person's bedroom their easy chair had substantial staining on the base under the cushion. They had a lanyard with their bedroom door key which was visibly soiled. There was a cobweb hanging from the ceiling.
• We checked another person's easy chair and around the base under the seat cushion was also visibly stained.
• Peoples bedrooms did not always have soap to enable people and staff to wash their hands.
• A communal bathroom had cobwebs, there was hair in the plug hole and the bath seat was stained underneath.
• In the laundry room, both sinks were heavily stained, and the linen cupboard was visibly dusty. The floor covering had a split which meant it could not be thoroughly cleaned.
• The medicine trolley was visibly dirty, and floor was dusty.
• Staff did not consistently comply with current good practice guidance regarding the use of face masks.
• A relative we spoke with commented, "Hygiene stuff could be better, they need to improve their laundry too."

We found no evidence that people had been harmed however, there had been a failure to do all that was reasonably practical to ensure the premises and equipment were clean and to reduce the risk of transmission of infection. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.□□

Assessing risk, safety monitoring and management
• People's risk assessments were not always an accurate reflection of their needs. For example, one person was not supported to bathe due to risks to their safety. They had two risk assessments in place regarding bathing, one of which noted they were not able to use the bath. However, their other risk assessment and their personal care plan made no reference to this.
• Another person had a risk assessment in place for them using a wheelchair. There was very little detail recorded as to how this should be used safely, for example there was no instruction for staff regarding the use of the wheelchair foot plates.
• One person was cared for on a pressure relieving airwave mattress. Their care records made no reference as to the correct setting to ensure the mattress was effective.
• Staff had received fire training, but of the 13 staff listed on the training matrix, eight had not refreshed their fire training in over a year. Fire drills were completed at each monthly staff meeting but there was no oversight of this, so the registered manager was unable to evidence all staff had attended a recent drill.

We found no evidence that people had been harmed however, there had been a failure to ensure the risks to the health and safety of people were robustly assessed and reviewed to ensure they were an accurate reflection of peoples care and support needs. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Regular checks were completed to ensure the premises and equipment were safe and maintained.

Staffing and recruitment
• There were systems in place to check candidate's suitability to work with vulnerable people, but these had not been robustly followed. For example, the registered manager had applied for a criminal records check (DBS) for one staff member who had recently commenced employment. We asked them to check the progress of the application, they told us the DBS was pending and no checks had been completed.
• Relatives told us there were enough staff to meet people's needs. One relative said, "If the bell is rung, they come pretty well straight away." Another relative told us, "Whenever I visited before there was always someone around… If we needed to call for someone it was never long before they came."
• None of the staff raised any concerns about the number of staff deployed on a daily basis. However, we were concerned the current staffing hours and deployment was not enough. This was evidenced from the poor standards of cleanliness around the home, the lack of baths people were offered and the lack of evidence to suggest people were able to participate in meaningful activities and social engagement.

We recommend the registered provider consider their staffing requirements to ensure all aspects of the service are operating in line with current good practice guidance.

Using medicines safely
• Improvements were needed to the management of people's medicines to ensure meet current good practice guidelines.
• Some people were prescribed 'as required' medicines. Protocols were available for staff, but they lacked detail. For example, one person was prescribed a medicine if they became anxious or distressed. The protocol did not detail how this behaviour presented or at what point staff should administer the medicine. Staff had administered the medicine on five days during August 2020. There was nothing recorded as to the rationale or the if the medicine had been effective.
• Staff who administered medicines to people had completed training and as assessment of the competency had been completed. However, the competency assessment had been completed by the registered manager who had not refreshed their training for over five years.

We recommend the provider consider current guidance on medicines management and take action to update their practice accordingly.

Systems and processes to safeguard people from the risk of abuse
• Prior to the inspection we were informed a possible safeguarding incident. We discussed this with the registered manager who assured us they would investigate the concern. They also told us they would discuss safeguarding thresholds with staff to ensure they were aware of the need to report any incidents to a more senior staff member.
• Staff we spoke with told us they had received safeguarding training.
• Both people we spoke with told us they felt safe living at Elm Lodge. Relatives also felt their family member was safe at the home. One relative told us, 'I'm absolutely sure [person] is safe."

Learning lessons when things go wrong

• Accidents and incidents were recorded and analysed to identify possible themes or trends.
• The registered manager demonstrated an open and transparent attitude towards learning lessons when things went wrong. However, as is clearly evidenced throughout this report, further work is needed to ensure that standards and quality are embedded and consistently applied.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• One person who lived at the home said, "I Like to get up early, we can get up when we want…Everything is so nice here, I have been here four years, I am very happy here." We observed people were relaxed in the company of staff and interactions between staff and people were respectful and friendly. It was clear from talking to staff, they knew people well.
• Each of the relatives we spoke with told us staff were caring and kind. Comments included; "I'm very happy. when I see [person's] face lit up at something the staff have said.. I know they are in the right place", "I think they know her well". Another relative said, "From what [relative] has said they are absolutely lovely." An external health care professional told us, via email, "I can confirm that I am satisfied with the care they offer to residents... Whenever I review the clients, they seem happy, well-cared for and have good rapport with the carers and management."
• However, when we reviewed peoples care records, we noted people's individual preferences were not always recorded or adhered to. For example, one person's care plan noted they liked their hair to be washed separately. They had been supported to bath, four times in August 2020 and only had their hair washed once as they had declined on the other occasions.
• People did not always have regular baths. Records for one person noted they were incontinent on a daily basis; however, they were only supported to bathe once during August 2020.
• Entries in daily notes, for four people who lived at the home, made frequent entries about them being ready for bed early and then going to bed after the night staff came on duty. None of their care plans recorded this being their preference.

We found no evidence that people had been harmed however, there had been a failure to ensure peoples care was appropriate and met their needs and preferences. This placed people at risk of neglect. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.□

Supporting people to express their views and be involved in making decisions about their care
• Relatives told us staff at the home kept them informed about their family members care and support. One relative said, "I felt I knew what had happened because they updated me… they did mention medication in the past when it changed." Another relative commented, "If anything changes, they will ring and talk to us."
• We heard staff most staff involving people in making decisions. This included which chair they wanted to sit in and if they wanted to eat their lunch in the lounge or the dining room. But this was not consistently applied. For example, we did not see or hear people being asked which biscuit they wanted with their mid-

morning drink. At lunch time, people were asked what they wanted to eat, but their meal was plated up in the kitchen. This meant they were not able to choose the individual components of their meal.

Respecting and promoting people's privacy, dignity and independence
• People's privacy and dignity was respected. A relative told us, "Before lockdown when I visited, I know they knocked on the door before they came in. If [person] needed changing they closed the bathroom door." Another relative said, "When I was visiting, they always closed the doors so no-one could see in."
• We observed staff knock on doors prior to entering people's bedrooms. We also saw staff use privacy curtains and close doors prior to any personal care intervention.
• Staff encouraged people to retain their independence. One of the staff we spoke with told us how they encouraged one person to wash and dry their own hands and face.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans lacked detail around people's individual needs, preferences. For example, there was a lack of detail about the time people liked to get up or go to bed. Individual clothing preferences were not recorded or the time they may prefer their bath.
• Daily records were not person centred and lacked detail. For example, the care plan for one person noted they needed staff to reposition them every four hours. There daily records did not evidence this was being adhered to.
• We saw an entry in a person's daily records regarding a recent review by their GP. Staff had recorded the person could get themselves "worked up". As a result, the GP prescribed an additional medication to alleviate this. Their daily records, in the three weeks prior to the review made no reference to any anxiety or distress.

We found no evidence that people had been harmed however, there had been a failure to ensure an accurate, complete and contemporaneous record was maintained for each person. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• There was a lack of evidence to demonstrate people were provided with opportunities for meaningful engagement or occupation. The activity board in the entrance to the home was blank had no detail of any activities scheduled for the coming week. The registered manager told us a member of staff was allocated to providing activities for people, although no additional staffing hours had been allocated.
• The care plan for one person noted, "Enjoying helping around the home, particularly the washing up". We reviewed their daily records for August 2020, there was no evidence to suggest this had been facilitated.

We found no evidence that people had been harmed however, there had been a failure to support people to take part in activities which were meaningful and appropriate for them. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.□

• We also reviewed the daily records throughout August 2020 for a further seven people. There was no evidence they had been offered or provided with any form of meaningful activity or social engagement.
• One person who lived at the home told us, "There are doing the garden. So people can come for visits. Its lovely inside." They pointed to a 'pod' in the garden which was to be used to facilitate garden visits for

people with a member of their family.
• The service had purchased an electronic tablet which enabled people to have regular contact with their family and friends. People were also able use it to access individual activities, for example scrabble.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Peoples care records included how they communicated with staff and any support they needed.
• Information could be provided in alternative formats if required.

Improving care quality in response to complaints or concerns
• The registered provider had a complaints policy in place.
• Relatives were aware of how to raise a complaint in the event they were unhappy with the service. One person told us, "I haven't had anything to complain about in the two years." Another relative told us they did not have any complaint but were confident to raise any issues if necessary.
• One relative told us they had raised a complaint with the service, although they did not feel the matter had been fully resolved.

End of life care and support
• At the time of the inspection no one was receiving end of life care.
• The registered manager was aware of how to access additional support in the event of someone's approaching the end of their life.

Requires Improvement

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
• Governance systems had failed to protect people from the possibility of harm and been ineffective in identifying shortfalls in quality. For example, the registered provider and registered manager completed a weekly walk around the home and a monthly infection control audit was completed. Neither of these processes had identified or rectified the concerns we identified with the cleanliness of the home.
• Systems and processes had failed to identify shortfalls in the quality of people's risk assessments, care plans and daily records. Staffing hours did not allow additional hours to enable cleaning to be undertaken when the domestic was not on duty or to enable staff to support people with activities. There had been a failure to notice a member of staff had commenced employment without a DBS being received.
• Furthermore, the registered provider and registered manager had failed to ensure compliance with regulations, best practice or to sustain a rating of good. This demonstrates neither the registered provider or the registered manager understood the principles of good quality assurance and lacked the skills and competence to drive sustained improvement.

The registered provider and the registered manager have repeatedly failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided and the quality of the experience of people who lived at the home. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We wrote to the registered provider after the inspection to ask for a written report as to how they were going to address shortfalls identified within this report.

• Relatives we spoke with were generally satisfied with the management of the home although their feedback was limited due to the restrictions on visiting the home in recent months. Comments included; "We chose this home because it's near me, as far as we're concerned, we're very happy with it" and "It was good when [person] first went there. I'd say it's even better now… and the way they've responding to Covid, they're constructing an outdoor pod so we can visit, it's so important for the residents to see their families."
• When we asked about the registered manager, relatives said, "We believe the manager is very good indeed, she's so caring", and "We have always got on well with the manager. She regularly sits with the residents and I really appreciate that, she makes sure she knows them all well."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff told us there were regular staff meetings. This was evidenced with minutes of all meetings being retained.
• There was also a record of regular meetings with people who lived at the home. Topics included menus and the impact of the pandemic on the home.
• Relatives we spoke had been unable to attend or be involved in any meetings at the home due to the pandemic and restrictions on visiting. One relative commented, "The only thing that would improve it, would be having a system for video calls during lockdown… if they would find a way of face to face zoom calls that would be lovely."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood their requirements to notify CQC of all incidents of concern, including serious injuries, deaths and safeguarding alerts. However, as evidenced in the safe section of the report, there was concern that some incidents may not have been reported as staff may not have reported all possible incidents to the registered manager.
• The previous inspection rating was displayed in the reception area.

Working in partnership with others
• The registered manager and staff worked in partnership with other health care professionals to ensure people received appropriate care interventions.
• Links with the local community had been put on hold due to the pandemic.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always appropriate or met their needs and preferences. People were not provided with the opportunity to take part in activities which were meaningful and appropriate for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The premises and equipment were not clean. Risks to the health and safety of people were not always robustly assessed and reviewed to ensure they were an accurate reflection of peoples care and support needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An accurate, complete and contemporaneous record was not always maintained for each person. Systems and processes of governance were not operated effectively.