Elmcare Limited

Elmwood House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Elmwood House is a residential care home providing personal and nursing care to 32 people. People living at the home had mental health support needs, learning disabilities, autism or physical disabilities. The home had four distinct living areas across three floors. It is a larger home which people move into to have additional nursing support.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Safe and Well Led the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Although staff were focused on providing person centred care to people some of the governance systems didn't ensure these values were embedded in the quality of the home. People were at risk because government guidance to implement infection control systems to reduce the risk of COVID-19 had not been fully implemented. The oversight and governance of people's care and treatment was not adequate to ensure they were able to live as healthy and independent life as they chose.

There were enough staff to meet people's needs promptly and some staff were skilled in supporting people in the least restrictive way identified. However, staffing levels were not regularly reviewed and the recruitment of new staff was not thorough enough. The guidance available for staff was not always detailed enough, reviewed regularly enough and for some circumstances such as certain medicines administration was not in place. This meant people were at an increased risk of harm.

People were included in discussions about the home through meetings and staff felt listened to. Other professionals reported good communication and relationships.

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 27 February 2018)

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding and managing risk. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions.

We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. We have found evidence that the provider needs to make improvement. Please see the Safe and Well led sections of this report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elmwood House on our website at www.cqc.org.uk.

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 as a result of this inspection.

We have identified breaches in relation to safe care and treatment, safe recruitment of staff and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Elmwood House

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 completed by two inspectors.

Service and service type
Elmwood House 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 did not have a manager registered with the Care Quality Commission, although there was a new manager in post. The was a nominated individual in post. A nominated individual is responsible for supervising the management of the service on behalf of the provider. The provider is 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 spoke with the local authority and other health care professionals to obtain their view on the service. We reviewed information we had received from the service such as statutory notifications. We used all of this information to plan our inspection.

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.

During the inspection
We spoke with four people who used the service and two people's relatives about their experience of the care provided. Some people were not as able to verbally communicate with us and so we observed their care and support in communal areas. We spoke with eleven members of staff including the nominated individual, nurses, care workers and kitchen and domestic staff. We also spoke with one visiting professional.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
• The provider had not ensured that COVID-19 government guidance for protecting people from infection during sustained transmission was implemented and followed.
• Personal Protective Equipment (PPE) was not always worn in line with guidance. Some staff were wearing non-surgical face masks which are not fluid repellent and therefore not effective in managing the transmission of infection. Other staff did not wear surgical masks correctly; for example, they had them below their chins, touched them frequently and did not clean their hands in between to replace them.
• At times some staff did not wear surgical masks and said this was because people living in the home did not tolerate them. However, there were no risk assessments completed and no evidence staff had followed government guidance to de-sensitise people to accept the PPE. The staff were close to people supporting them and this put the people at heightened risk of infection.
• Medical procedures were performed for one person which increased the risk of infection spreading and the provider had not ensured the correct PPE was in place for this.
• People were not admitted safely to the service; there were two people who should be completing a period of isolation after admission to the home who were not doing so. This increased the risk of COVID-19 spreading in the home.
• Testing of staff was not in line with government guidance and staff were not always tested weekly. We identified days when staff were at work when they hadn't been tested for over one week and there was no record of the tests they took at home. In addition, there was no record of agency staff testing records. This meant the provider had not implemented guidance to ascertain the COVID-19 status of staff working in the home to reduce the risk of transmission.
• People were receiving visitors in line with amended government guidance. However, the testing and monitoring of visitor's health in line with COVID-19 was not always sufficient to ensure they were free from infection. For example, there were minimal reviews of tests completed at home and checks at the door such as visitor's temperatures were not always completed and recorded.
• The hygiene practises in the home had been amended to increase cleaning, for example, of frequently touched points. However, some areas of the home were in a very poor state of repair which made cleaning them to a satisfactory standard impossible; for example, some carpets were so worn there was no carpet thread remaining and they could not be deep cleaned.
• The provider's infection control policy was not updated to include information about COVID-19. This, alongside the evidence above, meant we were not assured that any future infection outbreaks would be well managed or controlled.

The provider had failed to mitigate the risk of infection transmission and had not implemented guidance to manage COVID-19. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns with the provider during and after the inspection and they took immediate action to implement changes. We will continue to monitor this.

Assessing risk, safety monitoring and management; Using medicines safely
• Medicines and the risks associated with them were not always safely managed.
• There was no guidance in place for specific medicines administration including covert medicines (medicines given without the person's knowledge) and medicines administered through a tube straight into a person's stomach [this is a percutaneous endoscopic gastrostomy (PEG) feeding tube]. Nurses who knew people well could confidently describe the methods used for them. However, agency and newly employed nurses also worked at the home and there was a high risk they could make administration errors and cause harm to people due to this lack of guidance.
• There was guidance in place for the use of medicines which have a sedative effect for people when they are distressed. However, the oversight of the administration of this was not adequate to ensure it was not overly used. For example, one person was administered Lorazepam which has a sedative effect five times in the past two weeks and four of these were by agency nurse. There had been no follow up to ensure this member of staff was confident in understanding the person's support plan to manage their distress prior to giving them this medicine.
• When topical medicines (prescribed creams) were administered, they were not signed for by the member of staff who completed it but by nurses in the medicines electronic recording system. This is not in line with guidance and increases the risk of application of these medicines being missed or not completed correctly.
• The records for other risks were not always completed or reviewed frequently enough to guide staff in safe care and treatment.
• One person had moved into the home the day before the inspection. There was no assessment completed by staff in the home available. There was some information provided by the staff at the previous home but not all staff had seen this, and they were unable to locate it during the inspection visit. Therefore, staff had limited guidance to provide safe care to a person with a number of health conditions.
• The risk management of epilepsy was not detailed enough to ensure staff kept thorough records and could monitor the wellbeing of people. The guidance for staff to understand individual's epilepsy included generic information about seizures, rather than specific descriptions for individuals of their condition..
• COVID-19 risk assessments were not completed for people living in the home; this was particularly important for people whose pre-existing health conditions or ethnicity put them at a recognised increased risk of harm from the infection.
• Some important risk assessments were not accurate. A personal emergency evacuation plan (PEEP) for one individual was completed over eighteen months ago and the person's mobility had since changed considerably, and they required more support. Another PEEP had the incorrect room number on it. These plans are essential to guide staff and any other emergency professionals to evacuate people safely and must be up to date and accurate.
• Care plans were not always regularly updated. One person's epilepsy care plan had not been reviewed for four months despite ongoing seizures and another person's plan had not been reviewed after a period of being unwell including a hospital stay. This meant the guidance for staff was not current.

The provider had failed to always provide safe care and treatment including medicines management and ensuring systems to assess and mitigate risk were thorough. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns with the provider during and after the inspection and they took some immediate action to implement changes. They had some longer term plans to implement electronic care planning

which should address some of the omissions and we will continue to monitor this.

• Some staff had worked at the home for a long time and knew people well. People we spoke with told us they trusted staff and they were helpful. One person said, "The staff are understanding and caring."
• We saw staff support people in a person-centred way; for example, engaging them in activities when they were distressed or planning time for some people to follow their routines before meals.
• One professional told us that there was a lot of experience in the staff team and they were good at understanding changes in people's behaviour and communication.

Staffing and recruitment
• Recruitment procedures were not thorough enough to ensure staff employed were suitable for the role.
• Some checks to ensure staff were eligible to work in the country had not been fully completed.
• References to ensure staff were of good character had not always been obtained.
• There was no evidence of the interview procedure to demonstrate new staff had been able to prove their skills and experience.

The recruitment systems in place did not fully check that staff employed were fit and proper for the role. This was a breach of regulation 19 (Fit and Proper Person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider took action to implement changes to their recruitment procedure

• There were enough staff to meet people's needs and respond to them in a timely manner. Staff were allocated to certain areas and this meant they were able to build close relationships with people.
• Some people required additional support to keep them safe at home or when they were out, and this was provided.
• Relatives we spoke with spoke highly of individual staff skills in supporting people.
• Staffing levels were not regularly reviewed, we have reported on this in well led.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Staff understood how to report any safeguarding concerns and understood their responsibility to protect people from harm.
• However, after some significant incidents the procedures put in place to avoid repetition were not always clear. For example, after one accident some immediate action had been taken to protect people but the internal investigation and outcomes of it were not clearly identified..
• In addition, the findings around the management of COVID-19 did not demonstrate that lessons were learned from previous outbreaks within the home and guidance given at that time.

Inadequate

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The systems in place to ensure good governance of the care provided for people were not effective in identifying the concerns found during this inspection.
- The provider and managers within the home had not ensured all guidance to manage the transmission of COVID-19 had been implemented to protect people from harm. Infrequent testing, poor use of PPE, unsafe admissions, no close oversight of visiting and poor maintenance of the environment meant the home was not a safe place for people during the pandemic. In addition, there was poor oversight of vaccination status for staff and no specific risk assessments for staff who had an identified increased risk of harm. The recommendations for improvements to infection control management from a previous COVID-19 outbreak had not been implemented to reduce the risk of recurrence.
- Some new audits had been recently introduced; however, we found they were not always detailed enough. For example, the infection control audit had not been adapted to include COVID-19 guidance and did not check new cleaning schedules.
- Clinical oversight was not comprehensive. For example, epilepsy seizures were recorded as accident and incidents. There were limited records per individual of the frequency of their seizures. There was also no clear oversight by the managers of other clinical indicators such as weight, infections, or skin damage.
- The overall analysis of accidents and incidents was minimal, mostly only recording the number and category per person. There was no review of restrictive practises, such as physical restraint and sedative medicines, to ensure they were only used as a last resort to protect people from harm. Although initial debrief meetings were implemented the ongoing oversight was not and therefore the learning from incidents and actions recorded to reduce them was not in place.
- Care plans were not regularly audited to ensure the information contained in them was up to date and useful to staff.
- There was no tool used to monitor and regularly review the number of staff required in line with people's needs. This, alongside records such as PEEPS which should be used to plan safe staffing during the day and night. There was no evidence this oversight was in place nor regularly reviewed.
- There were limited systems in place to ensure agency staff were equipped to know people they were supporting. One person had a regular agency one to one support, but this was not part of their care plan. There were no systems in place for clinical oversight of this additional nursing input.
- At our previous inspection we rated the service requires improvement in well led and noted improvements were required in the detail and oversight of governance. At this inspection limited improvement had been made in this area.

The provider had not implemented systems and processes to ensure they could assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns with the provider immediately after our inspection and some were addressed straight away. Other improvements will be implemented with a new electronic care planning system and we will continue to monitor progress with this.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Regular staff knew people well and provided personalised support. People were engaged throughout the day, including some times of the day which were quiet and relaxing and other times when people gathered to watch a football match together.
• The new manager had recently re-introduced meetings and the people who attended focused on things which were important to them.
• Staff we spoke with also told us they felt included in the running of the home and their opinion was valued. They had supervision sessions and said they could raise ideas and concerns.

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 manager was aware of compliance with duty of candour. Relatives we spoke with told us communication and response to concerns had recently improved.
• The provider acknowledged our concerns at the inspection and immediately took action to address these.

Working in partnership with others

• There were good links with other health and social care professionals; for example the local GP practise completed weekly ward rounds and had regular contact with staff in the home in between.
• There were also links with local social and education groups. One person had a college tutor supporting them at the home to develop their independence skills, including cooking.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment systems in place did not fully check that staff employed were fit and proper for the role.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to mitigate the risk of infection transmission and had not implemented guidance to manage COVID-19. Medicines management and ensuring systems to assess and mitigate risk were not thorough.

The enforcement action we took:

We issued an urgent decision to implement conditions, including a restriction of admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not implemented systems and processes to ensure they could assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We issued an urgent decision to implement conditions, including a restriction of admissions.