Norse Care (Services) Limited

Ellacombe

Inspection report

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Date of inspection visit:
11 November 2019
12 November 2019

Date of publication:
31 January 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ellacombe is a residential care home providing personal care and support for up to 48 people aged over 65 years. Most people were living with dementia. At the time of the inspection, 36 people were living at the service.

People's experience of using this service and what we found
Environmental risks, maintenance and replacement of certain items of equipment and concerns around medicines management were identified which did not always ensure people's safety. Leadership and governance arrangements within the service were of concern, as they were not always identifying shortfalls and making changes to address them. There were breaches of regulation impacting on the quality of service provided to people.

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; policies and systems in the service were not always followed to support good practice. We recommended that the service build in checks of corresponding legal paperwork into their care record audits to ensure they consulted with people with the correct legal powers to make decisions on people's behalf.

We received mixed feedback from people on the levels of activities they were able to access, and to maintain hobbies, interests and social networks. Staff treated people with kindness and were polite, and we received mostly positive feedback from people's relatives about the care provided.

Management plans were in place for people needing support at the end of their life. The service told us they had good working relationships with health and social care organisations to ensure people received joined up care. The service held an end of life care accreditation.

The registered manager encouraged people and their relatives to give feedback on the service, and areas for improvement through questionnaires and community meetings.

Rating at last inspection: Ellacombe was previously inspected 29 March 2017 and rated as Good overall. The report was published 19 April 2017.

Why we inspected: This was a scheduled, comprehensive inspection, completed in line with our inspection schedule.

Enforcement
We have identified breaches of regulation in relation to safe care and treatment, maintenance of equipment, consent to care and support provided and good governance arrangements. Please see the action we have told the provider to take at the end of this report.

Follow up
We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was 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.

Ellacombe

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.

Inspection team
One the first day of the inspection there was one inspector and one medicines inspector. On the second day of the inspection there was one inspector, one assistant inspector and one 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 care service.

Service and service type
Ellacombe is a 'care home'. People in care homes receive accommodation and 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
The first day of the inspection was unannounced, the second day was announced to the registered manager.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection: We spoke with four people living at the service and observed care and support provided in communal areas. We spoke with four people's relatives or friends. We spoke with the registered manager, two deputy managers, two members of care staff and six members of ancillary staff, the regional manager and provider's medicines lead. We looked at four people's care and support records and 17 people's medicine records. We observed part of the morning medicine round. We observed the afternoon shift handover meeting on the second day. We also reviewed staff files as well as records relating to the management of the service, recruitment, policies, training and systems for monitoring quality.

After the inspection: We sourced additional information from the registered manager, this was provided within agreed timescales.

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 a rating of 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.

Assessing risk, safety monitoring and management

●We completed a walk around of the service with one of the deputy managers and found people had access to risk items including denture cleaning tablets, prescribed creams in a locked cabinet with the key in the lock, and other personal care products including razors. Most people living at the service were living with dementia and some people had a history of using items to harm themselves.

●We observed the cleaning trolley containing cleaning products to be left unaccompanied while the housekeeper was in rooms. This was addressed by the deputy manager during our walk around.

●We found windows without restrictors in place on the first floor to keep people safe when the windows were open. We also identified that the handle on a person's window was broken, and their window did not close properly causing a draft next to their bed. These environmental risks had not been identified or addressed as an outcome of quality audits being completed.

●From reviewing people's turn charts to reduce the risk of developing skin ulcers when in bed, the details recorded did not demonstrate that staff were following the time intervals recommended by healthcare professionals.

Risks to people and the care environment were not well managed. 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.

Following the inspection visit, the registered manager confirmed in writing, that a full check of the care environment had been completed, and changes made to address the risks identified. The person's window handle had been fixed by day two of the inspection.

●Equipment for fire safety and water quality checks were regularly completed to ensure that they worked correctly and were safe. Personal Emergency Evacuation Plans (PEEPS) were in place.

Using medicines safely

●We found there were no stock checks of medicines prescribed on a regular basis and boxes were not dated when opened. However, after the inspection we received updates from the registered manager to confirm changes were made to paperwork and processes as an agreed outcome of the inspection.

●We observed staff giving a person their medicines crushed on their breakfast. Two of the medicines that were crushed should have been dissolved in water prior to administration and for one of these it clearly stated this medicine must not be crushed. These concerns were investigated by the provider during the

inspection visit, and changes implemented.
●The date of administration for a pain-relieving patch was incorrectly recorded in the Controlled Drugs (CD) register, however when the Medicine Administration Record (MAR) chart was checked it had been applied on the correct day. Staff kept written records when they administered medicines and were trained and deemed competent before they administered medicines.
●Where people were prescribed 'as and when required' medicines there were protocols to assist staff to understand when to administer such medicines and how to assess whether they were effective. There was a system of reporting and recording medicines errors and action was taken to resolve individual errors.

Preventing and controlling infection
●Staff had access to personal protective equipment (PPE) such as aprons and gloves. However, we asked the registered manager to review storage arrangements of PPE and waste disposal bag as there were large amounts of these items being stored in communal bathrooms accessed independently by people. We asked the service to incorporate these risks into their environmental risk assessment and linking this to individual people's risk profiles where applicable. We received assurances from the provider, after the inspection visit, that measures had been put in place to mitigate these risks.
●The service had recently been awarded a four-star food hygiene rating but was displaying a five-star rating sticker on their main entrance door. This was taken down at our request to prevent any misunderstanding.
●The standards of cleanliness were good throughout the service, with no malodours identified with the exception of a couple of bedrooms. The service had already identified this as an area of concern and was supporting people to manage their personal hygiene needs whilst respecting their wishes and preferences.
●Regular infection, prevention and control audits of the environment were in place.

Staffing and recruitment
●Safe recruitment practices were in place to ensure staff were suitable to work with vulnerable people. Staff and people told us there were enough staff on shift. New staff completed an induction programme and shadowed experienced members of staff.
●Staff were familiar with lone working polices and procedures and told us they felt well supported by the management and on-call staff team.

Systems and processes to safeguard people from the risk of abuse
●People told us they felt safe living at the service, however we found environmental issues which posed a risk to people's safety.
●We observed staff offering reassurance and support to people if they were feeling worried or anxious during our visit.
●Staff demonstrated clear awareness of the service's policies and procedures in relation to safeguarding. Staff spoke confidently about safeguarding escalation and reporting processes. The service kept a log of safeguarding alerts submitted to the local authority and the corresponding notifications submitted to CQC in line with their regulatory responsibility.

Learning lessons when things go wrong
●There was a written log of accidents and incidents. The registered manager oversaw the monitoring of this information, completing internal investigations and implementing actions to reduce the risk of reoccurrence where applicable.
●The registered manager reviewed incidents for themes and patterns and liaised with healthcare professionals as required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to a rating of Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Some people were at risk of losing weight. Their care records contained recommendations from dieticians for people to be weighed either monthly or more frequently. From reviewing people's weight records, we identified that people had not been weighed since September 2019. This was due to both sets of weighing scales being broken. No remedial action had been taken by the registered manager to mitigate this risk.
- The lack of accurate weight records impacted on the accuracy of assessing and monitoring other aspects of people's healthcare such as their pressure care requirements, as these can be affected by changes in weight.

The service did not ensure all equipment was maintained or replaced. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection, we received an update from the registered manager to confirm measures had been put in place to ensure each person now had an up to date weight recorded.
- The service had a good working relationship with the local GP practice, pharmacy and social care teams. The GP visited the service on a weekly basis or more frequently when required.
- Care records showed people were supported to visit the dentist, chiropodist and attend medical appointments. Staff had received oral hygiene training designed in collaboration with a local dentist.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.
●We identified that where people were assessed to lack capacity, the service was consulting with relatives and friends about key decisions relating to people's care and medicine management. From reviewing these people's care records, we identified that whilst the service was ensuring relatives and friend involvement, these relatives and friends did not have the relevant legal powers in place to make those decisions on the person's behalf. We also identified that where required, records did not contain evidence of consultation with healthcare professionals such as the GP or pharmacist.
●We found that those relatives and friends listed as having lasting power of attorney (LPA) either for health or finance on MCA paperwork, were not accurate when checked against the corresponding LPA paperwork.
●We identified that the service had covert medicine paperwork in place, to give a person their medicine mixed in food or drink. They had not completed the relevant MCA and best interest checks with healthcare professional involvement regarding this decision. When this matter was looked into, we identified that medicines were being given in food due to swallowing issues rather than due to the person's lack of compliance to knowingly take them. We requested for arrangements to be reviewed to be clear whether medicines were being given linked to the MCA or not.

Staff did not consistently work within the principles of the Mental Capacity Act (2005). This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Staff had completed MCA and DoLS training, or dates for refresher courses had been arranged.

Supporting people to eat and drink enough to maintain a balanced diet
●We identified a person that was meant to have a fluid monitoring chart in place, as a recommendation by a dietician. There was no fluid monitoring paperwork in place when we completed the inspection.
●Where fluid monitoring forms were in place, these did not contain target levels so it was not clear to staff if a person had drunk enough. After the inspection, the registered manager contacted us to confirm all required paperwork was in place and changes made to ensure fluid charts included target levels.
●Overall, we found people's dining experience to be positive. People were offered choice and shown plated up meals to aid decision making. People were encouraged to eat, and complete tasks such as pouring their own gravy to maintain independence.
●Table mats contained details of the daily menu as a visual reminder for people on what would be available. People gave feedback on the food provided. One person told us, "The food's very good. There are a couple of choices at lunchtime. The staff ask you which one you want. Yes, the trolley comes round with drinks and biscuits and you can always get a cup of tea."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Care records were written in a person-centred way, detailing people's preferences, likes and dislikes. They contained detailed personal profiles and documents that would be used if they were admitted to hospital to support them while in an unfamiliar care environment.
●Care records were reviewed and amended on a regular basis and following any incidents or changes in risk presentation.
●The service completed preadmission assessments to gain information regarding people's past medical history and risk profiles.

Staff support: induction, training, skills and experience
●The service held a training matrix listing completion of courses and dates for when refresher courses were due. Staff demonstrated implementation of training into their practice.

●The service had an induction process, with staff shadowing shifts with an experienced member of staff to ensure they were familiar with people's care and support needs before working on their own. We observed that an induction was also provided to an agency staff member on shift during the inspection.
●The management team held regular staff meetings and incorporated discussions around policies and procedures, incidents and areas of improvement.
●Changes had been made to the supervision and appraisal structure by the provider. Staff received supervision at regular intervals across the year and annual performance-based appraisals. Work based competency assessments were also completed to check implementation of training into practice.

Adapting service, design, decoration to meet people's needs
●Adaptations had been made to the environment to assist people living with dementia to become familiar with the environment and maintain their independence.
●Consideration was given to the layout of furniture in peoples bedrooms to assist with use of equipment, or to reduce the risk of falls.
●There was appropriate signage in place throughout the service.

Good

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 remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- We observed kind, caring and polite interactions between people and staff. One person told us, "The staff are so patient, they're [staff] really good." A person's friend told us, "The staff are very good here, attentive, kind and caring. The staff often spend time with [Name] in the afternoons."
- Staff placed value on the things that were important to people, including hobbies and interests and people's protected characteristics such as relationships and friendships.
- We observed staff to knock before entering people's bedrooms and explain what they were going to do for example when supporting people during mealtimes.
- Staff told us how important it was to treat people with kindness and to empower people to meet their full potential. One staff member said, "As long as the residents are happy, we make sure we give the time to spend sitting with them to ensure they have enough stimulation."

Supporting people to express their views and be involved in making decisions about their care

- People and relatives had opportunities to meet with staff to discuss people's care and support needs and contribute to the development of their care records. Through getting to know people, their past hobbies and interests, this information was used to develop the service's activity programme of events.
- Service improvement questionnaires were sent out regularly to source feedback from the relatives and staff. The service also approached visiting healthcare professionals to seek their feedback on their experiences of working with the service.
- The service held regular community meetings for people to raise concerns or contribute ideas to the running of the service. This offered an opportunity to review their care records, along with any incidents or concerns that had arisen since the previous meeting.

Respecting and promoting people's privacy, dignity and independence

- Staff promoted independence and personal choice. People's bedrooms were personalised, with objects and items of personal importance on display.
- If people experienced changes in their behaviour, mental health presentation or became unwell, staff told us about support and measures put in place to maintain the individual's privacy, dignity and safety.

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 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

- Not all care and medicine records were accurately completed, this impacted on aspects of the personalised care provided at the service.
- We identified risks to people's health and wellbeing that were not being met, due to long-standing broken equipment, inconsistencies or a lack of recording to demonstrate healthcare professional advice was being consistently followed. We were therefore not assured that people's assessed needs and risks were consistently met and changes in presentation responded to.
- Staff demonstrated a good understanding of people's needs, preferences and interests which gave them choice and control over the care provided. Lounges had been decorated in different themes linked to people's interests, including a football and sports lounge.

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.

- We received mixed feedback on the level of activities available at the service. One person said, "No. I have a lack of purpose. I don't know where I want to be or what to do. We enjoy it when our family come. There's really not much to do." Another person told us they chose not to participate in activities, "I don't do activities, but I can do if I want." One relative told us, "No I don't feel there's enough going on." Another told us, "The staff seem to have lost their oomph and I think perhaps it's because of the limited resources available."
- The service shared information on current and planned activities being developed in line with the provider's dementia and wellbeing strategies.
- People's care records contained details of past hobbies, interests and occupations. Staff encouraged people to access activities in groups and on a one to one basis to reduce social isolation.

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.

- The service implemented accessible communication standards for example providing information in alternative formats or providing information face to face rather than in writing. Staff told us about techniques they used with people to aid communication and understanding, such as ensuring information was given at certain times of day, topics were discussed more than once.

Improving care quality in response to complaints or concerns

●Relatives told us they would speak with the registered manager or care staff if they had any concerns or wanted to raise a complaint. There was complaints information displayed in communal areas of the service.

●There had been five complaints received by the service in 2019. These had been investigated in line with the service's policies and procedures, and a written response provided to the complainant. The service also sourced feedback through questionnaires.

●The service also kept a record of compliments they had received from relatives and visiting professionals, which they shared with us.

End of life care and support

●The service had completed an end of life care accreditation.

●There was no one receiving end of life care at the time of the inspection. However, people's care records contained information on their wishes and preferences in relation to care provision at that stage of their life.

●Care records contained details of protective characteristics such as cultural, religious and spiritual needs and preferences.

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 now deteriorated to a rating of 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; 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 and provider team completed a range of quality audits. However, we identified areas of concern, including environmental risks, equipment maintenance issues, medicines management and documentation concerns that had not been identified through the quality checks and audits in place to maintain consistent standards of care provision.
- The service had not maintained a rating of Good since the last inspection, and we identified breaches of regulation. We were therefore not assured that the service was consistently well-led or that the registered manager fully understood their regulatory responsibilities.

The governance systems and processes in place were not always protecting people from 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 identified inaccuracies in people's care records in relation to the legal powers held by friends and relatives to make decisions on their behalf. These inaccuracies had not been picked up as part of the service's auditing processes.

We recommend that checks of legal paperwork are built into the services' care record audits.

- Complaints and incidents were appropriately managed. The registered manager and staff understood their responsibilities under the duty of candour. The registered manager completed thematic analysis of accidents and incidents to monitor for patterns and trends.
- The registered manager and staff demonstrated a commitment to providing high standards of person-centred, dementia specialist care. People were placed at the centre of care planning and delivery. Staff told us they enjoyed working at the service. One staff member said, "Morale is good within the team. We have enough time to spend with people and overall good staffing levels."
- The provider and registered manager demonstrated that they considered the feedback we gave and shared our feedback within their service and the wider organisation to implement changes to safety checks, audits and certain recording paperwork as an outcome.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●The service benefited from consistent leadership and stability to continue to drive improvement. We found the registered manager and the staff team responsive to our feedback and acted on any concerns we raised. Staff were encouraged to give feedback and hold lead roles in relation to areas of interest; this offered development opportunities.

●The registered manager was experienced, and we saw examples of where they had taken action to address shortfalls in staff performance.

●Staff gave positive feedback about the support provided by the registered manager. Staff described the manager as "approachable", with an open-door policy. One relative told us, "We can give feedback at the meetings. The manager listens and responds, yes." Another relative said, "The manager says at every meeting that their door is always open. It's true too. They are approachable and usually available."

●Detailed information in relation to healthcare needs, changes in risk presentation and follow up actions were discussed and recorded during staff shift handover meetings. This was to ensure information was shared and updated between each shift.

●There were some gaps in the service's mandatory training record, but the service had a list forthcoming date and was sending reminders to staff to sign up to courses.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

●People, relatives and staff were encouraged to contribute their views on the running of the service.

●There was an ongoing refurbishment plan for the service to continue to improve the overall conditions of the care environment.

●Staff meetings and supervision sessions were being held regularly. There was a clear agenda of information being disseminated and discussed at each meeting and in supervision sessions. Staff confirmed that if they were unable to attend meetings, the minutes were shared to ensure everyone had access to the information discussed.

●Staff contributed to people's care review meetings and worked closely with the local GP practice and health and social care professionals.

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 11 HSCA RA Regulations 2014 Need for consent The care provider did not always work within the principles of the Mental Capacity Act (2005) Regulation 11 (1) (2) (3) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not always assessing risks to people and the environment, and putting measures in place to mitigate risks and keep people safe from harm. Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The care provider did not ensure all equipment was maintained or replaced. Regulation 15 (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not always have good governance and leadership in place. Audits and quality checks in place were not consistently

identifying risks and shortfalls.

Regulation 17 (1) (b)