The Whitepost Health Care Group

The Elms Nursing Home

Inspection report

Ranelagh Road
Redhill
Surrey
RH1 6YY

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18 January 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Elms Nursing Home provides accommodation and personal care for up to 19 older people, who may also be living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation is set over one floor with communal lounge and dining areas. On the day of our inspection 17 people were living at the service.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager (known as the manager) in post who started at the service in November 2017. The manager was about to commence their application to register with CQC.

We last carried out a comprehensive inspection of this service on 17 May 2016 when we rated the service as Good. However, we had received some concerns regarding the service and therefore brought forward this comprehensive inspection to check people were receiving safe care. Although we found on the whole that people received the care they needed, we identified some concerns which told us that people's care may not always be responsive to their needs. We found records in relation to people were not up to date or accurate which meant that some people could be at risk.

People's risks had been identified, however it was not always clear that action was taken by staff to satisfy themselves that people were kept free from potential risks. People lived in an environment that was not suitable for their needs or sufficiently hygienic and well maintained.

Medicines management procedures were not always followed in line with best practice and the legal requirements in relation to obtaining people's consent were not being adhered to. Quality assurance processes in relation to care records and the monitoring of the service being provided were not robust. Although the manager had identified many of the areas that we had concerns in and as such had developed an action plan which they were working to. The manager had only commenced in post in November 2017 so they were still getting to know the service. They told us it may take them a year to achieve what they planned for the service.

The registered provider was not aware of their statutory duties in relation to CQC and as such had not notified us of some significant events. Staff received training to carry out their roles and as such relatives and professionals felt staff were competent. The manager had been undertaking supervisions with staff.

People felt safe living at The Elms Nursing Home and staff were aware of their responsibilities to ensure that if they had any concerns about the way people were being cared for they should raise this. In the event of an emergency people's care would continue in the least disrupted way possible.

People enjoyed the food that was provided to them and told us they could eat their meals in the place of their choice. People had access to health care professionals as and when needed and when people moved into the home staff assessed their needs in order to help ensure they could provide appropriate care.

People were cared for by staff who were kind, attentive and respectful to them. People and their relatives gave us very positive feedback in relation to staff and the way that they treated them. We observed gentle, caring interactions between staff and people and it was clear staff knew people and their family members well. People did not always have the opportunity to participate in activities that were individualised and meaningful to them. The manager had identified that an additional activities co-ordinator was needed and they were actively recruiting to the role.

In the event that people or relatives felt the need to complain they told us they would not hesitate to speak to the manager or staff. We saw any complaints received by the service were addressed.

People, staff and relatives did not have the opportunity to be involved in the service through meetings although we did have feedback that the manager had already made positive changes. Staff told us they felt supported and valued by the manager and enjoyed working in the home. The manager had a clear vision for the service and the care they wished to provide and they worked closely with external healthcare professionals and agencies.

During our inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We also made four recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Staffing levels were not always sufficient to meet people's needs promptly.

Risks to people were not always appropriately assessed and managed.

Good medicines management processes were not always followed and people lived in an environment that posed risks due to a lack of suitable infection control procedures.

Appropriate recruitment checks were carried out to ensure suitable new staff were employed.

Staff understood their roles and responsibilities in safeguarding people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow the legal requirements in relation to consent.

Staff received training and the manager had started to ensure staff had the opportunity to undertake supervision.

People were provided with food they enjoyed.

People's needs were assessed when moving into the home and staff followed guidance from external agencies and professionals.

People had access to healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People had warm and positive relationships with the staff who supported them.

Staff treated people with dignity and respect.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People's end of life wishes were not sought or recorded.

People may not always receive responsive care because of a lack of guidance for staff.

Where people had a reason to complain they could follow the provider's complaint policy.

People did not always have access to a range of activities.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a lack of robust quality monitoring processes in place to ensure people received the best care possible. Records in relation to people were not well maintained.

People and relatives did not have the opportunity to feed into the service. Staff felt supported and we received feedback that the manager had already made positive changes.

The registered provider was not aware of their statutory duties. The manager was hands on within the service and as such strove to make improvements.

The Elms Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was a re-inspection of this service to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide an updated rating for the service under the Care Act 2014.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. In the planning of this inspection, we gathered feedback from other health and social care professionals who have recently been involved with the service.

On this occasion we did not request a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because the inspection was brought forward due to concerns we had received.

This inspection was carried out on 18 January 2018. The inspection was carried out by three inspectors. As part of our inspection we spoke with three people, the new manager, three members of staff, one relative and two health care professionals. We also looked at the care records for six people, medicine administration records, seven staff files and quality assurance processes and systems. We observed interactions between people and staff to see how people were being cared for as many people living at The Elms were unable to speak to us to give us their views.

Requires Improvement

Is the service safe?

Our findings

People were cared for by a sufficient number of staff to meet their physical needs and a healthcare professional told us they felt usually there were enough staff around. However we found there were times when staff could not respond promptly to people's individual needs. We saw staff working hard during our inspection. One person, we were told by the manager, needed constant supervision when they were sitting in the lounge. However, we did not always see this happen. This was because most people required two staff to assist them with personal care or to transfer them using a hoist and there were an insufficient number of staff to allow this to happen as well as supervise people in the lounge. We did not see staff always have the time to sit and socialise with people when they were in their room or the lounge area. We were told by one person that at times of staff shortage people were kept in their beds, rather than being taken to the lounge.

During our observations at lunch one person had to wait 25 minutes before a member of staff could support them with their lunch as there were not enough staff available to assist all of those who needed it at the same time. We sat in the lounge area during lunch time. We saw two people sitting in front of their meals which had been given to them 10 minutes previously. Neither person was eating and there were no staff in the lounge as they were attending to other people in the dining room. It was a further 10 minutes before staff appeared in the lounge. Although we saw staff were very attentive to people at that time and were encouraging and prompting them to eat, people's meals would have been cold. We observed the activities coordinator engage with some people in the lounge during the day, however other people sat for long periods of time with little interaction from staff. Two people dozed most of the day. A staff member told us they had discussed staffing levels with the previous manager, but had yet to raise it with the new manager.

The manager told us during the morning there was one nurse and four care staff for 17 people. This meant that if two care staff were attending to one person, this left two other staff to attend to the needs of the remaining 16 people. Although the nurse told us they would assist with personal care and were hands on the nurse had other duties to complete, such as medicine administration. They also said that as the manager was only at the home two or three days a week this impacted on their work as in the manager's absence they, "Had to deal with phone calls and queries." Staff told us they felt there should be five care staff as well as a nurse on duty each day. One staff member said that most people required one to one support with eating and some required two to one support for personal care and as such felt an additional staff member on duty each shift was needed. Following the inspection we were told by the registered provider that a deputy manager had been recruited to assist the manager and staff.

The lack of a sufficient number of deployed staff to respond to people in a prompt manner was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with staff. One person told us, "I am safe living here." Another said, "I feel safe with staff, they come and help me when I need help." One relative said, "I have no reason to think she is not (safe). She has never suffered any falls."

Risks to people's health were identified however there was not always evidence that staff took appropriate

action to address these risks. This was sometimes down to poor record keeping. Staff told us they did not read the risk assessments and we found staff were not able to always give us details about people. One staff member could describe the risk of falls for one person but was not aware of any other risks. Another staff member had no knowledge of risks and said they had not read the risk assessments. One person was recorded as having no history of falls, yet we read in their daily notes they fell twice on the same day in December 2017. This same person was at high risk of malnutrition when they moved into the home. This was clearly recorded on their pre-admission assessment. We noted that staff were only weighing this person monthly, although the manager told us it should be weekly. Staff had completed a MUST (malnutrition assessment tool) but they had recorded this person's height incorrectly. This meant that their MUST score came out that they were at low risk of malnutrition, rather than at high risk. Although staff were recording this person's food and fluid intake, there was no daily target and as such even though we noted this person on some days had drunk as little as 350mls, staff had not followed up on this. Furthermore, this person's care plan recorded that they should be encouraged with finger foods; however we only ever saw staff give this person biscuits between meals. The kitchen staff confirmed they had not been asked to prepare finger foods for this person.

Other people were at risk of dehydration and although staff recorded what amount people drank again there was no target for the day. It was unclear therefore at what point staff would know when to take action. We found a jar of thickening powder in a drawer in the dining room. This had been prescribed to one person living at The Elms. Although people did not appear to be at risk of picking it up and inadvertently ingesting it, the thickening powder was not being stored in line with an NHS England safety alert in 2015 that recommended that thickening powders should be stored securely, out of reach of people.

One person was recorded as having wounds on two areas of their body, however staff had not developed a wounds care plan in relation to this. The nurse was able to demonstrate photographs of the wounds had been taken but these had not been printed off and put in to the person's care plan in order that staff could monitor improvement or deterioration. Staff told us that this person would sit on a pressure cushion when in the lounge; however we did not see this happening in practice. We were also told that the dressings for this person would be changed every three days and the care plan would be updated as such. However, we found the last recorded dressing change had been made on 12 December 2017.

The lack of making sure people received safe care was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in premises that were dreary and uncared for and could potentially pose a risk to people. We found the lighting very dim in most areas of the home. One person had missing knobs on their wardrobe doors which left exposed screws sticking out. We found a raised toilet seat stored on the floor behind the sink in one person's room. The floor area looked unclean. In another room the wooden casing around the sink was water damaged and rotting. In addition, boxes of equipment were being stored in this person's room rather than a stock room. A further person had a gap between their bed head and pillows and the pillows were falling down the gap. This person was also sleeping on an old hospital bed. Old hospital beds are not always safe for use because pressure relieving mattresses do not usually fit them, they are not adjustable which means people may be at risk of falling from a height, there is not an option for sitting up comfortably and they are much heavier to move by staff. One person's en-suite toilet was out of order and there was water damage on the ceiling. Other rooms had curtain rails hanging down, handles missing off wardrobes, clinical pads stored loose under furniture and stained and dirty furnishings. A store room with the sign 'keep locked' was unlocked all day.

We noted that the outside area to the rear of the garden had a high metal fence around the grass area. The

manager told us this area was for the use of people living in a separately registered service in the same building. We asked what area could be used by residents of The Elms Nursing Home and were shown a small paved patio area. This was located on the side of the building and as such we saw this was used throughout the day as a thoroughfare for staff working in the separately registered service. The manager told us they had already identified the need for people to have better space outside and the provider planned to alter the layout of the garden area to give people living at The Elms their own personal garden.

Some aspects of the cleaning regime were not completed robustly. One person's room had a very strong malodour. We found this was down to two empty, but dirty, urine bottles that were stored in there. We also saw a small fridge in the dining room area which was stained and dirty inside.

The lack of high standards of hygiene and properly maintained and suitable premises was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see staff using appropriate personal protective equipment (PPE) such as gloves and aprons when attending to people and carrying out personal care and staff confirmed they received training in infection control. We found there were stocks of PPE available for staff. The manager told us that nurses carried out monthly hand-washing audits for staff and that they used an external cleaning company to carry out specialist cleaning of pressure relieving equipment, such as mattresses.

People told us they got their medicines when they needed them. One person told us, "I have painkillers for my knees." A second person said, "I have tablets and get them on time."

People's medicines were managed safely and they received the medicines they needed. We found that staff were checking the temperature of the main clinical room and the fridge. This is important to help ensure medicines are stored at the optimum temperature, as outlined by the manufacturer. Each person had a Medicine Administration Record (MAR) which recorded which medicines they were on, the dosage and the time they should be taken. We noted no gaps or errors were recorded in the MAR charts for people. In addition where handwritten entries were included we found these had been double-signed by staff to help ensure they were accurate. However we found protocols for 'as needed' (PRN) medicines such as painkillers were not in place for each person. These guidelines are particularly important for people living with dementia as they may be unable to communicate that they require pain relief. We spoke with the manager and nurse about the PRN protocols for people who told us they would address this straightaway.

We recommend the registered provider ensures that best practices in relation to medicines processes are followed at all times.

Where people had accidents and incidents, action was taken in response to these. One person had fallen out of their bed on several occasions and as such staff had lowered their bed and placed a crash mat on the floor beside it. This had stopped the incidents of falls. Where people were at risk of falls from their bed they had bed rails and bumpers fitted to their beds to prevent the risks of falls. These had been risk assessed. Where previous incidents had occurred, such as safeguarding incidents or incidents of harm to people being cared for by staff we noted that staff had understood their responsibilities in raising concerns and reporting them externally. One person had developed pressure sores due to their medical condition. We noted staff had reported this to the GP, provided suitable equipment and were following professional advice in relation to carrying out treatment.

People were kept safe from potential abuse as staff were aware of their responsibilities in relation to this. Staff were able to list categories of abuse and confirmed they had received training. One staff member told

us, "I would report all abuse to the manager and if I needed I would also go to the local authority." Another staff member said, "If I saw anyone abusing a resident I would immediately report it to the nurse in charge and the manager. I would also go to the safeguarding team at the local authority if I did not believe action had been taken." We found information in relation to abuse displayed around the home. The manager demonstrated to us that where previous concerns had been raised with the local safeguarding team they had worked with them to respond to these concerns. On another occasion a staff member had been suspended and the police notified when there was an allegation of abuse.

Fire safety within the home was checked. The manager had identified that not all doors were self-closing and most did not have appropriate fire seals. This meant that people may have been at risk in the event of a fire. They told us and showed us evidence to demonstrate that action had been taken and work was almost completed in this area. Environmental risk assessments were undertaken which covered trips and hazards, Legionella checks and the first aid box. However we found that although people had personal evacuation plans in place these were not individualised. We found they included information such as people's allergies, rather than the support a person would need from staff should there be a need to evacuate the building. The manager told us they had already identified this and showed us it was in their action plan to address.

People were kept safe from being cared for by inappropriate staff as the provider carried out robust recruitment processes. We found staff had to complete an application form listing previous employment, provided two references and identification, as well as evidence they were entitled to work in the UK. Disclosure and Barring Service (DBS) checks were carried out to ensure people were suitable to work in this type of care setting and qualified staff had to provide evidence that they were registered with their professional body.

Requires Improvement

Is the service effective?

Our findings

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 people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if staff were following the legal requirements in relation to consent and we found a lack of mental capacity assessments for people living at The Elms. A large majority of people had bed rails. We found no mental capacity assessments had been carried out to determine if they had capacity to agree to these and no best interests discussions had been undertaken prior to the bed rails being fitted. One person had been refusing their medicines regularly and yet the staff had not completed a mental capacity assessment to determine whether they should consider alternative methods of giving this person their medicines. In addition, the front door to the home was locked and again there were no mental capacity assessments for this.

The failure to follow the legal requirements in relation to consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us they had not received training in the MCA and DoLS, although they were aware that they should presume people had capacity until it was deemed otherwise. Staff said they always asked people for their permission before they did anything with them. One person told us, "Staff ask for my permission."

A relative told us, "The food is all home cooked and of good quality. They (staff) try to feed her with good food." Where people had specific dietary requirements this was known by staff and we found that people on pureed diets had their meal displayed nicely on their plates. Even though the majority of people living at The Elms were living with dementia they were asked by staff to make their food choices on the previous day. This meant people may not always remember what they had chosen. However, the manager showed us some food picture charts that they planned to introduce. These would be displayed each day as part of the menu. This would help staff use alternate ways to help ensure people could make their own choices about the food they ate.

People lived in an environment that had not been adapted to suit people's needs. The manager told us that everyone apart from one person was living with dementia. However, we found there was a lack of signposting for people and a lack of sensory items. People's rooms were not identified in a way that would help a person recognise their own room. For example, we found one person's room had their name handwritten on their door in biro. In the lounge there was a pile of dolls and soft toys, these were stored on

top of an unused recliner chair and as such were out of reach of people. In addition, chairs were placed in front of the book case in the lounge area which meant people could not access it.

We recommend the registered provider considers ways to ensure that the environment people live in and the facilities available are suitable for people who may be living with dementia.

The manager told us they were aware that some staff supervisions had not been taking place in line with the service policy and as such they had started afresh for this year. They demonstrated to us they had already met with all the nurses working in the home and supervisions for care staff were scheduled in. Staff confirmed with us that supervisions had now started and said that they had been told they were going to be every two months.

People were cared for by staff who had access to sufficient and appropriate training. A relative told us, "The qualification of staff is good." Staff told us they had received mandatory training and the training was refreshed every year. Training included moving and handling, first aid, food hygiene and person-specific training such as challenging behaviour. One staff member said they had received an induction when they first started at the service. They said, "I did all the mandatory training during my induction." Staff were able to describe what they had learnt from their training and that training was specific to the needs of people. A staff member said they had received dementia training and told us, "You have to be very patient in your approach to people who have dementia. We have to come to their level and make eye contact when we talk to them. If people refuse to do anything we will walk away and return later to ask if they are ready." Staff were able to describe to us the procedure for transferring a person using a hoist.

Assessments in relation to people's health care needs were carried out upon admission to check that staff were able to meet people's needs. One person had recently moved into The Elms from another organisation and we found the pre-admission assessment carried out by the manager was very robust. The manager had worked across both organisations to help ensure that as a result this person had received coordinated support moving to The Elms. Where people had input from external professionals staff continued with their guidance and involvement such as in the case of one person who had a community psychiatric nurse.

People received the healthcare they required and had access to healthcare professionals when they required them. There was evidence in people's care plans that people saw the dentist, optician, dietician or podiatrist. The GP visited the home each week (or more often if needed) and we saw a healthcare professional visiting on the day of our inspection. A relative said, "Senior staff are very efficient about medical needs. My mum has access to the GP, etc." A healthcare professional told us they felt staff followed instructions they had given them.

Good

Is the service caring?

Our findings

People and relatives told us they felt staff provided good care. One person told us, "I think it is lovely here." A relative said, "Staff have got a good attitude and genuinely care for people." A professional told us they felt people were very well cared for at the home and staff did their best. We found this to be the case and we observed individual staff were caring and attentive to people.

Individual staff were caring and we observed some nice examples of a caring approach by staff to people. For example, we saw people being shown patience. During lunch time staff engaged in conversation with people by asking them questions and discussing things that interested people. Staff told people what their lunch was and what was coming up for dessert. One person did not want to eat anything and staff tried patiently and asked if they would like something different. Fresh fruit was brought to try and coax them to eat. Those people who required assistance to eat their lunch received it in an unhurried manner.

Staff showed genuine interest in people. Staff engaged with people and talked to them in a gentle and caring manner. One person became agitated and staff talked to them in a calm voice asking if they were okay and needed anything. The person became calm and started to watch a film on television that they had asked for. Another person was engaged in some colouring and staff commented on it when they came into the room. A healthcare professional told us they noted staff talked to people in a caring manner. We watched as staff transferred people from their bedrooms into the lounge area and heard them talking to them all the time.

People were shown respect and dignity by staff. We observed staff knock on people's doors or asking if they could enter when people's doors were open. One staff member told us, "I always knock on their doors and wait to hear something from them. I close the curtains and doors and cover exposed parts of their body when I attend to their personal care."

People were encouraged to do as much as they could by staff. One staff told us they encouraged people to wash their face or eat by themselves. We saw this happen. At lunch time staff were prompting people to use their cutlery themselves.

People were enabled to have privacy if they wished and to make their own choices. Some people chose to remain in their room most of the time and we saw staff respected this. We saw people being served their meals in their room. People were given a choice of drinks and one person we spoke with was drinking fresh orange juice. They told us how lovely it was and were clearly enjoying it. One person told us, "I can choose what I want to do. I can get up when I like and I can go to bed when I like."

We saw that people received visitors. One relative told us, "I come often and my sister is here every day." Visitors were friendly with staff and it was clear they were regular guests in the home.

Requires Improvement

Is the service responsive?

Our findings

People may not always receive responsive care as we found limited information in people's care plans and staff did not take the time to read them. One person was diabetic and although they were having their blood sugars tested regularly there was no diabetes care plan in their records. We also noted that within their nutrition care plan there was no mention that they were diabetic. Another person suffered from mental health needs, but there was a lack of information in the person's care plan to guide staff in the best way to care for this person. Their care plan referred to 'aggressive behaviour' for this person but there was no evidence that staff had taken any action to identify the reasons for this. This same person suffered from depression and again there was no care plan in relation to this detailing how staff could help. A third person had some medical conditions such as high blood pressure, but there was a lack of individualised care plans for any of them. Another person had moved into The Elms with two hearing aids, glasses and top and bottom dentures. We noted during our visit that they had neither their glasses on or hearing aids in and only one set of dentures. We spoke with a staff member about this. They told us the person would take their glasses off and they would not wear their hearing aids, however they said the person had been seen by the audiologist and they were waiting for new hearing aids to be sent. They could not tell us how long this person had been without them. We also spoke with the manager who told us, "I have been liaising with the GP about this and we are waiting for the audiologist to send a new hearing aid." However, from this person's care plan we read that a new hearing aid had already been sent to the home which neither the staff member or the manager were aware of. Another staff member was able to tell us that this person took off their glasses and took out their hearing aids, but this showed us that staff were not always communicating effectively to ensure people received care in line with their needs. Staff told us that the nurses were responsible for writing care plans and reviewing them. We asked staff to tell us what was in particular people's care plans however they said they had not read the care plans for people. We asked staff how they got to know about people and their needs and they said they got the information on a daily basis from the nurses at handover meetings. This meant that staff did not take the time to get to know people as individuals and to learn about their backgrounds or life histories.

People's wishes about their end of life were not always recorded. The manager told us that people living at The Elms were very frail and yet, there was a lack of information on how people would wish to spend their remaining days. One person's care plan stated only, 'family will arrange'. We noted that the manager had arranged for a healthcare professional to meet with them and staff to look at advanced care plans as they had identified these were not in place.

The lack of ensuring people's individual needs were met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did however contain relevant information about the care that they needed. They included areas such as their mobility, skin integrity, communication, sleep, nutrition and continence. Information was generally clear and relevant for people and we could see that care plans were reviewed each month.

People did not always have access to activities and as such they could feel isolated, due to a lack of appropriately deployed staff. We were told the theme for the day of our visit was Winnie the Pooh and that a Pets for Therapy dog would be visiting. During the course of the day we saw the activity coordinator engage with one person in colouring related to the theme and heard them reading a short story to another person in their room, again related to the theme of the day. We also heard them chat to a couple of people about a film that was being shown in the lounge. The Pets for Therapy dog came to the home during the morning and we saw people engage in this activity and we saw it was taken to people's rooms individually. We saw pictures displayed in the corridor of the home depicting previous activities that had taken place and noted the service had arranged for visiting Carol singers and a Christmas party during the festive period. A relative told us, "I think staff try, they try to get everyone into the lounge. Staff make an effort."

Most people however were seen sitting or dozing in the lounge or their bedrooms for the majority of the day and the only engagement from staff was task orientated such as giving them a cup of tea or assisting them with their lunch.

The manager told us they had an activity coordinator three days a week. We asked the manager what happened for the other four days and were told that care staff or the nurse would lead on activities, "Depending on work pressures." The manager told us that they had already identified the need for more individualised, meaningful activities and as such they were in the process of recruiting more staff to undertake these. Staff also told us they felt there should be an activities person five days a week.

We recommend the registered provider ensures people have access to meaningful, individualised activities in order to reduce the risk of social isolation and connection.

There was a complaints policy in place. The manager told us that there had been no formal complaints received since the last inspection. We did note however a compliment which read, 'I can see that mother is being well looked after by you and your staff'. A relative told us that any small issues they had raised with the manager had been addressed. Staff told us if anyone wished to make a complaint they would refer them to the manager.

Requires Improvement

Is the service well-led?

Our findings

People's care plans were not completed in a person-centred way. One person was recorded as, 'prefers female staff for personal care' on their pre-admission assessment. However in their care plan it was recorded, '[Name] and family have no concerns re male and female staff attending to [name] with personal care', but later on it stated, 'prefers female carer. She does not like male carers and tends to use abusive language'. This same person was noted as requiring weekly weighing until their weight improved and yet we found they had only been weighed monthly. Another person had written in their 'hopes and concerns for the future' care plan, '[Name] has no hopes and concerns'. It later stated, 'staff must involve her next of kin in all aspects of their care'. However, staff did not have any contact details for them. In addition, their care plan recorded they should be motivated to go to the dining room and interact with other people but the manager told us this was incorrect as this person always stayed in their room. People's daily records were written in a very task orientated way. For example, 'skin intact, fluid taken, medication given'. There was a lack of person-centred element to people's records. They did not record how a person presented, what mood they were in or what they did during the day.

Internal auditing and monitoring lacked robustness to help ensure that people received good, high quality care. Accidents and incidents were analysed monthly by the manager to look for themes or emerging trends. However, we found that not all accidents and incidents were recorded properly which meant the manager's analysis may not always include all the events that had taken place. For example, we read of two accidents for one person and two for another person and yet these had not been included in the manager's analysis and they were unaware of them. A third person's care notes recorded three incidents relating to them, but again none were recorded in the accident and incident folder. Accident and incident logs contained little detail in most cases and staff had not always recorded action taken.

The lack of robust quality assurance monitoring and record keeping was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider was non-compliant in their statutory requirements to submit notifications of important events that take place within a service. For example, one person was found to have unexplained red legs and bruises, another had a sore on their foot and yet neither of these had been notified to us. We also found one person had suffered two head injuries but these had not been sent through as notifications.

The lack of notification of incidents within the home is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager had identified areas within the service and the care provided that required improvement and as such held an action plan. This included the refurbishment that was needed and the purchasing of new furniture. We read that some actions had already been addressed such as fixing a door and drawing up wheelchair risk assessments. Other areas for improvement were to install a new call bell system which would allow the manager to monitor the response to people requiring attention.

The manager had a hands-on approach within the service and they were visible and involved. Following our inspection the manager provided us with evidence that they had responded to concerns that we had raised with them and had started to address them. For example, they sent us information to show that disposable urinal bottles had been ordered to reduce the risk of the continued malodour in one person's bedroom. They had recorded the need to ensure risk assessments for people were individualised and that accidents and incidents had to be completed in more detail. The manager had only been in post since November 2017 and was still getting to know people and their needs. We had confidence that the manager had a determination to improve the service people were receiving to help ensure it was of a standard that people should expect. A healthcare professional told us, "Yes, there are areas that the Elms could improve on, but on the whole they do a reasonable job with the new manager."

The manager had clear visions on how they planned to improve the service provided. They showed us a clinical risk register they had developed to help them determine people's dependency and as such staffing levels. The manager worked with external professionals to share knowledge and expertise. We had already noted a meeting had been arranged with a professional to look at advanced care planning. In addition the manager planned to organise dementia support group sessions to look at providing activities suitable for older people and people who are living with dementia. In addition the registered provider held a contract with the physiotherapy team which meant people had access to a certain number of hours from this service.

The manager told us that resident and relatives meetings had not been held routinely and they planned to reintroduce them. In addition, no surveys had been carried out to give people and their relatives the chance to submit any comments or suggestions on areas they felt required improving. Again, this was something they planned to address.

Staff felt supported by the manager. One staff member told us, "I can always talk to the manager, she walks the floor every day. We are able to put forward our ideas and she listens to them. For example, I raised the issue about the flooring on the ramp and it was replaced with non-slip flooring." A healthcare professional told us the manager had made changes for the better. For example, they told us people now had drinks and their walking aids near to them at all times. In turn the manager told us they felt supported by the provider and issues they had already raised with them had or were being addressed. They told us the provider was open to their feedback.

Staff had the opportunity to meet as a group to discuss all aspects of the service as staff meetings were held. We noted the last meeting covered topics such as recruitment, supervision, the Mental Capacity Act and the clinical risk register. Our observations of staff during our inspection was that they worked together. There was a good culture within the team and they helped and supported each other throughout the day to ensure people's needs were met.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify us of significant events within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people's assessments had taken into account specific issues in relation to people's needs or conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to follow the legal requirements in relation to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure people would always receive safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure

Treatment of disease, disorder or injury	high standards of hygiene and properly maintained and suitable premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure there were robust quality assurance processes in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide sufficient number of staff to respond to people in a prompt manner.