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The Royal Elms Care Home

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
The Royal Elms is a care home providing accommodation and personal care to 20 people aged 65 and over at the time of the inspection. The service can support up to 26 people. The home is in one adapted building over two floors. People accessed their rooms via a stairwell or passenger lift. There are two communal lounges and large dining room and an outside decked area.

People's experience of using this service and what we found
Infection control across the home was not safely managed. Personal protective equipment was incorrectly stored. Three staff members were seen to be wearing their facemask under their nose and parts of a bathroom were not clean and rust had formed on a bath. Cleaning products were accessible as the store room was not locked. The health and safety of the home was not well managed. The firefighting equipment had not been serviced in timely intervals and the gas safety check had not been completed in the time required. Risks to people did not always feed into care plans.

We have identified an incident in relation to the absence of the manager which should have been notified to CQC. We will deal with this outside of the inspection. The provider had not assessed, investigated and concluded a safeguarding allegation or supported staff to raise a safeguarding or whistle blow any concerns they had. The provider lacked oversight of the management of the service and had not ensured one staff member was safely recruited. The audit process was not robust as the issues noted during inspection had not been identified. A manager from another of the provider's homes was overseeing the management of the home and staff found this to be supportive.

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 15 June 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the management of a safeguarding concern and because the provider had not reported the registered manager was no longer working at the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 will continue to monitor the service and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, good governance and fit and proper

persons employed.

Please see the action we have told the provider to take at the end of this report.

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 for 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 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 their 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.

The Royal Elms Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors visited the home on the first day of inspection. One inspector made telephone calls to relatives and the staff team.

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

The service had a manager registered with the Care Quality Commission, however they had not worked at the service for over 12 months.

Notice of inspection
We gave the service 24 hours' notice of the inspection as we were aware the home had an outbreak of COVID-19 and we wanted the staff team and people living in the home to be aware of our visit.

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. We used all of this information to plan our inspection.

During the inspection
Due to the home having an outbreak of COVID -19, we spoke to two relatives, three staff members and the manager by telephone. We observed people within the main corridor of the home and spoke with the administrator, cook and senior carer during the inspection. We reviewed a range of records. This included two 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 audits, health and safety and policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 prevention and management of infection control was not well managed.
- The home was part of a regular testing programme for COVID-19 and people were being supported in their rooms following receiving a positive test.
- Personal protective equipment (PPE) was readily available and staff were aware of what items of PPE they should be wearing, however, we observed three members of the staff team wearing their face mask under their nose.
- Stocks of PPE was not always safely stored. Gloves and aprons were stored across the home on radiator covers and units. These areas were frequently touched by people living in the home and staff and this increased the spread of infection. Following the inspection, the items were removed to a safer location.
- A waste bin for the disposal of PPE was placed in a busy corridor and accessible to people walking by.

This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not follow guidance for the safe storage of PPE and did not reduce the risk of infection spreading in the home.

- The provider followed national guidance and visitors were discouraged from visiting the home during the outbreak.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Assessing risk, safety monitoring and management
- The safety of the premises was not always robust.
- External checks of the firefighting system and gas safety had not been regularly completed by a qualified person.
- There were patches of rust on the ground floor bath which posed a risk to people's skin integrity. Additionally, a patch of lino was missing on the flooring of the bathroom which posed a trip hazard and was unclean.
- Mop buckets were left half full and unattended throughout the ground floor which could cause a trip and slip hazard. The cleaning materials cupboard was left open with accessible chemicals inside.
- Risk assessments were in place to support people with known risks. However, the risks didn't always feed into care plans. For example, for one person who needed repositioning every two hours, this information was not captured in the care plan. For another person who was at high risk of falls and took an

anticoagulant medicine, there was no information recorded that staff should seek medication intervention in the event of a head injury resulting from a fall.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2018. The provider did not ensure the premises was clean and free from risks to people's health and safety. Regular maintenance checks of safety equipment had not been maintained within the appropriate timescales. Guidance to support staff to manage risks was not always documented.

Staffing and recruitment

● Staff were recruited with pre-employment checks in place. However, one person recruited during the pandemic had a disclosure and barring service (DBS) check in place which was over two years old and a risk assessment had not been completed to ensure the person's suitability to work with vulnerable groups.

● Agency staff had been used more recently in the home but there was only evidence one agency worker had received an induction to the service. There was no evidence that agency staff's skills had been reviewed to ensure they were suitable to work at the home. Only one agency worker had a profile of their skills in place.

This was a breach of regulation 19 (fit and proper persons employed)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure all staff had the appropriate pre-employment checks in place. The provider did not ensure all agency workers received an appropriate induction and had not assured themselves the agency workers had the appropriate skills and experience to work at the home.

● Staff said there was generally enough staff on duty at any one time.

Systems and processes to safeguard people from the risk of abuse

● The staff we spoke with could describe signs of abuse and felt confident to report any concerns they had. Not all staff had received training in safeguarding vulnerable adults. However, staff had received a copy of the whistle blowing policy and had signed to say they had read understood this.

● Safeguarding concerns were not always investigated in a timely manner. Following CQC reviewing information into the safeguarding, we found a member of the staff team were aware of the allegation but did not raise it as a concern.

● Relatives felt their relative was safe at the home. One relative told us, "Yes, [Name] has settled in well, the staff are good." Relatives said they felt confident to report any concerns to the manager.

Using medicines safely

● Medicines were administered and recorded according to the prescriber's instructions.

● People were supported with the administration of food and fluid thickeners, but each dose given was not always recorded. Following the inspection, a new document was implemented to ensure each dose administered was appropriately recorded.

● Audits of medicines showed good compliance with the safe management of medicines.

Learning lessons when things go wrong

● Accidents and incidents were reported and recorded.

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 good. 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; 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 provider did not ensure there was consistent leadership and risks were not always investigated.
- Prior to the inspection, a serious safeguarding alert had been raised. The provider did not robustly assess, investigate and conclude any investigations into the allegation despite requests to do so. In addition, the staff involved in the safeguarding had not received support from the provider to disprove the allegation and the providers own disciplinary procedure was not followed.
- We reviewed the provider's whistle blowing policy and found it didn't give staff the guidance to whistle blow on poor practice.

This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure safeguarding concerns were raised in a timely manner. The provider did not comply with their own disciplinary policy and did not assess, investigate and conclude a safeguarding investigation. The provider did not ensure all staff were given training in safeguarding vulnerable adults from abuse and whistle blowing.

- The registered manager of the home had not worked at the service for over 10 months. Despite previous requests to the provider, they had not informed the Care Quality Commission (CQC) of the absence, nor had they shared plans for the management of the service going forward. The provider must legally inform the CQC when there are changes to the person who manages the service. We have since received this information
- A manager from another of the provider's services was overseeing the management of the home. Staff told us this has been a positive addition to the team, the manager was supportive and had made some changes to the home for the better. Staff told us, "[Name] is been a great help to improve the home."

Continuous learning and improving care

- The provider did not ensure they continuously improved outcomes for people in the home.
- The manager had completed some audits had highlighted gaps in care planning, however further improvements were needed as care planning and risk assessment did not always captures the risks people presented. Audits did not identify where external maintenance visits were overdue.
- Where maintenance checks had not been completed as scheduled for firefighting equipment and gas safety, no risk assessment was in place to support the lack of testing by a qualified maintenance person.

Following the inspection, the maintenance checks had been completed.

This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have robust oversight and good governance processes in place to monitor and improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- A person-centred culture was not always promoted nor inclusive.
- Following the outbreak of COVID-19, people were being encouraged to stay in their rooms and not enter any communal areas. Whilst this was following the correct guidance for those who had received a positive test, those people who had tested negative were often wandering in the corridor or isolated in their bedroom. This restricted people's movement and the provider had not considered other strategies to support people to access communal areas of the home safely.
- As visiting was restricted to the home, a relative told us, "Although I think [Name} is well, we haven't been able to visit and [Name] is isolated in the bedroom."

This was a breach of regulation 17 (good governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The provider did not identify strategies to allow people living in the home to continue to access communal areas of the home to reduce isolation. The provider did not assess the risks and impact this had on people living at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Feedback from staff had been obtained since the last inspection which was positive.
- There had been no further feedback on the home obtained from people living in the home, their relatives, professionals or stakeholders since the last inspection.
- Staff were able to attend staff meetings but the supervision records for staff were intermittent. Staff told us they could raise anything with the manager if they needed to.

Working in partnership with others

- The staff team worked with health professionals to ensure people's physical and mental health was regularly reviewed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not follow guidance for the safe storage of PPE and did not reduce the risk of infection spreading in the home. The provider did not ensure the premises was clean and free from risks to people's health and safety. Regular maintenance checks of safety equipment had not been maintained within the appropriate timescales. Guidance to support staff to manage risks was not always documented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure all staff received the appropriate pre-employment checks in place. The provider did not ensure all agency workers received an appropriate induction and had not assured themselves the agency workers had the appropriate skills and experience to work at the home.

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 17 HSCA RA Regulations 2014 Good governance The provider did not ensure safeguarding concerns were raised in a timely manner. The provider did not comply with their own disciplinary policy and did not assess, investigate and conclude a safeguarding investigation. The provider did not ensure all staff were given training in safeguarding vulnerable adults from abuse and whistle blowing. The provider did not have robust oversight and good governance processes in place to monitor and improve the service. The provider did identify strategies to allow people living in the home to continue to access communal areas of the home to reduce isolation. The provider did not assess the risks and impact this had on people living at the home.

The enforcement action we took:

Warning notice