The Whitepost Health Care Group

The Elms Nursing Home

Inspection report

Ranelagh Road
Redhill
Surrey
RH1 6YY

Date of inspection visit:
17 May 2016

Date of publication:
05 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Elms Nursing Home is registered to provide accommodation and nursing care for up to nineteen people some of whom may be living with dementia.
The home is located in Redhill and is part of the Whitepost HealthCare Group. On the day of our inspection 16 people lived at the service.

There was a registered manager in place who was present on the day of the inspection.
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.

People were not always cared for in an environment that was in a good state of repair. We noted bed rail bumpers were worn and could not be cleaned effectively and areas of the home required to be redecorated.

There were enough staff employed in the service to meet people's needs. People said staff were kind and cared for them well.

People received their medicine as prescribed and medicines were administered and stored safely. Risks had been assessed and managed appropriately to keep people safe. Risk assessments for people were detailed and informative and included measures that had been introduced to reduce the risk of harm.

In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe.

Accidents and incidents were recorded appropriately and evaluated to prevent or minimise reoccurrence.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff recruitment checks had been undertaken before they started work to protect people.

People's rights were protected under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that people were consenting to their care. This also ensured that people who were unable to consent to restrictions to their freedom and liberty had DoLS assessment in place that had been authorised by the local authority.

People received care from staff who had received appropriate training to meet people's needs. The provider ensured all staff were kept up to date with the mandatory training including moving and handling and health and safety.

Staff were supported in their work and said that they had regular supervision with their line manager. This

gave staff the opportunity to discuss their performance or any other issues with their manager and these sessions were formally recorded.

Nutritional assessments were carried out when people moved into the home which identified if people had specialist dietary needs. People had access to a range of health care professionals, such as the GP, dietician and chiropodist.

Staff at the service were caring and supportive and treated people with dignity and respect. We saw that care plans were person centred and had involved people whenever possible. Staff knew and understood what was important to the person.

People were supported by staff that were given appropriate information to enable them to respond to people effectively. Where it had been identified that a person's needs had changed staff were providing the most up to date care.

People who were able could take part in limited activities which they enjoyed. People and relatives told us that they knew what to do if they were unhappy about something. There was a complaints procedure in place for people and relatives to access if they needed to.

Staff said that they felt valued and listened to. Systems were in place to monitor the quality of the service that people received. This included audits and surveys. However audits did not always identify issues relating to the environment and some record keeping.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way.

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 home was safe.

Areas of the home required redecoration and bed rail bumper protectors needed to be replaced.

There were enough staff employed in the home to meet people's needs.

Risks were assessed and managed well. Care plans and risk assessments provided clear information and guidance to staff.

People received their medicines on time and as prescribed. Medicines were managed safely.

People told us they felt safe. Staff understood what abuse was and knew how to report this if they needed to.

Safe recruitment practice was followed.

Is the service effective?

Good

The home was effective.

Staff had a good understanding of the needs of people who lived at the home. Staff were up to date with their mandatory training.

Staff said they felt supported and had regular supervisions and appraisal with their line manager.

People's human rights were protected because the provider had followed the requirements of the Mental Capacity Act 2005. Appropriate applications had been submitted to the local authority if people were being deprived of the liberty.

People were provided with enough food and drink. People said the food was good. People's weight and nutrition were monitored and they had access to healthcare services to maintain good health

Is the service caring?

Good

The home was caring.

People were treated with kindness and compassion and their dignity was respected.

Where people had expressed preferences around their care, these were supported by staff.

People's rooms were personalised to reflect individual personalities.

Is the service responsive?

Good

The home was responsive.

People had needs assessments in place.

Staff were aware of the needs of people they were supporting. There was a limited activities programme which people participated in whenever possible.

There was a complaints policy and people and their relatives understood what they needed to do if they were not happy about something.

Is the service well-led?

Good

The home was well-led.

People, relatives and staff said they liked the way the service was managed.

There were procedures in place to monitor the quality of the service. We noted issues during our visit that had not been identified during quality monitoring audits.

Staff said that they felt supported, valued and listened to by the management.

Notifications of significant events in the service had been made appropriately to CQC. □

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 inspection was planned to check whether the provider is 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 a rating for the service under the Care Act 2014.

This inspection took place on 17 May 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed all the information we had about the service. This included information sent to us by the provider in the form of notifications and safeguarding referrals made to the local authority. Notifications are information about important events which the provider is required to send to us by law. The provider completed a Provider Information Return (PIR) before the 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.

During our inspection we spoke with the registered manager, the deputy manager, five people who used the service, three relatives, five members of staff and three health care professionals. We looked at five care plans, five staff recruitment files, medicine administration records, supervision records for staff, and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included audits of the home. We observed care being provided throughout the day including during a meal time.

At our previous inspection in July 2014 we had not identified any concerns at the home.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said "Yes I feel I am safe here." They told us that when they needed support staff came to attend to them quickly. A relative also told us that they felt their family member was safe living at the service.

People were not always being cared for in an environment that promoted their safety. Some people were at risk of infection because some bed rail protectors were cracked and damaged which meant they could not be cleaned effectively and may harbour infection. Upholstery on chairs in some bedrooms were torn and again could not be cleaned properly putting people at risk of infection. The walls in the main corridor were scuffed from wheelchairs and when notices and pictures had been removed the walls were not repaired leaving them looking in a state of disrepair. An assisted toilet was mounted on a wooden plinth that needed to be replaced as the wood was also in a state of disrepair could not be cleaned effectively.
We recommended the provider gave consideration to redecorating the hallway and replacing the bumpers on bedrails and assisted toilet.

People were kept safe because staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said that they would refer any concerns regarding 'unkind treatment' to the registered manager and if necessary to someone more senior. There was a Safeguarding Adults policy in place and staff had received training regarding this. There were notices and leaflets in the nurses the office to guide staff about what they needed to do if they suspected abuse.

There were sufficient numbers of staff employed in the service to meet people's needs. We looked at the staff duty rotas for the previous four weeks and saw the numbers of staff on duty were appropriate in meeting people's needs. There were four care staff and one qualified nurse employed in the service throughout the day to support people. One qualified nurse and two care staff worked during the night. The service also employed ancillary staff for example housekeepers and maintenance staff to further support people's needs.
Call bells were being answered throughout our visit in a timely way and people did not have to wait when they called for help.

There was a staff recruitment procedure in place. The staff recruitment files were well maintained. The employment files we looked contained a completed application form with a full employment history. The provider ensured that the relevant checks were carried out that ensured staff were suitable to work at the service and included criminal records checks and references. Staff files included a recent photograph and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or are barred from working with adults at risk. Staff confirmed that they were unable to start work at the service until these checks had been undertaken. We found that the registered manager had a robust system in place for checking qualified nurses' PIN numbers with The Nursing and Midwifery Council (NMC) which they require to practice professionally.

People's medicines were administered and managed safely. Medicines were kept in a dedicated clinical

room in secure cupboards and trolleys. There was an up to date medicines policy and staff's medicine competencies were regularly reviewed. The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. We spoke with the pharmacist who confirmed the medication practices at the service were satisfactory and they undertook audits to support this.

We examined the medicine administration records (MAR) charts which were well maintained. Staff locked the medicine trolley when leaving it unattended and did not sign the MAR charts until medicines had been taken by the person. There were no gaps of signatures in the MAR charts and if medicine was not given for a particular reason the correct codes were used to record the reason why. For example if a person was in hospital. People's medicines were reviewed regularly by the GP. Medication training was provided to nurses at least annually.

Where people had 'As required' (PRN) medicine there was guidance for staff on when to administer this. We heard staff ask people if they were in pain and they needed any medicine for this. Staff followed guidelines by signing when PRN medicine had been given and the information was shared at staff handover to ensure staff knew medicine had been given.

When people could be at risk of harm this was identified and appropriately managed. Risks assessments had been undertaken when necessary. These were included in people's care plans and guidance was given to staff to reduce the risks. For example how to move a person with a hoist, the amount of staff required and the type of sling used. When a person was at risk of developing a pressure ulcer they had a skin integrity assessment undertaken called a Waterlow score and appropriate plans were put in place to minimise the risks. Staff were aware of risks to people and were able to demonstrate to us how they managed them. For example using appropriate pressure relieving equipment as agreed in people's plans and changing a person's position regularly. These were regularly reviewed and staff were made aware of any changes or updated of risk to people.

Accidents and incidents were recorded and the provider ensured steps were in place to reduce the reoccurrence of these. For example when someone had an increase in the amount of times they had fallen this was discussed with the GP and a plan of action was implemented like undertaking a urine test, and monitoring their blood pressure to identify the possible cause an minimise any further risks to the person.

People would be safe in the event of an emergency because appropriate plans were in place. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and made them safe. There were personal evacuation plans for each person that were updated regularly and a copy was kept in the reception area so that it was easily accessible.

Good

Is the service effective?

Our findings

People who were able to spoke highly of the staff. One person said "They seem to know what they are doing." Another person said "They look after me ok."

People were cared for by a staff team who had the skills and qualifications required to deliver care effectively. Staff said they received training to undertake their roles. They told us they had undertaken induction training when they commenced employment and were mentored by an experienced staff member until they were competent to undertake tasks alone. Mandatory training was provided regularly and included manual handling, health and safety, first aid, pressure area care and fire safety awareness. Records seen confirmed this. Staff were seen throughout the day undertaking their roles competently which reflected the training they had undertaken.

Qualified staff were able to undertake further clinical training to further their development and practice. This provided them with up to date skills and knowledge to undertake their roles safely and prepare them for revalidation. This is essential to enable them to continue clinical practice.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were implemented appropriately. Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 make a particular decision any made on their behalf must be in their best interest and as least restrictive as possible. Mental capacity assessments had been carried out for people. Examples of where decisions had been made in line with the act included people receiving medicine and personal care.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. For example when people required bed rails to keep them safe and did not have capacity to agree a decision was taken in their best interest to keep them safe.

Staff understood the importance of gaining people's consent and we saw evidence of this during the inspection. For example one member of staff asked someone if they could take them to the bathroom to assist them with their personal care and they waited for the response. We heard another member of staff explained to someone they were going to change their position in bed to make them comfortable. They said "Can you squeeze my hand if that is ok with you." The person did this before the procedure was undertaken.

Staff received appropriate supervision in line with the provider's policy. Staff told us they had regular meetings with their line manager to discuss their work and performance. One member of staff said "I have

regular supervision with my line manager and this is every ten weeks." All the staff we spoke with said that they felt supported. Records of supervision were maintained in staff files.

Staff received annual appraisals to discuss their performance over the year and further training and development needs. Staff told us they had received an appraisal with their manager. Both supervision and appraisal are important to help ensure staff were working competently and appropriately and provided the best care possible for the people they support.

People were offered enough to eat and drink. Two people told us they enjoyed their food. There was a choice of meals provided and if people did not like what was available they could choose an alternative. One person told us "The food is lovely." A second person said "The food is always good." A relative told us "The food was good and always looks appetising."

People were able to eat their meals where they chose. Some people chose to eat their meals in the communal dining room whilst others preferred to eat their meals in their rooms. We observed lunch in the main dining room was relaxed and people sat at dining tables that were nicely laid. People were offered a selection of fruit juice and water with their meal.

We heard staff explaining to a person what they were being served when they had forgotten and offering to cut people's food if they required this. Staff sat with people and provided support for people who required help to eat their food. Several people were being nursed in bed and staff supported them with their meals. They sat with them and gave people enough time to enjoy their food at their own pace.

Individual nutritional plans were in place that outlined people's specific dietary needs. These were based on the malnutrition universal screening tool (MUST) which is an assessment tool used to monitor if people may be at risk of malnutrition. Nutritional care plans included individual risks and when someone required a soft or pureed diet, diabetic, low or high calorie, vegetarian or cultural diet. When people were assessed as being at risk of choking specialist input from the speech and language therapist (SALT) was in place to minimise the risk. Some people required thickeners with their fluids to prevent them from choking and staff were aware of this. People's weights were monitored monthly to confirm they were having enough to eat and drink. One person sat in front of their food for about twenty minutes and then refused to eat their meal when offered help. A member of staff offered a drink supplement which they accepted. The staff member did not record this in a timely way. We discussed this with the deputy managed who ensured this was recorded. They also demonstrated systems in place to monitor people's appetites and this included monitoring their weight more frequently.
The chef was kept up to date with people's dietary needs and new information was made available to the catering staff.

People were supported to remain healthy. Care records showed people's health care needs were monitored and action taken to ensure these were addressed by appropriate health care professionals. People were registered with a GP who visited the home weekly or more frequently if required. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included a speech and language therapist, local authority DoLS team, a tissue viability nurse and Older People Community Mental Health Teams.
On the day of our inspection the registered manager was meeting with the Nurse Advisor for Care Homes and the GP to review people's general health in order to drive improvement. We noted that advice and guidance given by these professionals was followed up in a written report to the head of care and communicated to the staff team. For example specific guidelines around eating and medication. Appointments with consultants or specialists were made by a referral from the GP if people's health needs

changed. People also had access to a chiropodist, dentist, audiologist and an optician regularly. One relative told us "I feel my family member's health needs are met, they get good health care here."

Good

Is the service caring?

Our findings

People told us that the staff at the service were caring. One told us "Staff are very good here." A second person said "The staff are nice and help me." One relative told us "The staff are kind and caring and I can ask them anything."

There was a calm and caring atmosphere in the home during our inspection. When people called for help staff responded in a kind and sensitive way even when people had forgotten why they had called. Each time a member of staff asked them what they wanted and stayed with them for a few moments to ensure they were comfortable and settled.

Staff were visible in people's bedrooms ensuring people were comfortable and had drinks. A member of staff told us "We make sure there is always someone allocated to observe and regularly check people if they are unable to use their bell or call for assistance."

People looked well cared for. Their clothing was clean and fresh and their hair was neatly combed. Staff also ensured that when people wore dentures these were cleaned daily and when people wore glasses that they were reminded to use them.

Staff treated people with dignity and respect. Staff were seen to always knock on people's bedroom doors before entering. One person told us that their door was always shut when staff gave personal care. People were called by their preferred names by staff which was clearly recorded in their care plan. Staff gave us examples of how they treated people with dignity and respect. One staff member told us "Some people like to keep their doors open to see what's going on but I always close the door when I am undertaking personal care." Another member of staff said "I always lock the bathroom door when I am in there with a person to protect their privacy." The head of care told us "Some people like to keep their door open during the night and we respect their choice."

People's private information was held securely people's care records were kept locked in a filing cabinet which meant private information could not be accessed by unauthorised people. Conversations about people's care were held in the nurse's office where they could not be overheard by other people or visitors.

People and their relatives were involved as much as possible in their care planning. There was information in the care plans around people's choices, likes and dislikes. A relative told us they were asked what was important to their family member because due to advanced dementia they were unable to participate in their care planning. Another relative said "We were asked about their previous life, their job, where they lived and their children." They said "It was good that the home took an interest in the person's previous life, it shows they care."
Staff were able to explain the needs of people they supported. One staff member said "I read the care plan and try to understand what people were like before they came here. I treat them like I would like to be treated myself."

Staff communicated with people in a meaningful way. Some people were unable to verbally communicate with staff and others required a little more time to make themselves understood. One staff member showed a person a puzzle and a book to help them decide what they would like to do and then sat with them to support them. There was guidance in the care plans for staff on how best to communicate with people.

Some people's bedrooms were personalised with family photographs and ornaments that were important to the individual. Other people liked to have religious items on display while other people chose music and their television. The level of personalisation and individuality varied according to relative involvement and people's frailty. One person's bedroom was used to store large quantities of their medical supplies which made the room cluttered. We recommended the provider found an alternative storage space to improve the appearance of the room and make it more homely for that person.

Relatives and friends were welcomed in the home at any time. One relative told us "The staff always make me and my family very welcome." Another relative said "I am very satisfied with the standard of care here. My relative is very frail and they are looked after exceptionally well." A further relative said "It's not like a hotel but the care is good." Relatives told us the staff always kept them informed and updated with changes that took place and included them in all decisions about their family members and in home events.

People's independence was promoted and supported. People who required had the space they needed to move freely around the home. Grab rails had been fitted to encourage independence and bathrooms and toilets had been adapted to meet people's mobility needs. Hoists and slings were provided and staff knew how to use the equipment in place. There were ramps provided to enable people to access the patio and garden at the back of the home.

Good

Is the service responsive?

Our findings

Pre-admission assessments were completed before people moved into the service to ensure that staff were able to support their needs. Relatives told us they were asked to participate in these assessments when people's mental frailty prevented them from answering relevant questions. Care plans were written with people's input whenever possible and supported by relatives. Care plans were detailed and covered relevant information with personal preferences noted. Care plans also contained information on people's medical history, mobility, communication, and essential care needs including: sleep routines, continence, diet and nutrition and mobility. These plans provided staff with information so they could respond positively, and provide the person with the support they needed in the way they preferred. For example there was detail around how best to provide personal care to someone who was nursed in bed. Another care plan had management details around how best to provide support to the person who became agitated.

Care plans were generally well maintained and reviewed to ensure they reflected people's current needs. Where a change to someone's needs had been identified this was updated on the care plan as soon as possible and staff were informed of the changes. One person had a change in their medication following a doctor's visit and this was communicated to staff during handover and written in the communication book to ensure the information had been shared with staff. However we noted two care plans had not been updated to indicate unchanged needs.

Where clinical needs had been identified the nursing staff had updated people's care plans with guidance on how to provide care to meet the identified need. For example around care for people with nutritional needs and what food supplements and support was required to keep people healthy. Care plans for management of skin integrity were good and gave a specific account of the concern and how the care should be administered.

Staff had a handover between shifts to endure staff were provided with up to date information. Daily records were written by staff each shift which included detail about the support people received throughout the day. Relatives said that they were kept up to date regarding any changes in their family member's care. One relative said "The registered manager and the head of care were very good getting in touch with me if something changes with their family member."

There was a limited structured activity programme in place that included external entertainers and animal therapy. Staff were providing activities during our visit. These included sitting with people in the lounge watching television and supporting people to do colouring and puzzles. One staff member was undertaking a hand massage and another staff member was talking to a small group of people. They were planning an old film show for the afternoon. A member of staff sat with a person in their bedroom while they were completing their daily notes. They said "It is important that people know we are about and care."

People's spiritual needs were respected and visits from local clergy were organised on request.

When asked people who were able told us that they would have no concerns making a complaint if they

needed to. One person told us "I have never made a complaint." One relative told us if they had any issues they would talk with the registered manager who would deal with the matter immediately. There was a complaints procedure in place for people to access if they needed to. We saw that there had been no complaints made this year. The head of care told us because they had an open culture within the home people and relatives were able to talk about any issues before they became a complaint. Staff said that if people had concerns or a complaint they would support them to speak to the manager.

Good

Is the service well-led?

Our findings

There was a positive culture in the home and people told us the manager was "Good". One relative said "We are very well supported by the manager and she is very capable and kind." Another relative said "The manager will contact us if there is any change in treatment and always keeps us updated."

The registered manager was present on day of the inspection. They were supported by the head of care who is also the deputy manager and qualified staff who also undertook some of the management responsibilities in the home. The registered manage also manages another location in Kent which is part of The Whitepost Health Care Group and divides their time between both homes. They informed us they had recently appointed a clinical led nurse to take responsibility for the daily clinical management of The Elms to drive further improvement in care.

The registered manager encouraged communication between people, families and staff. They encouraged an open door policy and welcomed feedback on any aspect of the service. Staff said they were supported by the registered manager and felt they could raise any concerns or issues they had in confidence. One member of staff felt they were valued and said "The manager recognises our hard work and I appreciate that." Another member of staff said "I am always asked for my views and I value that." Staff told us the deputy manager was present in the home every day worked alongside them. Staff understood what whistle blowing was and that this needed to be reported. They said they never had to do this but had confidence they would be listened to if required to do so.

Staff meetings took place and staff said they could have daily discussions amongst themselves to talk about anything they wished.

An auditing system was in place to monitor and drive improvement. The registered manager had a clear management structure in place so the staff knew their roles and responsibilities. The registered manager delegated various tasks to senior staff. For example reviews of care plans, medicine plans, risk assessments, and needs assessments were undertaken by the clinical staff and updated as and when required. We noted some audits could be more effective in recognising records that required updating, for example care plans. This was addressed immediately.

Health and safety audits were undertaken by the administrator to ensure the safety and welfare of people living in the home, people who visited the home, and to promote a safe working environment for staff who worked in the home. Records relating to health and safety included utility checks, fire safety, and equipment were maintained to ensure the safety of people, visitors and staff. We noted the damaged bed rail bumpers, the scruffy paint work and the assisted toilet stand had not been identified during these audits, and needed to be reviewed to drive improvement.

Systems were in place to monitor the quality of the service that people received. People and relatives were asked for their views in a questionnaire that was distributed yearly to people. Questions included quality of care, cleanliness, attitude of staff, environment, and catering. The overall comments were positive for

example "The home is good and I am glad I chose it for my relative". "The food is good and my relative seems to enjoy it." There was total satisfaction with the standard of care provided. Relatives said staff were kind and knew their family well.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The provider had informed CQC of significant events that happened in a timely way. This meant we could check that appropriate action had been taken. The PIR had been completed when requested and the information given by the registered manager matched with what we found on the day.