Care UK Community Partnerships Ltd

Elmstead House

Inspection report

171 Park Road
Hendon
London
NW4 3TH

Tel: 02082026177
Website: www.elmsteadhousehendon.co.uk

Date of inspection visit:
14 November 2016

Date of publication:
10 March 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 14 November 2016. It was an unannounced focussed inspection. We inspected for the domains of Safe, Effective and Well-Led.

Elmstead House is a nursing home that is registered to provide accommodation with nursing and personal care for up to 50 people. The service specialises in dementia, diagnostic and/or screening services, learning disabilities, mental health conditions, physical disabilities, and caring for adults over 65 years old. The home was divided into two units, one for people who are living with dementia and are physically frail, and the other for people with a mental health diagnosis. At the time of the inspection there were 44 people living in the home with 28 people in the dementia unit and 16 in the mental health unit.

Prior to this inspection we had carried out an unannounced comprehensive inspection of this service on 16 June 2015 at which two breaches of legal requirements were found. This was because people were not fully protected against the risks associated with medicines. There were also some gaps in records for people who were unable to consent to care and required best interest decisions to be made on their behalf, so it was not always clear if all relevant parties had been consulted in line with the Mental Capacity Act 2005. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We found the service was meeting these legal requirements when we undertook a focused inspection on the 10 December 2015.

The service had not had a registered manager since January 2016. 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 recently appointed manager who told us they intended to apply for registration.

During our inspection we found three breaches of the regulations in infection control, nutrition and hydration and good governance.

Although staff had received infection control training we observed poor infection control practice in particular the disposal of protective equipment such as gloves and contaminated waste.

We found people were offered a good choice of meals however they did not have access to snacks throughout the day. In addition drinks were not available to people at all times. We found some fluid charts contained significant gaps in recording. This meant that people were not being effectively monitored to ensure they remained well hydrated.

Daily recordings such as re-positioning charts to manage pressure ulcers care contained significant gaps. This meant that people were not being monitored effectively to ensure their medical conditions were well managed. We found that the nursing staff were well informed about people's health requirements. People

were supported to access health care professionals. Nurses demonstrated they understood what medicines they administered were used for and we found medicines were stored safely. Administration was completed appropriately in the majority of instances.

Although there were governance systems in place to assure the quality of the service given we found that these had not been effective in monitoring and addressing the issues we found during our inspection. In addition staff morale was low and the provider had not ensured staff felt valued and listened to. Staff told us they were too short staffed at times to meet the needs of people living at the service. The provider demonstrated to us that they employed agency staff in response to staff absence and used a dependency tool to identify staffing need.

We found the service was not always safe as the service had been broken into twice in recent months and although some security measures had been taken further measures were required to make the service safe for people.

We made a recommendation to the provider to obtain expert advice to make the service secured.

The service demonstrated they recorded mental capacity decisions in people's records and but did not in all instances record the best interest decision clearly to show it was the least restrictive option. However the service had made Deprivation of Liberty Safeguards applications appropriately and had requested reviews in a timely manner. Staff demonstrated they understood the need to obtain people's consent and gave people choice.

Staff had received supervision from the deputy manager and had received a good standard of training from the training manager to equip them to undertake their work. Staff demonstrated to us they were knowledgeable about the people they supported.

We found overall three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 always safe as although staff had received infection control training we observed some poor infection control practice.

There were robust recruitment systems that ensured staff were safe to work with vulnerable people.

The provider had taken some action to ensure the building was secured however we saw some areas of concern.

Nurses were knowledgeable about the medicines they administered and stored medicines in an appropriate manner. However we noted an unsafe medicine administration practice, and a gap in recording.

Staff had received safeguarding adults training and understood their responsibilities to report abuse concerns to the appropriate authorities.

Is the service effective?

Requires Improvement

The service was not always effective. Although people were offered a choice of meals there was not always access to snacks and drinks during the day, and records were not maintained where required.

There were significant gaps in the recordings of repositioning and pressure mattress checks. As such the service did not maintain robust monitoring of people's wellbeing.

The service worked under the Mental Capacity Act 2005 by making Deprivation of Liberty Safeguards applications to the statutory body. However documents did not always evidence the least restrictive option had been identified.

Staff received supervision and training to support them to undertake their role.

Is the service well-led?

Inadequate

The service was not well-led. There was a newly appointed

manager to the service but there had not been a full time registered manager in post since January 2016.

A staff survey had been undertaken but actions had failed to address some identified issues including low staff morale in the service.

The service had undertaken checks and quality assurance audits however these had not been effective in identifying and addressing the recording and infection control concerns we found during our inspection.

Elmstead House

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 14 November 2016. It was an unannounced focussed inspection. We inspected under the domains of Safe, Effective and Well-Led.

The inspection team consisted of four adult social care inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We spoke with the commissioning body prior to our visit for feedback on their visits to the service.

During our visit we spoke with three people using the service and spoke with five people's relatives, we looked at five people's care records, this included reviewing documents such as risk assessments, daily records and turning charts. We observed five people's medicines administration and reviewed their medicine administration records. We checked storage of medicines and controlled drugs. We observed staff interaction with people throughout the day. We reviewed seven staff personnel records, interviewed two care staff; we spoke with support staff and the senior staff including nurses throughout the day. We met with the deputy manager and newly appointed manager. We spoke with the Operations Support Manager. Following the visit we spoke with two health and social care commissioning bodies.

Requires Improvement

Is the service safe?

Our findings

Staff had received infection control training and there was a poster containing information to remind staff of good practice to prevent the spread of infections including the norovirus. We saw that cloakrooms contained hand sanitiser and paper towels and reminders to wash hands appropriately. However we found poor staff infection control practice during our visit. For example there were three instances when protective gloves were disposed of incorrectly. A used pair of gloves was left on a table in a corridor and one used pair was left in the cleaning store cupboard. Also a single used glove was left on the ground in the service garden by a bin. This was an infection control hazard.

One of the yellow bins used for the storage of contaminated waste was overflowing. The lid was pushed open and yellow bags were visible raised above the top of the bin. The other three yellow bins had plenty of space inside them but staff had not used these. There is a risk if contaminated waste is not stored appropriately as the yellow bags can become torn and the contaminated contents present an infection control hazard. We brought this to the attention of the deputy manager at 10:00AM however this had still not been addressed at 7:00PM.

In addition in one unit there was a full sharps bin for the disposal of used syringe needles. The bin had been waiting since August 2016 for collection. The November collection had not been made on the allotted date. This was a hazard and should have been removed from the service in a timely manner.

We noted one instance when the nurse did not use protective gloves when they crushed and administered a person's medicines.

We saw cleaning staff used colour coded mops to avoid cross infection. Although both units looked clean there was a malodour of urine particularly stairwells and in both bathrooms in one unit. We noted that this had improved in the afternoon following the cleaning of these areas.

The above concerns were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment.

Staff told us there was not enough staff to manage the needs of the people living in the service. Staff told us for example "We are always short of staff and I am tired of that," and "sometimes we have to leave people in bed for longer, so we can manage" and "We have to rush to give them breakfast" and "We have no time to help with activities."

During our visit we saw that in the morning there was initially a shortage of staff to meet people's needs. On the day of inspection we observed in one unit morning medicines were still being administered at 11:30AM. We spoke with the nurse who explained that due to unexpected staff absence they had to work with the staff to get people up and as such had started the medicines administration later than usual. In the other unit we were told one person required one to one twenty four hour support and the nurse in charge had provided this support due to another unexpected staff absence so the medicine round did not start until 9:00AM. We

observed in this unit people sitting in the lounge with no staff present and very little or no interactions with staff throughout the morning.

We observed staff approached the nurse on two occasions during the medicines round. This is not good practice as the nurse should be undisturbed when concentrating on administering medicines to avoid errors being made.

Staff told us "When one of us is sick they don't provide cover." However on the day of inspection the management team requested agency staff to cover three absent staff. We were told the management by agency staff arrived in the unit by 10:00AM, another by 11:00AM and the third by lunchtime. We noted that the atmosphere changed in the afternoon with the extra staff. Staff talked and interacted with people in an appropriate manner whereas earlier in the morning the staff approach focussed only on tasks prior to the agency staff arrival.

The Operations Support Manager told us that the numbers of people living in the service had dropped from fifty to forty four and the staffing levels are assessed using the CAPE tool to determine safe staffing levels. Following the inspection we were sent information to evidence staffing was sufficient and safe in the service giving a breakdown of the staffing provided. There was one week highlighted by the Operations Support Manager where there was a staff shortage of 58 hours for the week. We were assured by the Operational Support Manager agency staff was used when there was staff absence.

The evidence provided by the Operational Support Manager was comprehensive however was at odds with the staff feedback. We saw action was taken by the use of agency staff and saw that agency staff had been used at times during the past months. We saw in an audit undertaken by Care UK on 20 July 2016 described that staffing was "under resourced to deal with all of the eventualities at the time." An audit review undertaken by Care UK on 28 September 2016 found the situation improved and stated "the majority of the time there were sufficient staff on duty to meet resident's care and social needs".
.
Prior to our visit we had been informed the service had been broken into in September and October 2016. Staff said the building is "as safe as it could be without being a prison…we have to be vigilant." The deputy manager showed us the site where the access had been gained had been partially secured by the use of raised wooden panels. We saw there was night lighting around the building and CCT cameras in place which was a robust security measure.

Between the two units there were key pads to allow access from one unit to another. The number code was hidden in a picture hung on the outside wall as a prompt for staff. This number would not be obvious to someone with a cognitive impairment to read. However it would be obvious to somebody intent on entering the building illegally, as such we raised this to the management team to address. In addition we observed one person living in a unit sat by an entrance and told us loudly each time we left what the code was. This meant there was a possibility that people who might not be safe to leave without support could also hear the code and use the key pad to leave. The service manager told us that there had been a risk assessment undertaken by Care UK prior to our visit that included security of the service however this was not available for us to look at.

Prior to our visit we had been informed that one person had left the building for a very brief period when they were under a Deprivation of Liberty Safeguard (DoLS) that specified they did not have capacity to leave the building without support. We found that the incident had occurred when a workman had left a gate open and the person had walked out, staff realised immediately and found the person at the front of the building. It is important that any maintenance work undertaken is risk assessed to ensure the safety of

people living at the service. On balance although some good measures had been put in place the service had not taken enough action to ensure the building was secured at all times.

We recommend the provider takes advice from an expert in security management.

There was a robust recruitment process that included applications forms and interviews, followed by proof of identity checks and disclosure and barring service checks to ensure staff were considered safe to work with people. The service had ensured nurses were registered to work by checking there were no restrictions to them practising on the Nursing and Midwifery Council website.

Nursing staff were well informed about people's health requirements and demonstrated they understood what people's medicines were used for. Medicine administration records were completed without error with the exception of one unexplained gap where a staff signature should have been or an explanation as to why the medicine was not administered. As stated morning medicines were given very late but nursing staff showed us they had ensured people who had lunch time medicines were being given the morning medicines early to allow an appropriate time gap between doses. There were clear instructions and mental capacity assessments for the administration of covert medicines that were reviewed as best practice on a regular basis. We noted one instance where the nurse administering medicines would not have rinsed the medicine crusher before crushing another person's medicines without the inspector's intervention. There was a danger of particles of medicines from one person being given unintentionally to another person. We checked the storage of medicines, controlled drugs, and found these to be stored appropriately. Stocks of controlled drugs tallied with the controlled drugs log. Two staff signed the log to confirm the controlled drugs were administered appropriately.

People had risk assessments to keep them safe. Assessments covered, for example, moving and handling, risk of pressure ulcers, administration of medicines and the risk of choking. One person had risks identified in relation to their diabetes including the risk of hyper and hypoglycaemia. However we noted this was only documented on the computer system and not in the diabetic risk assessment. All risk assessments indicated a hazard and risk rating to show level of risk; however it was not always clear how the rating was reached. We discussed our findings with the management team who showed us they were in the process of changing their risk assessment format and explained the new format would address the concerns we had raised.

People had personal evacuation plans for staff reference in the event of fire. There was a colour coded system so people at high risk who required two people to support them to evacuate had a red sticker on their risk assessment and on their bedroom door frame to alert staff and the Fire Service.

Following the inspection the service sent us certificates that demonstrated yearly checks were undertaken to ensure the safety of the building and that weekly checks were completed to ensure fire alarms were in working order.

The deputy manager told us all staff had received safeguarding adults training in last six months and that safeguarding concerns were reported to the appropriate bodies. A staff member told us "We make sure they are cared for and it is safe." All staff spoken with demonstrated an understanding of the signs of abuse and could tell us how they would report abuse appropriately. We had received notifications from the service that demonstrated the management team understood their responsibilities to report safeguarding concerns and take necessary actions to ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

We saw the chef had won an award last year as the best chef in Care UK organisation. Meals served were of an appropriate size and we saw there was a choice of menu including a vegetarian alternative. Both kitchen staff and care staff were able to tell us who required support to eat and what their dietary requirements were. For example people who required it, received a pureed diet due to swallowing problems and one person who was diabetic was supported to have sugar free food and drink. People were monitored for their weight and staff told us "if people are losing weight we call a dietician and we give them protein drinks and double cream" We noted however that there were no snacks available to people sitting in the lounge areas and saw this issue had been raised as a concern in the July 2016 quality assurance audit undertaken by Care UK.

We were told by a staff member that drinks were served to people between meals at 11:30AM, 3:30PM and 5:30PM to ensure people have adequate fluids to remain hydrated. During an observation at 2PM there were two people with drinks therefore nine people did not have access to fluids. Whilst not everyone would have been able to drink without support there should still be fluids available for people to indicate they might be thirsty and to allow staff to offer or prompt a drink.

Some people had fluid charts to record what they had drunk, however we saw a number of gaps in recordings for example one person who received nutrition and fluids via a percutaneous endoscopic gastrostomy (PEG). This is a medical procedure most commonly to provide a means of feeding when oral intake is not adequate. In the week prior to our inspection there were gaps in recording on the 5 and 7 of November. There were no recordings for a 23 hour period from 8:00PM on the 08 November until 9:00PM on the 09 November 2016. There was another gap of 13 hours for the same person on the 13 November 2016 from 8:00AM until 9:00PM. It is essential there are clear recordings of fluid consumption for people using a PEG feed. The service did not demonstrate they were ensuring people were kept well hydrated and were not monitoring effectively people's fluid consumption.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 Meeting Nutritional and Hydration Needs.

Other records of people's care were not consistent, for example we saw gaps in one person's daily check list to ensure their electric bed and mattress settings were appropriate on the 8, 9 and 13 of November 2016. There were also gaps in their 15 minute observation chart for example there were no checks recorded on 17 October 2016 from 2:15 PM until 8:00PM. This was of concern because they were at risk of poor skin integrity and also required regular checks to ensure their safety when they remained in their bed room alone.

We looked at repositioning charts for other people and again found gaps in recordings. For example we found significant gaps in the records for one person who should have been repositioned on a four hourly basis according to their care plan to prevent pressure ulcer damage. There was a gap of 12 hours throughout the night between the 7 and 8 November 2016 and a nine hour gap on both the 10 and 11

November. There was a five hour gap on the 12 November. The service was failing to ensure medical records were updated .The above issues were of concern as without robust monitoring there is a danger that the correct practice to support the person is not taking place, and without repositioning a person's deteriorating medical condition could be over looked by staff and medical support not requested in a timely manner.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had received MCA and DoLS training and could tell us how they gave people choice "We always give people a choice at meal times, there are two menus and they are changed monthly." Staff were able to explain how they got people's consent and one staff member explained how they asked people for their permission to give care and support demonstrating they try different approaches if they felt the person needed care.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that Elmstead House as the managing authority had applied for DoLS from the statutory body appropriately, having taken into account the mental capacity of people at the service to consent to their care and treatment.

There was evidence that mental capacity assessments had taken place to determine if people had capacity to make decisions for themselves in specific areas such consent to care. However in a number of records we saw people were found to not have capacity in the mental capacity assessment but the best interest decision was not documented. As such it was not always possible to see who had been involved in making the best interest decision and if it was the least restrictive option available. We brought this to the attention of the service manager and manager who agreed this would be addressed as a matter of urgency.

A staff member told us "supervision is important to improve our practice." Staff told us they had regular supervision at least every three months and that they found supervision useful, and confirmed they were able to see managers at other times if required. We found there were some gaps in supervision records but the deputy manager told us group supervision was filling the gaps for personal supervision and he had been line managing every staff member until the week before the inspection when the new manager had started.

Staff told us they received regular mandatory training and said training was regular and of a good quality with a good mix of on-line and classroom based training. "It's the best as far as training is concerned." Most staff had nationally recognised qualifications in health and social care. The training manager was also a skilled trainer in a range of key areas. They told us "each staff does at least four training courses a year, for example dignity, diabetes and pressure care." All new staff undertook care certificate training to ensure they had the skills required to undertake their role.

Staff were able to tell us about the people they cared for and confirmed they had received specific training so they could support people with both physical and mental health conditions. "We have had training about

diabetes and mental health." Staff were able to describe different mental health conditions for example bipolar disorder. We asked staff how they supported people to manage their continence and remain comfortable throughout the day. All staff spoken with confirmed that they used the appropriate incontinence pads for the person and that people were changed at regular intervals during the day. If people did become wet this was recorded in the daily records and highlighted to all staff to avoid a reoccurrence.

We looked at people's records and saw that people were supported to access appropriate medical health care. For example people received regular visits from the podiatrist and the GP. Referrals were made to the dietitian when people were losing weight. People who were receiving end of life care were supported by the community palliative care team who visited the service and advised staff.

Inadequate

Is the service well-led?

Our findings

There was a newly appointed manager who had just started working at Elmstead House. They intended to apply to the CQC to be the registered manager. Prior to their arrival the Operation Support Manager had divided their time between several services and was not based at Elmstead House. The deputy manager had provided the day to day management cover in the service. All staff spoke positively about the deputy manager for example "the deputy is very good, he is here all the time and knows the residents well." Whilst we acknowledged that the provider had just employed a full time manager we were concerned that there had been no full time registered manager for the nursing home since 25 January 2016 given the size of the service and the complexity of people's needs catered for.

We found staff morale was low. For example staff told us "We are working too much, this company doesn't care about us" and said "We have been short staffed for a long time, the managers are aware." Staff told us they did not feel listened to by the provider. This did not demonstrate a positive staff culture within the service. Low staff morale affects staff turnover and the quality of care provided to people living at the service.

There were external quality assurance systems in place. Care UK undertook audits completed by governance managers. For example we saw records for July and September 2016. Audits looked at the service using the CQC format of five key questions. The service was found to require improvement by the governance managers on both occasions. It was not always clear from the reports if the issues identified at the previous audit were now addressed. For example in the July audit it was identified that there were no snacks available to people sitting in the lounge areas. Actions written by the management team included providing snacks bowls for people in the lounge areas. However the September audit review did not address this matter so there was no indication to confirm this was being done. When we visited we had concerns that no snacks were made available to people. Similarly the September audit review identified the medicine crusher was being used multiple times and was not always cleaned in between use. We found this practice still occurring during our visit.

There were checks by the deputy manager on the work of the nurses. These focussed on medicines administration and we saw evidence that poor practice had been challenged. There was also unannounced night time checks and actions had been taken in response to poor practice. There was an online matrix for risk assessments for people to ensure timely review and risk assessments were quality checked by the deputy manager and reviewed every month. The service used a system called 'Resident of the day' this identified a person in each unit and nurses ensured their risk assessments, care plans and documentation were reviewed. However the current systems had not identified the significant gaps in recording and so were not effective. There was an infection control audit completed on the 1 November 2016, however we found concerns around staff infection control practice.

We found that although there were systems in place to monitor and quality assure the service provided, there was not a cohesive approach in auditing to ensure that concerns identified were being addressed. In addition the morale of the staff had not been addressed through the staff survey findings. Work was required

to identify and address the issues around the low staff morale

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

We found that there were good systems of communication between permanent staff on a day to day basis. We observed staff handover was thorough to the oncoming shift. There were "Take Ten meetings". This was led by the deputy manager a ten minutes 'catch up' each day where they discussed people to enable good communication about support needs and discussed best practise. There were also team meetings for all staff to attend on a monthly basis. Senior staff attended regular clinical meetings and the Operational Support Manager told us they met with and were well supported by the provider.

We saw there had been a staff survey in 2016.The provider told us there had been a 100% response rate which was up from the previous year by 77%. This indicates staff felt able to contribute their views to the provider. This was comprehensive and compared the service responses with other Care UK services. There was an action plan to identify what needed to take place. For example 'My immediate manager tells me when I have done good work' had a score of 54% and was identified as a poorer score than on the previous staff survey in 2015. Actions identified were around staff appraisal and to improve communications with staff. We saw that the deputy manager was meeting with staff daily in the 10 minute 'catch ups' as a response to improving communication.

The service held residents meetings on a frequent basis and had relatives meetings so people and relatives had the opportunity to raise concerns to the management team. There had been a relative's survey to obtain feedback from people's family members.

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 Regulation 12 (1)(2)(a)(b)(h) The service was not ensuring the staff controlled the risk of infection by taking the appropriate measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14((1)(2)(a)(b) The service must demonstrate they are ensuring people are kept well hydrated and are monitoring effectively people's fluid consumption.

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 Regulation 17(1)(2)(a0(b)(c)(d)(e)(f) There must be a registered manager. There must be effective monitoring and auditing that ensures health care checks and measures are in place.

The enforcement action we took:

Warning notice.