Care Quality Commission

Care UK Community Partnerships Ltd

Elmstead House

Inspection report

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Overall summary

We 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 undertook a focused inspection on the 10 December 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Elmstead House' on our website at www.cqc.org.uk

Elmstead Nursing Home 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 split into two units, one for people who have memory problems and are physically frail, and the other for people with mental health difficulties. At the time of the inspection there were 44 people living in the home with 28 people on the dementia unit and 16 on the mental health unit.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our focused inspection on 10 December 2015, we found that the provider had followed their plan which they had told us would be completed by 30 September 2015, and so legal requirements had been met.

Improvements had been made in the administration of medicines to people living in the home. The practice of delegating administration had stopped, and there were clear records of how people's medicines should be administered particularly if they required covert medicines (without their knowledge) with consultation recorded with all the relevant people. There were regular audits of medicines administration, and all prescribed medicines were in stock and clear records of administration were recorded.

Summary of findings

Improvements were made in recording people's consent to care and best interest decisions made on their behalf under the Mental Capacity Act 2005. There were clear systems in place for assessing and monitoring people who were subject to Deprivation of Liberty Safeguards.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We found that action had been taken to improve the safety of the service.

People received their medicines safely from appropriately trained nurses. Supplies were available to enable people to have their medicines when they needed them.

Records showed people were getting their medicines when they needed them, and were clear about the way in which they should be administered.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Is the service effective?
We found that action had been taken to improve the effectiveness of the service.

Staff understood people's right to make choices about their care and the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Care records had been updated to show clear consultation about best interest decisions made on people's behalf.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive 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.

We undertook a focused inspection of Elmstead House on 10 December 2015. This was conducted by two inspectors, one of who was a pharmacist inspector. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 16 June 2015 had been made.

We inspected the service against two of the five questions we ask about services: is the service safe, and is the service effective. This is because the service was not meeting legal requirements in relation to those questions.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

During the inspection we spoke with six people living at the home, and looked at the care plans, risk assessments, and mental capacity act records relating to ten of the 44 people who were living at Elmstead House. We also spoke with the clinical development manager, two nurses, and four care staff. We checked the medicines administration record sheets and medicines for all of the people living at the home.

Is the service safe?

Our findings

At our comprehensive inspection of Elmstead House on 16 June 2015 we found that people did not always receive safe support with their medicines particularly due to delegation of medicines administration and insufficiently rigorous auditing of medicines records. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 10 December 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 as described above.

People told us that they were given their medicines on time, and did not have any concerns about their administration. We saw appropriate arrangements in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. We checked the medicines for all the people who used the service and saw no medicines were out of stock.

We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

Controlled drugs were stored and managed appropriately. When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual 'when required protocols', (administration guidance to inform staff about when these medicines should and should not be given) were in place. This meant there was information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they needed them and in a way that was both safe and consistent.

We also saw the provider did monthly audits to check the administration of medicines was being recorded correctly. Medicines were only administered by qualified nurses who had their competency assessed in this area. Each person had a medication care plan which gave detailed information on how medicines should be given. On the day of the inspection we found that 11 out of 44 people had their medicines administered covertly (without their knowledge) or crushed due to a swallowing difficulty (with their knowledge). When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

On the day of our visit, the registered manager and deputy manager were off sick, the administrator was on leave, and we were told that three care assistant shifts which had been booked to be covered by agency staff had not been filled. This placed staff within the home under considerable pressure, and we were concerned about security arrangements in the home with no one covering the reception area. We discussed our concerns with the clinical development manager who was visiting the home that day. However, it was clear from looking at the rota for that month, that staffing levels on the day of our visit were unusually low, and this was not the case on an ongoing basis. We will look at staffing levels again in greater detail at our next comprehensive inspection of the service.

As noted in the provider's action plan following our last inspection, we found choking risk assessments were in place for people who were at risk, and these were reviewed monthly including details of how to reduce the risk of choking.

Is the service effective?

Our findings

At our comprehensive inspection of Elmstead House on 16 June 2015 we found that there were insufficiently clear records of people's consent, or of best interest decisions made on their behalf in accordance with the Mental Capacity Act 2005. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our focused inspection on 10 December 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 11 as described above.

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). 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.

As detailed in the provider's action plan, we found that documentation for people on covert medication had been rewritten, to ensure that all appropriate persons were consulted and their views had been documented and considered in making a best interests decision. We were told that these would be reviewed annually or sooner should changes occur.

People told us that they were able to make choices about their care. We found that assessments were in place under the MCA regarding people's capacity to make decisions and consent to their care and treatment. Staff had received training on the MCA and were aware of the need to ensure that those with capacity were supported to make their own decisions and choices. This was achieved by the staff asking permission to carry out each task to gain their consent.

Deprivation of Liberty Safeguards (DoLS) were in place for a large number of people living at the home due to being unable to go out unsupervised and not having capacity to consent to this arrangement. Each person's care plan had a section to indicate whether they were subject to DoLS including review dates, and evidence of appropriate assessments such as those by an Independent Mental Capacity Advocate. Staff at the home applied for renewal of these safeguards in good time when needed.

A small number of people had conditions attached to their DoLS authorisations. However the nurses on duty were not aware of these conditions, and could not easily demonstrate that they had been met. For example, two people's DoLS conditions included regular consultation with their partner, and one person's conditions included reviewing their financial care plan, but there was no record of these taking place. We discussed this issue with the clinical development manager who undertook to follow this up with the registered manager.