Bupa Care Homes (ANS) Limited

Elm View Care Home

Inspection report

Moor Lane
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21 September 2018

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We undertook the inspection of Elm View Care Home on the 20 & 21 September 2018. This inspection was unannounced, which meant that the provider did not know we would be visiting.

Elm View is a 'nursing home'. People in nursing 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 care home accommodates 43 people in one building providing nursing care and personal care. At the time of our inspection 37 people were accommodated in the home.

At the last inspection the service was rated as Good. At this inspection we found the service Requires Improvement in Safe and Well-led.

There was a registered manager in post. 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.

The providers quality assurance system had not identified shortfalls found during the inspection.

We found shortfalls relating to people's individual care needs such as, wound care, nutrition, re-positioning records and the storage of people's thickener which required improving.

People were supported by staff who received supervision an annual appraisal and training. Checks had been completed prior to starting work at the service. Staff felt the home was a nice place to work and that they felt well supported.

People were happy with the care they received and all felt the staff were kind and caring.

People's care plans were person centred and contained important information relating to their likes and dislikes. People felt able to raise any complaints and various compliments had been received regarding working at the home and positive experiences of the care people had received.

People felt safe, and staff were able to recognise the different types of abuse and who to report it to.

People had choice in the meals and had access to drinks throughout the day. Medical appointments were arranged as and when required.

People had choice about how they spent their time and there was access to a variety of activities throughout

the month.

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.

Records were not always accurate and up to date relating to people's current care needs.

People had mixed view on the staffing within the home.

People received their medicines safely and when required.

People felt safe and staff demonstrated a good understanding of abuse and who to report concerns to.

Is the service effective?

Good

The service remained Good in Effective.

Is the service caring?

Good

The service remained Good in Caring.

Is the service responsive?

Good

The service remained Good in Responsive.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

The providers audits had not always identified shortfalls relating to incomplete records, and care plans.

People and staff felt the management was good and that it was a nice place to work.

The service undertook quality assurance systems to seek feedback from people regarding their care experience.

Elm View Care 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.

The inspection was carried out by two adult social care inspectors, an expert by experience and a specialist advisor on the first day. The second day was undertaken by one adult social care inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a nurse.

Following the inspection we left messages with three health care professionals but we were unable to gain views from them.

During the inspection we spoke with eleven people living at the service and three visitors. We also spoke with the registered manager, the regional director along with the deputy manager and four staff.

We looked at six people's care and support records and three staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies and procedures, audits and complaints.

Before the inspection we reviewed the information, we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us. We also reviewed the Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

People had risk assessments in place although guidelines and outcomes were not always recording ongoing support or actions taken. For example, one person required a specialist diet their care plan confirmed the risk of choking including how their food should be prepared. The registered manager confirmed the person had capacity to make decisions regarding their diet and current weight loss. The persons' care plan contained limited information relating to their wishes where some days they would choose not to have their specialist diet or would decline meals and food. The person's care plan contained assessments and outcomes from health professionals who were involved in the person's care and following the inspection we were sent their eating and drinking care plan and evaluation. This meant records could be improved to demonstrate people had made an informed decision about their care. The registered manager confirmed following the inspection action they had taken to update the person's records and we were sent the person's updated care plan.

People's care plans did not always have up to date records relating to the person's wound management. For example, one person's care plan had confirmation of their wound. But there was no confirmation whether the wound had improved or what support the person required apart from an initial photograph. We asked staff what the current support was for the person relating to their wound. They were unable to advise us if the person still had the wound or what their care was relating to it. The registered manager reviewed the situation. They confirmed the person's skin had improved after a few hours of the initial photograph being taken. This meant the person's care plan did not clearly record the improvement. Following our inspection we were sent updated information relating to the person's skin care plan. The registered manager however, showed us good examples of where people had detailed care plans relating to their wound management. This meant positive examples were found of care plans that contained peoples' wound care.

One person had no diabetes information in the person's care plan that confirmed if monitoring had stopped and if so why. The registered manager confirmed the person no longer required their blood sugar recordings. This meant their care plan needed updating to reflect the changes to their care needs.

Where people required support with their skin care we found not all records were up to date and accurate to show the person had received their care as required. For example, one person required repositioning every 4 hours. This was confirmed on their positional change form. We found there were no records that the person had received their re-positioning as required.
This meant by not having accurate and up to date records it was unclear if the person had received their care as per their assessment.

People's care plan's had risk assessments in place that included mobility and moving and handling. This gave staff important information relating to how to support the person with their care.

People received their medicines safely and by staff who were competent at administering their medicines. Peoples' Medicines Administration Chart (MARs) were current and up to date.

Medicines were stored safely. Stock controls were managed to ensure only the amount needed was available. During the inspection we observed staff responsible for administering medicines were not always free from distractions. For example, there was a phone on the trolley that rang three times whilst the member of staff was administering medicines. This meant any interruptions could potentially lead to the member of staff becoming distracted. The providers policy confirmed, 'Ensure you have all the correct equipment prepared to enable medication round to be conducted without interruptions'. The Safety section within the policy stated, 'Minimise distractions and do not multitask whilst doing medication rounds'. This meant this practice was not line with the providers medication policy.

People who required a thickening agent adding to their fluids, did not always have this stored safely. For example, during the inspection we observed people's thickening agent on the side in their rooms. We raised this with the registered manager and regional director. They confirmed they were aware of this practice and that people should have it stored in their drawers or cupboards so that it was out of sight. They felt the risk to people' within the home was low however there was no paper risk assessment in place that identified the risk or confirmed what actions were taken to reduce the risk.

People felt happy with the support they received from staff with their medicines. People told us, "They give me my tablets and wait by my bed until I have swallowed them". Another person told us, "I get my tablets regularly, they watch me take them".

People were supported by staff who demonstrated good infection control procedures. For example, people and staff had access to liquid hand soaps and paper towels and staff wore personal protective equipment throughout the home.

People and staff felt the home was safe. People told us, "I feel safe, everybody is on hand to help if needed". Another person told us, "It is safe, doors are locked at night and there are people around all night. Another person said, "It is safe, I am comfortable with the whole set-up".

During the inspection we were given details of an incident involving one person whose specialist mattress equipment had deflated. The registered manager took immediate action to raise the concern during the inspection and the local authority confirmed no section 42 enquiry was required. Following the inspection, the registered managed confirmed they would now use the safeguarding threshold tool for all future safeguarding queries.

Staff were confident about identifying different types of abuse and who to report abuse to. One member of staff told us, "Different types of abuse are physical, financial, sexual, neglect, institution, modern slavery, mental and emotional, verbal". They felt all people were safe in the home and if they had any concerns they would raise it with the manager or the local authority. They also confirmed the provider had a whistleblowing help line that they could ring to raise any internal concerns.

People during the inspection were supported by enough staff to meet their needs although people had mixed views on the staffing levels within the home. On the first day of the inspection we observed one person who was in bed at 10am. We asked them if this was their choice. They replied, "Sometimes it is 8:30 sometimes 11:30. I know they are busy". They said that they didn't mind that staff were busy, we shared this information with the registered manager. On the second day of the inspection we observed the person was sat in their chair at 10:20 having been supported with all their care needs.

People told us, "Could do with more staff". Another person said, "Should be more staff; bell usually answered in 5 minutes but can be 25 minutes". Another person said, "Nowhere near enough staff. If there

were more I wouldn't have to wait when I use my call bell". Another person said, "Staff are a bit short at the moment, maybe because staff are on holiday but they come quickly if I call". The registered manager confirmed that call bell response times were reviewed. This was to ensure there were enough staff on to respond to people's needs but also to identify any changes to a person's care needs.

Staff felt there were enough staff to meet people's needs. They also confirmed the registered manager booked where possible the same agency staff for consistency. One member of staff told us, "Yes we have enough staff. There are now additional staff in the lounges. Agency staff work well. We try and book same staff regarding blocking generally the same staff". The registered manager had a dependency tool that worked out the staffing hours based on people's needs. They confirmed they had flexibility in changing the staffing levels based on the needs of the service. The regional director confirmed they were happy for the registered manager to make decisions about the staffing levels in the home.

People were supported by staff who had checks to ensure they were suitable to work within the service. For example, staff files contained references, an application form and a Disclosure and Barring Service (DBS) check. A DBS helps employers to make safer recruitment decisions by providing a check on the person's suitability to work with vulnerable adults.

The home had relevant safety checks undertaken relating to water temperatures, legionella checks, radiator covers and window restrictors. Tests were undertaken to electrical appliances and equipment this is called PAT testing. The handyman confirmed these had recently been requested as they were due soon. The maintenance operative also undertook maintenance to equipment such as wheelchairs and wear and tear within the home and the garden area. Visitors signed a visitor's book. This meant there was a clear record of who was visiting the building in case of an emergency.

Good

Is the service effective?

Our findings

The service remained Good.

People were supported by staff who received regular supervision and an annual appraisal. Supervisions were a combination of one to one meetings, team meetings and clinical supervision. Staff felt well supported. One member of staff told us, "We get six a year. One every couple of months. We also have daily handovers and can get support in-between sessions". Appraisals were an opportunity to review staff's performance and set goals to achieve for the coming year. Records we saw confirmed this. Following the inspection we were sent confirmation where staff had received supervision highlighting areas to improve on following the inspection.

People were supported by staff who had training to ensure they had the skills and competence for their role. Staff told us, "I have received training in, manual handling, infection control, data matters, safeguarding, mental capacity act, everything". Records confirmed this. People were also supported by staff who received additional training to ensure they had additional skills and competency to support people's individual needs. For example, staff had received additional training in dementia and catheter care.

The Mental Capacity Act 2005 provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's care plans confirmed if people lacked capacity. Where people lacked capacity a mental capacity assessment was in place. Mental capacity assessments were decision specific and detailed who had been involved in the decision-making process. For example, assessments and best interest decisions were in place for bed rails and modifying diets. Where people were supported with their decisions by a relative the person's care plan confirmed the details of the power of attorney and what it was in relation to.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest 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 and they were. Applications had been made when required and the registered manager kept an up to date log of what had been authorised and what applications were pending.

People were supported by staff with their medical appointments when required. People's care plans confirmed records of visits and appointments with district nurses, dietitians, GP's, opticians and dentists. Information was also available in people's care plan relating to other appointments they had attended including any outcomes. One person had been supported by the service to attend a regular outpatient appointment. This person was escorted by a member of staff due to their visual impairment.

People were supported to have a varied diet that included plenty of choice and different options. People could choose where to have their lunch. Either in their room, the main dining area or the Oak room. The Oak room was used to allow people the option of a quieter dining experience however on the day of the inspection we observed the other side of the room was being used for a quiz and people seemed to be distracted by the noise. We raised this with the registered manager so that they could review people's dining experience in this area.

We observed during lunch one person who required support and assistance with their meal could have benefited from a more positive interaction including better communication. For example, within the Oak room we observed a member of staff supporting a person with their lunch. The member of staff provided very little information about how they were supporting the person with this activity. They cut the persons food up, placed the food into their mouth on a fork, offered drinks without giving the person information on what they were doing. The only conversation we heard was the person being told to swallow. We fed this back to the registered manager who confirmed following the inspection the actions they had taken.

Tables were well presented with table cloths, flowers, condiments, and paper napkins. Most people felt happy with the meals. They told us, "Food is very good, puddings better than the main course". Another person told us, "Food very 'samey' choice boring but I get more than enough to eat". Another person told us, "I find food very good, quite a variety and cooked dinner every day. I would like scotch eggs sometime". Some people raised with us improvements that could be made to their dining experience. Comments included, "Meals could be hotter" and "Food has gone downhill lately although the Chef is good; we get near enough the same food week to week, and they load the plates too much so it puts me off". The registered manager had recently sought people's views on the dining experience within the home and this was an area they were looking to improve. Some people felt the dining room could be noisy and this they felt was due to the new 'hot hatch'. We fed this information back to the registered manager so they could re review people's dining experience.

People had access to a selection of hot and cold drinks. In the corner of the dining room was a new coffee machine. People and visitors could help themselves to a hot drink whenever they wanted one.

Good

Is the service caring?

Our findings

The service remained Good.

People and relatives felt supported by staff who were kind and caring and all were very happy with the support they received. People felt nothing was too much trouble for staff. People told us, "All the carers are lovely to me, they are kind and thoughtful". Another person told us, "Carers are kind and polite, they treat me well". Another person said, "They are all happy, the older ones are the best, nothing is too much trouble for them". Relatives told us, "I cannot thank the carers enough, when my [Name] came here two years ago we thought it was the end. But because of their care and how well they have looked after [Name] they are still with us and doing well". Another relatives commented on how well presented the person was when they come to visit. They told us, "Staff are fantastic, my [Name] always looks clean and smart. They tell us when [Name] needs anything new, and they make sure that she has perfume on everyday which is important to her.

People were supported by staff who treated them with respect and who showed them privacy and dignity. Staff were able to demonstrate how they supported people with their dignity. For example, staff confirmed they shut people's doors and curtains before providing personal care. If they needed to have private conversations with people these were held in people's rooms and with the door shut so that they couldn't be over heard. One member of staff told us, "I always assist the person with towels to cover people, making sure doors are shut and the person is comfortable and happy". During the inspection we observed people being treated with dignity and respect and staff knocking on people's doors and waiting for a reply before entering. Where people were supported by a carer of a certain gender these wishes were respected and recorded within the persons care plan.

People were supported by staff who had a good understanding of equality and diversity. For example, one member of staff told us, "It is about treating people the same not judging the person, their race, sexual orientation. Giving people the same opportunities in the work place, religion and ethnicity". The member of staff gave an example of how they had supported a person individually with their gender identity and sexual orientation. This meant staff were able to demonstrate a clear understanding of equality and diversity and give an example of how they had done this in practice.

People were supported by staff who demonstrated positive interactions. Staff spoke with people by their preferred name, using appropriate volume and tone of voice. People were asked, "What are you going to do today" and "Would you like a drink". Staff showed people compassion and support when they requested support from them.

People were encouraged to remain independent. Staff gave various examples of how they enabled people to be independent and how they promoted their independence. Staff gave positive success stories of when two people had regained enough independence to go back living in their own homes. They were proud of the support they had provided and that the person was able to return living in their own home.

Good

Is the service responsive?

Our findings

The service remained Good.

People had care plans that were person centred and included important information. For example, such as likes and dislikes, people's life histories, dietary preferences, how people like to be washed and dressed, what support they required with their skin and important information relating to their health care needs. However, there was very little detail relating to whether people would prefer a wet or dry shave or liked to wear makeup. There was also limited information relating to how people preferred to dress and what specific support they required with their oral care. Staff knew people well and had become familiar with their individual care needs. One staff member said, "I have been here for more than 10 years, I get to know people and how they like things done."

Care plans included information relating to people's medical needs. For example, care plans had details on dietary preferences and requirements such as textured diets. Those who required support with repositioning had clear instructions on how this should be done. Repositioning instructions were also available to staff in their bedroom this was to remind staff on the procedures.

People had pre-assessments undertaken prior to moving into the home. Care plans were regularly reviewed throughout the year and evaluated monthly. One person told us, "I have never bothered to look at my care plan, all I know is that, I am being well cared for in the way I want and lack for nothing". Care plans recorded family had been involved in reviews at least once a yearly and were kept up to date with any changes.

People's social, cultural beliefs and religious preferences were actively encouraged by staff. Staff were confidently able to describe and recognise people's differing religious beliefs. There was a monthly church service every month. Staff gave examples of how they had provided support to meet the diverse needs of people living at the home. This included supporting people with their disability, gender, ethnicity, faith and sexual orientation.

People had choice and felt able to choose how they spent their time. People told us, "I can please myself what I do, I choose my own clothes and go to bed when I please". Another person told us, "They let me lie in bed if I want to, and I can have my meals in my room". Someone else said, "You can please yourself what you do. When you get up and go to bed or if you want to join in activities, they are not my thing and I am not interested; nobody makes you do anything you don't want".

People had access to a variety of activities. For example, people undertook arts and crafts, or could spend time sitting quietly reading newspapers or watching television. One person said, "The Activities Co-ordinator is excellent, we do a variety of interesting things, some of us are knitting squares which will be sewn together then donated to a local hospice". People participated enthusiastically whilst staff gave encouragement and enabled people to participate. For example, one person cut pictures from a magazine to support the current art project, this was brought to their room. Another person had been involved in the design of the art display as they had artistic talents. The activities time-table for the week, was produced in large print this meant

people could easily read it if they had problems with their sight. The other activities available to people included carpet bowls and group poetry, a sing along with a local musician and Care Zone Theatre who bring in a large screen to watch films on.

The registered manager confirmed following the inspection that a newly formed partnership for the day centre was working well. It was providing additional activities to people for example the choir had, 'tripled in size'. There was also an event where the home was supporting a local Mencap group. People within the home could benefit from these additional activities.

People had access to various activities. We were shown a remembrance table, where people could put cards, small ornaments, light a candle or sit in memory of past friends. Some people had formed a choir which had recently sang at a funeral of a person who had lived at the home. One person said, "The choir is important, it brings us together and keeps us happy". During the inspection we were shown a garden. This was accessible to all including, those with mobility aids such as wheelchairs. Staff showed us a memorial corner in the garden that had been designed in-part by a retired Royal Air Force personnel and a retired military officer who had lived at the service. The memorial is now the focal point each year during the home's Remembrance service.

People were supported by staff who recognised the importance of supporting people to maintain contact with friends, family and their local community. Staff told us "[Person] like to go out to the library and the local church. We make sure breakfast is ready for [Name] before [They] go." At the inspection we observed one person calling their friend using their mobile phone. Staff told us how the service had used technology to skype into a wedding in Australia. This enabled a person to be part of an important family occasion. People could receive visitors throughout the day and we observed them being welcomed by staff and the management and coming and going throughout the day.

People had access to the providers complaint policy and all people felt able to raise any concerns should they occur. People told us, "No complaints, staff will sit and talk if I am upset". Another person said, "Would complain if necessary or tell my family". People felt if they had a reason to make a formal complaint, any concerns would be dealt with swiftly and efficiently to their satisfaction. Since the last inspection, the service had received six formal complaints. These had been investigated and appropriate action taken including the outcome.

People spoke complimentarily about the service and felt their ideas and suggestions from people were listened to and actioned. People told us, "I find the residents' meetings useful, the manager does listen and take notice". Another person said, "The manager has listened to anything I have brought up in the meetings". Minutes confirmed this. For example, one person had suggested having a single sex toilet. The registered manager had actioned this. This meant people were part of making suggestions about improvements to the service. The minutes from the meeting were produced in various print options to support people with their visual impairment.

People's care plans had a End of Life Care (EOLC) wishes document. However, not everyone within the service had expressed their wishes for this part of their care to have recorded. We reviewed one detailed end of life plan it contained important information the person wanted respecting at the end of their life. Staff confirmed they worked closely with the local hospice and the Advanced Nurse Practitioner attached to one of the local GP surgeries. Staff could access equipment and support from the should they need it and training was also available.

Requires Improvement

Is the service well-led?

Our findings

The provider had audits that identified most shortfalls and areas for improvement which was recorded on an action plan. However we found three people's care plans that required additional information relating to one persons' nutrition another person's wound care and diabetes. We also found records were not always completed to confirm the person had received their repositioning as required. We also found people's thickening agent was unlocked and accessible within people's rooms. The registered manager confirmed there was no risk assessment in place relating to the risk of leaving people's thickener accessible to anyone although they had identified action was required to store the thickener out of sight in people's rooms. This meant although the risk had been identified no action had been taken at the time of the inspection.

Various audits were in place including medication, care plans, bed rails, equipment. The regional director confirmed that they had identified and were aware of improvements required to Topical Medication Administration Records (TMAR's). The monthly medication audit had identified this shortfall.

The service was managed by a registered manager and a deputy manager. There was a team of nurses and care staff, cleaning, kitchen assistants a chef, a maintenance operative and activities co-ordinator and a service administrator.

People and staff all felt the home was a nice place to be and that there was a good staff team that worked together. One member of staff told us, "I love working here, good team work. We get lots of support". Another member of staff told us, "It's a friendly nice environment". Another member of staff told us, "I like working here. A lot of support from [Managers]. Very nice job, I love to be here they encourage and support me". People told us, "This place is well run, well maintained, clean and has a friendly atmosphere". Another person told us, "This Home is far superior to my previous home, and we are treated as individuals". Another person told us, "There is a happy friendly environment here, staff are honest and tell it as it is, this is the best place for [Name]". Another person told us, "This is a nice place to be, it is very relaxed and there is nobody bossy".

The provider's 'Bupa Code', this included values such as be passionate, caring, open, authentic, accountable, courageous, extraordinary. Staff were familiar with the 'Bupa Code' and felt proud of where they worked. One member of staff told us, "Bupa values we work towards providing good care for everyone, welcoming none judgemental. Person centred care working with each resident and relatives. We have a Bupa Code".

The registered manager held regular residents' meetings. People felt able to voice their concerns and opinions on their care experience within the home. People told us, "I find the residents' meetings useful, the manager does listen and take notice". Another person told us, "The manager has listened to anything I have brought up in the meetings". Another person told us, "You can express your views at the residents' meetings". Minutes confirmed it was an opportunity for people to discuss various topics including the meal experience and improvements people would like to see.

The registered manager knew people and their relatives well. During the inspection we observed them talking to people and visitors in a friendly helpful manner. People and visitors described the registered manager as being friendly, helpful and easy to talk to. One person told us, "If I see [Registered manager's name] in passing she always has a chat. Another person told us, "[Registered manager] is usually around, I feel comfortable with her she is easy to chat to".

Staff had regular staff meetings these were an opportunity to discuss updates on people and their care, training, staff changes or anything else.

People had their views sought through an annual satisfaction survey. Comments received from December 2017 were 100% were happy and content and satisfied with the care home. One area the registered manager had identified to work on following this survey was the catering. The registered manager had recently undertaken another survey to review improvements made to the catering within the home. The providers quality improvement plan identified catering, nutrition and meals as an area to improve upon. This meant the service sought people's views so that improvements could be made.

Following the inspection the registered manager confirmed 66% of staff had completed the annual staff survey. The registered manager felt this was a fantastic achievement and would enable the service to capture staff feedback to utilise the information once received.

The registered manager was not always making notifications to the Care Quality Commission when required. A notification information about specific events that the service is legally required to send. Most notifications had been submitted when required although we found one notification was required where a person's bed had deflated and had left them with changes to their skin reddening to their skin.

The provider was displaying their rating for the service at the time of the inspection. This was accessible to people within the entrance lobby and on the providers website.