Mr & Mrs T F Chon

Elmhurst Residential Home

Inspection report

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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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 19 and 24 July 2018 and was unannounced. The last inspection took place over three days on 29 March, 12 and 17 April 2018 where we found six breaches of legal requirements. This focused inspection was carried out to check that improvements to meet legal requirements had been made.

We inspected the service against three of the five questions we ask about services: is the service well led, is the service safe and is the service effective? This is because the service was not meeting some legal requirements in those areas. This report only covers our findings in relation to those requirements. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elmhurst Residential Home on our website at www.cqc.org.uk.
Elmhurst Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elmhurst Residential Home is registered to provide care for up to 34 older people. There were 17 people living in the home at the time of this inspection. The provider informed us that the local authority had placed an embargo on the service which meant no new people would be moving in until the legal requirements had been complied with.

There was no registered manager in place at the time of this inspection. The registered manager had recently left. 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. At the time of this inspection one of the joint owners of the home (referred to as "the provider") was managing the home and a manager from their other registered care home was assisting.

At the last inspection we found six breaches of legal requirements. One breach of legal requirement was about safe care and treatment. Two people's care plans did not contain adequate information for staff about their diagnosed medical conditions. One person was not receiving safe care despite the provider knowing they had a medical condition which posed risks to their health and wellbeing. Some medicines were not being given as prescribed. The second breach was due to not meeting some people's nutrition and hydration needs. The third was about insufficient oversight of the care by the provider. We served three warning notices on the provider requiring them to make the necessary improvements by 10 June 2018.

The other three breaches of regulations were about staffing and staff supervision, failing to notify us of serious incidents and lack of appropriate person-centred activities. At this inspection we found that the provider still had no written dependency tool to enable them to work out staffing requirements. Despite this, staffing levels were adequate for the people in the home at the time of the inspection with the exception of early mornings. We have recommended that the provider, in the absence of a system, reviews staffing levels by consulting with people in the home and staff working there. Supervision of staff was improving since the last inspection. The provider had notified us of serious incidents since the last inspection as required. We did not look closely at activities during this inspection so could not confirm whether people felt the activities had improved to meet their needs. This will be addressed at the next inspection.

Although we did not look at whether the service is caring at this inspection, we did note that staff interacted with people in a caring way and a relative, three professionals and people living in the home told us that the staff were very caring.

There was one continued breach of legal requirement as some concerns about medicines had not been addressed despite a warning notice being served. One was an administrative error where a person's medicine was given but not recorded and the other was a failure of the provider to ensure staff had written protocols to follow for medicines given "as and when require" so that staff knew in what circumstances to give the medicines. 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 consistently safe. Although there have been recent improvements in the management of medicines, there was a lack of written guidance for people's "as and when required" medicines, no protocol for giving medicines covertly and an error not found by the auditing of medicines meant there was a risk that people may not receive their medicines safely.

A person's unmet health need had been addressed so that they were now receiving safe care and treatment. Staff knew people's medical conditions and these were addressed in their care plans. Staffing levels were adequate to meet people's needs with the reported exception of early mornings.

Is the service effective?

Requires Improvement

The service was effective. The provider had made improvements so that people's nutritional and hydration needs were being met. People's diet had improved.

There were deprivation of liberty safeguards or applications in place for those who needed them and recently updated care plans checked for the person's consent to care.

Staff training and supervision had improved since the last inspection. People said staff cared for them properly and met their health needs.

We could not improve the rating for 'Effective' from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The provider had worked hard to make improvements since the last inspection three months previously and had plans in place for further improvements. Storage of people's confidential information and record keeping had improved.

Some systems, such as ensuring all information from a needs

assessment was addressed correctly in a person's care plan and medicines audits were not yet fully effective in order to ensure safe care and treatment.

Elmhurst Residential 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 checked 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 19 and 24 July 2018 and was unannounced. The reason for this inspection was to check whether the provider had complied with three warning notices served after the last inspection in April 2018.

The inspection was carried out by one inspector and a pharmacist inspector. Prior to the inspection we checked notifications made by the provider since the last inspection.

We spoke with the provider, deputy manager, three senior care assistants and one care assistant working in the home. We carried out pathway tracking for five people where we read all their care records and checked whether their assessed needs were being met. We spoke with one visiting healthcare professional to ask their views on the quality of care provided in the home. We spoke to thirteen of the seventeen people living in the home and one of their relatives.

We read all food and fluid charts, weight charts, medicines records for seventeen people, menus, medicines audits, Deprivation of Liberty Safeguard authorisations for four people, mental capacity assessments for three people, staff rota, medicines audits and health and safety records.

We observed two mealtimes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. After the inspection the provider sent us staff supervision and training records. We also received information from three representatives of the local authority safeguarding, quality assurance and commissioning teams.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we asked the provider to make improvements to the management of medicines and improve the care for people with complex medical conditions. We had found serious concerns with the care of a person with a medical condition, lack of risk assessments and people were not being given their prescribed medicines safely. We served a warning notice on the provider which required them to make improvements by 10 June 2018.

At this inspection we found the care for a person with the medical condition had improved. Previously this person was receiving inadequate care as, although their needs assessment clearly stated they had the medical condition, the service had no risk assessment or care plan for this and failed to provide a safe diet or assess the person's capacity to understand their illness despite us raising this several times. At this inspection we found that the provider was now providing safe care for this person and they had care plan detailing their needs. We spoke to two staff about this person and both said they had read the care plans, that it had been discussed with them and they now understood this person's medical condition.

The other person whose health condition was not included in their care plan had left the service since the last inspection by choice. We checked the care records for one of the two people who moved into the home since the last inspection. We found an example of information from their assessment of needs incorrectly written in their care plan, stating they had a medical condition that they had many years ago and no longer had. Although this had no negative impact on the person we advised the provider again of the importance of ensuring medical information in a person's initial assessment is shared with staff correctly so that their health needs are known and met in the home. Other care plans included medical conditions such as diabetes so that staff knew people's health needs.

The management of medicines had improved significantly since the last inspection in April 2018 but the warning notice was not fully complied with. At that time people who had prescribed inhalers and topical creams were not being given these correctly as prescribed. The service had introduced charts for each topical cream with a body map diagram showing staff exactly when and where to apply the cream. We checked the charts and found staff had signed that they had given the cream to the person as prescribed. There were no errors or omissions on the charts. A person whose complex medicines regime was not being managed safely had left the home since the last inspection.

The provider and a manager from the provider's other care home had been carrying out weekly audits of medicines administration records in June to check that they were being given correctly. This had led to improvements.The provider had not ensured that these audits were carried out every week and no audit was carried out when the last stock of medicines arrived. This meant that an error on one person's chart had not been noticed and one person's inhaler had not been signed as given since 2 July 2018. This was the same person who was not being given their inhaler as prescribed at the last inspection. Staff assured us they were now giving the person their inhaler correctly despite the lack of written evidence on the records.The last written medicines audit was 27 June. There was then a gap if three weeks where there was no audit so the error was not picked up. The provider told us they carried out an audit on 23 July which was in the

process of being written up.

The provider had failed to ensure there was a written protocol for each medicine that was given "as and when required" such as painkillers. We found that there was still no guidance for staff on what the medicine was prescribed for nor what signs to look out for if a person needed it. One person had been prescribed a medicine for their mental health and there was no protocol for when to give it. The GP had written a note in the person's records but the provider had not shared this information with staff in a written protocol so staff had no guidance when to give it. This left the person at risk of not getting this medicine appropriately.There was no information about medicines in people's' care plans.

The above amounted to a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection one person was being given their medicines covertly (hidden in food without their knowledge) and some tablets crushed without consulting a pharmacist on whether the tablets were safe to crush and without any assessment to determine whether giving medicines covertly was in the person's best interests. This had still not been done at this inspection but the provider said they had stopped giving the medicines covertly and found the person was willing to take their medicines from a spoon. We advised that no further covert medicines must be given without following the required protocol.

Controlled drugs were stored and managed safely.The medicines refrigerator was maintained at a temperature appropriate for the medicines stored in it. Staff completed medicines training in May 2018 and further training was booked for August. People told us that as far as they were aware they received the right medicines at the right time.

Since the last inspection the provider made improvements to people's individual risk assessments. We checked four people's risk assessments and found that they reflected the risks to each person's safety such as risks of sustaining a pressure ulcer, risks associated with existing health conditions and risk of malnutrition. These set out what staff had to do to keep the person safe and respect their rights.

Since the last inspection there had been a safeguarding investigation due to a person sustaining a fracture in a fall. The local authority made recommendations for improvement and the provider was implementing these.

There had been another unwitnessed fall where a person sustained a fracture. A nurse from the local authority's Care Homes Assessment Team (CHAT) was helping the provider to develop a falls prevention plan for those people at risk of falls in the home.

Staff understood about safeguarding people from abuse and the provider knew how to raise a safeguarding alert if there was any allegation or suspicion of abuse.
There was a breach of regulation at the last inspection about staffing as here was no clear system for determining the number of staff required. At this inspection the provider told us that they had worked out staffing levels by deciding whether people had high, medium or low needs but this was not in writing. Four days a week one of the night staff worked until 9.30am to help with people's morning personal care. On the days where this person was not working staff found it difficult to manage as there were three staff to support people with personal care, breakfast and medicines. The provider said that the manager used to help by doing the morning medicines round but now senior care workers were doing this. Staff and people living in the home thought that their mornings would be easier if there was another staff member to help every morning through personal care and breakfast. We recommend that, in the absence of a written analysis of

staffing needs, that the provider determines staffing needs by consultation with staff and people living in the home.

We did not check staff recruitment practice at this inspection as we checked this in at the last inspection and found no concerns. The provider informed us that no new staff had been employed since the last inspection.

People were protected by the prevention and control of infection. The home was cleaned to a high standard. We observed that staff wore protective gloves and aprons when assisting people with personal care. Staff said there was a good supply of personal protective equipment. People living in the home told us they were happy with the standard of cleanliness. Their comments included; "They keep my room very clean", "I clean my room but they will always mop and help me", "Yes they wear gloves and an apron when they shower me" and," I don't worry about the cleanliness here, that is not a problem."

People had their own personal emergency evacuation plan for staff and the fire brigade to consult in the event of a fire. We checked five of these and found them to be up to date reflecting the person's needs and detailing what equipment they needed to evacuate the building.

People said they felt safe in the home. One person told us, "I didn't choose to come here but as I'm here I make the best of it. The girls do look after me and make me feel safe." Other people's comments included, "the girls are good. They care about me", "Yes the staff make me feel safe as they keep a close eye on me" and "The nurses are very nice people.They help me and are beautiful."

Requires Improvement

Is the service effective?

Our findings

At the last inspection we asked the provider to make improvements to meet people's nutritional and hydration needs. We found that the service was not following dietitian advice for one person resulting in them continually losing weight due to lack of adequate nutrition. There was also insufficient monitoring of the food and drink of people who were at risk of poor nutrition and dehydration. We also found that people were not being offered enough drinks to maintain good hydration and staff were not supervising and supporting people at mealtimes properly. We served a warning notice on the provider which required them to make improvements by 10 June 2018.

At this inspection we found that improvements had been made. The warning notice had been complied with.

Staff were following the advice from a dietician and providing an underweight person with suitable food and snacks between meals. The provider had written a care plan regarding this person's nutrition which staff were following. The cook and care staff knew the foods this person liked and was able to eat and records showed they were giving the person foods they liked. We saw that this person's dinner was not fortified with cheese as recommended by the dietitian.The person told us they did not like cheese in that meal and the cook had added some butter instead. We saw this person enjoying their meals and weight records showed that since the improvements to their diet they had maintained their weight and not lost further weight.

Staff were completing records of food eaten and were recording all food and drink for those people at higher risk of malnutrition or dehydration. The records showed evidence of good nutrition and hydration. We observed staff offering people drinks at mealtimes and in between meals.People told us they had enough to drink. One person said, "They are always giving me drinks." Another person said, "Yes I have enough drinks and they always give me a cup of tea." One staff on each shift was allocated the task of offering drinks to people every hour which was a positive initiative to ensure people kept hydrated.

Two people said they didn't like the food and we saw staff talking to them about what meals they would like. Another person said they only wanted to eat soup and bread and we saw that the cook prepared this for them. We saw that four choices of lunch had been offered on the day of the inspection and two people had other alternatives which they had chosen. Most people gave positive comments about the food saying it was, "good", "good enough" and "I eat it, it is quite nice." A relative said they thought the food was "Marvellous."

One person was on a gluten-free diet. We saw from records that this person ate a limited diet but they said they liked what they ate. We noted this person ate cheese sandwiches for tea every day but when we looked in the kitchen there was no gluten free bread available in the home. When we brought this to the provider's attention they asked the cook to go out and buy this. We advised that the service should always have suitable food in stock so this person could have a sandwich on request. The cook and care staff were aware of this person's dietary needs. A visiting professional told us that they thought the cook had a very good understanding of the person's dietary needs.

Staff were available to support people at mealtimes and the medicines round had been changed so that it did not coincide with mealtimes. This meant all staff were available to help people at mealtimes. The provider said that the menu would soon be reviewed to reflect people's ethnic backgrounds and favourite meals. We saw that some people had their own food items in a small kitchen which staff helped them to have when they wanted. We saw that people chose what they wanted from a choice of meals and if they didn't like the meal when it arrived staff offered them a sandwich or extra dessert.

A person who did not receive support to eat their meal at the last inspection had someone sitting with them at mealtimes during this inspection to assist them to eat their food, which we saw they enjoyed.

The provider assessed people's needs before they were offered a place in the home but information on the assessment was not always accurately reflected in the resulting care plan. This is addressed in the "Well Led" section of this report as this was a concern about the system operated by the provider.

We found that care plans had improved and people's medical conditions were recorded in their care plans with some guidance for staff on how to meet their health needs. The provider had used the expertise of the Care Homes Assessment Team (CHAT) nurse to help them devise care plans for people's medical conditions. Staff said that they contacted the CHAT nurse whenever they had a concern about somebody's health and followed their advice. Records showed that staff contacted the GP promptly when people were unwell. Staff gave people support with their health needs and recorded the outcome of medical appointments so that there was a clear record of the person's health history. People living in the home told us that staff looked after their health well. Comments included; "They call the doctor for me when I don't feel well", "Yes they look after me well. They don't let me suffer" and "I go the doctor on my own but they come with me if I want." One person was concerned about their health and we advised them to go and speak with the CHAT nurse who then spoke to the GP on the person's behalf.

Staff took people's blood pressure and tested their blood glucose levels when this monitoring was needed and kept records so that healthcare professionals could have the information they needed when they saw people. The service arranged for blood tests to be done in the home so that people did not have to attend the surgery if this was difficult for them.

People told us that staff were "caring" "kind" and "very nice." One said, "I think they look after me very well, I have no complaints." We observed staff providing care to people in an effective way. They asked for the person's consent before carrying out any task, were discreet when offering support with personal care and responded well when a person's behaviour was challenging.

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. After the last inspection where some people told us they did not want to live in this home we brought this to the attention of the local authority. One person had moved since the inspection. Another was in the process of moving on to more suitable accommodation. Another person had been assessed by the local authority as having full capacity and

therefore an application to deprive this person of their liberty was denied. This person said they were looking forward to being able to leave the home. Another person remained unhappy at the home and said they were there without their consent. The provider was fully aware of this person's complex situation and was trying to support the person. Decisions had been made following proper processes and a capacity assessment.

Since the last inspection the provider has applied appropriately for further deprivations of liberty for two people whose liberty was restricted as they were not able to leave the home and who had continuous supervision in the home. We advised the provider that their pre-admission assessment should include checking the person's consent to moving to the home and whether they consent to short term or long-term care.

The provider did not have training records available for inspection in the home but did send these to us after the inspection. They informed us that they were booking training on 9 August 2018 for challenging behaviour training and 4 September 2018 for moving and handling training as refresher training was due.

Most staff were up to date with required training topics and the provider had developed a matrix which identified which staff need to update which training. They told us they were engaging three training providers to develop a training profile for all staff.

Staff supervision records showed that most staff had not been receiving regular supervision and some senior staff and the cook had no supervision in the first six months of the year. This was evidence of a lack of support and guidance for staff. The provider had commenced supervision for some staff since the last inspection. Two staff said they had received supervision since the last inspection. The provider told us that supervision was not up to date but their priority had been making improvements in the highest risks areas to comply with the warning notices.

There were suitable adaptations in the home for people who used walking frames and wheelchairs. There was a lift and fully accessible bathrooms and bathing/shower facilities.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we asked the provider to make improvements to the governance of the home. We had found there was a lack of oversight by the provider and registered manager of risks and a failure to monitor health, safety and welfare. There was also no effective system to work out staffing requirements, ineffective medicines audits, no management monitoring of nutrition and confidential records were not stored securely. We served a warning notice on the provider which required them to make improvements by 10 June 2018.

We found that most of the concerns we highlighted in the warning notice had been addressed.

The registered manager left after the last inspection and the provider had been working full time in the home to make the required improvements. The manager of the provider's other local care home had also assisted in making improvements in the home. The provider had not yet advertised for a new manager but told us they planned to do so shortly.

We found that the provider had improved the monitoring of people's health, safety and welfare by improving the risk assessments, reviewing people's care plans and maintaining an oversight of day to day practice in the home. This meant people were more likely to receive safe care. There had been improvements in the management of people's medicines but a failure to provide staff with a written protocol for as and when required medicines left people at risk of not receiving those medicines appropriately. A failure to have sufficient oversight of medicines by implementing weekly audits as per the provider's own policy left a person at risk of unsafe or inappropriate care.

There was clear evidence of provider oversight of mealtimes, food eaten in the home and records of nutrition and hydration for people at risk as these were signed by the provider or the manager of another home when they were checked and any remedial action recorded. Systems for checking and making improvements resulting from the checks had improved since the last inspection.

Confidential records were now being stored securely and there was no confidential personal information displayed in the home as the provider had removed this since the last inspection. People's care records were better organised to help staff find information quickly and old information no longer relevant was removed. However, the feedback from the local authority was that not all care files were improved and some were still disorganised and containing old out of date information.

Systems and processes in the home were not all effective. The system for ensuring a full needs assessment resulted in a care plan which reflected the person's medical needs accurately was not consistently effective. At the last inspection we found an important medical condition identified in a person's needs assessment had not been shared with staff or addressed in the person's care plan. After our intervention this had been rectified. At this inspection we identified another error when there the provider had written incorrect information in the person's care plan suggesting the person had a serious medical condition that the

assessment clearly showed was not the case for approximately 25 years. The provider agreed to rectify this. Although this error had no impact on the person, the system for ensuring people's needs were properly assessed and addressed was not effective. As the assessments were carried out by the provider and not the care staff this was a problem with management rather than care.

Staff morale was low as staff were working under pressure having to make improvements in the home and being subject to scrutiny by external professionals and the provider. The provider's style of management was mentioned by a staff member, a person living in the home and a professional working with the home who all indicated that their management style was not supportive. One person living in the home informed us that there was a problem between the provider and staff and indicated that they had seen staff getting "told off" in public. We spoke to the provider about this who agreed to address this issue. Another person said, "By and large they are generally good" and another said,"There's a bit of a funny atmosphere between the owner and staff but staff are very good." People living in the home praised the care staff and said they were very caring. One said, "They really look after me and make sure I am alright." Professionals also gave positive feedback about the care staff. The provider informed us that there had been a meeting for relatives since the last inspection seeking their views on the home. The minutes of the meeting were not available so we could not see what had been discussed.

They had found improvements had been made since the last inspection. The local authority had contacted relatives and reviewed the care of people living in this home and informed us that they had noted improvements made since the last inspection and that relatives of people living in the home were general happy with the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not have all the required protocols in place for the safe management of medicines.