The Elms Care Centre Limited

The Elms Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This was an unannounced inspection, carried out over two days on 4 and 6 March 2015. The Elms Care Centre provides accommodation for up to 37 older people who require support in their later life, with nursing care needs. The care home also supports people who are living with a dementia. There were 31 people living at the home when we visited.

Accommodation was arranged over two floors and there was a passenger lift to assist people to get to the upper floor. The home had 33 single bedrooms and two double bedrooms. Some bedrooms had en-suite facilities. There were also three shared lounges, a conservatory/dining room, a small secure outside patio, toilets, bathrooms and shower facilities.

There was a registered manager in place. 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.

Summary of findings

We last inspected The Elms Care Centre in May 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

People told us they felt safe living at The Elms, and we found people were protected from avoidable harm and abuse that may breach their human rights. However, people's care plans showed that their consent had not always been obtained and mental capacity had not always been fully assessed and documented. Staff did not have a full understanding of the legal requirements relating to people giving consent to their care or where people's freedoms were restricted. The registered manager told us training was in place, but would review the reasons for staff's lack of knowledge. People's medicines were managed well which meant they received them safely.

People told us, at times, there were not enough staff; however the registered manager was aware of people's concerns and was taking action to make immediate improvements. Staff had the knowledge, skills and experience to carry out their role. The registered manager provided support, training and development opportunities for staff. Staff were aware of people's individual nutritional needs and drinks were available at all times. However, documentation was not always completed accurately and risk assessments and care plans were not always in place as required.

Positive working relationships were adopted by the registered manager with agencies and other professionals such as GPs, the local authority and external health professionals. This helped to ensure the approach to meeting a person's care needs was linked. There were systems in place to ensure staff shared information about people's health care. This encouraged effective communication, and meant staff were pro-active in meeting people's needs. However, staff had recently highlighted to the registered manager that improvements could be made.

People were supported by staff who were kind and caring. Staff were considerate and respectful which helped to ensure people's privacy and dignity were promoted. People, relatives and staff were encouraged to be actively involved in the running of the service by providing feedback to the registered manager. Their views were valued and used to facilitate change and improvement.

People received care which was personalised to their needs. Care plans did not always give clear direction to staff about how to meet a person's needs. But, from our observations and conversations with staff, it was clear they were knowledgeable about people. Care records did not always demonstrate people were involved in creating their own care plans and people told us they were not aware of their care plan.

People were encouraged to take part in social activities and continue to be part of the local community. Staff recognised and understood people's individuality and social engagements were tailored to suit. However, care plans were not descriptive about people's social interests.

The registered manager and registered provider promoted a positive culture that was open, inclusive to people, staff and visitors. There was a clear management structure in place. There were quality monitoring systems in place to help ensure continuous improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report.

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?

Good

The service was safe.

People told us they felt safe.

People, relatives and staff told us there were not always enough staff, which meant staff could not always spend sufficient time with people. However, we found improvements were being made by the registered manager.

Staff could identify the signs of abuse, and knew the correct procedures to follow if they thought someone was being abused.

When there was a risk identified, risk assessments were put into place. This helped to reduce any unnecessary harm and to provide guidance and direction to staff.

People's medicines were managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

People's consent and mental capacity was not always fully assessed and documented.

Staff had limited knowledge of the deprivation of liberty safeguards (DoLS).

People received care from staff who were trained to meet their individual needs.

People were supported to eat and drink and maintain a balanced diet. However, care plan documentation relating to the associated risks was not always in place.

People could access appropriate health, social and medical support as soon as it was needed.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People, visitors and families were treated with dignity and respect. People's feedback and contributions were valued.

Is the service responsive?

Requires improvement

The service was not always responsive.

People had a care plan in place; however, care plans did not always give clear guidance to staff about how to meet people's individual care needs.

Summary of findings

People had a variety of social activities to choose from and were encouraged to join social events within the local community.

Staff communicated with each other and external professionals to make sure people's health and social care needs were met.

People felt they could complain and were confident their complaints would be acted on.

Is the service well-led?

Good

The service was well-led.

There were formal auditing systems in place to help identify problems and ensure continued improvement.

There was a clear management structure in place and staff told us they felt supported by the registered manager and registered provider.

The registered manager monitored incidents and risks to help ensure care provided was safe and effective.

The registered manager was pro-active in working with external professionals to ensure people received co-ordinated care.

The Elms Care Centre

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 visited the home on 4 and 6 March 2015. Our first visit was unannounced and the inspection team consisted of one adult social care inspector. Our second visit was announced and the inspector was joined by an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

During our visit we spoke with 11 people living at the home, six relatives, two nurses, six care staff, one activities coordinator, one laundry assistant, and one chef. We also spoke with, the registered manager, a visiting GP and a pharmacist. We observed care and support in communal areas and spoke with people in private. We looked at six care plans and associated care documentation. We also looked at records that related to the home's management, this included policies and procedures, training records, staffing rotas, complaints, four staff files, and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. After the inspection we contacted health and social care local commissioners of the service who funded people who lived at The Elms Care Centre to obtain their views. We made contact with four GPs, two social workers, one speech and language therapist, and one specialist nurse assessor.

Good

Is the service safe?

Our findings

People told us they felt safe and would feel comfortable about speaking with care staff and management if they had any worries. People approached staff and would ring their call bells with ease.

Staff told us what action they would take if they suspected abuse was taking place. Staff told us they would have no hesitation in reporting it to the registered manager, and were confident their concerns would be acted on. Staff confirmed they had access to the relevant policy as well as contact details for the local authority safeguarding team.

When there was a risk identified, risk assessments were put into place. This helped to reduce any unnecessary harm and to provide guidance and direction to staff. For example, one person was at risk of falling out of their bed. Their risk assessment identified the necessary measures and equipment which were required to be put into place to provide protection.

The registered manager had a system in place to monitor falls; this helped to identify trends and to make improvements. If a person fell, information relating to the fall was collated on an accident form and the information used to update the person's care plan.

People told us they did not think there was adequate staffing. People and their relatives told us, "I don't think there are enough staff, X sometimes has to wait to be dressed". When we asked one person whether there were enough staff, they replied "no" and went on to explain how this affected them. They told us, "I have to wait longer than usual for help…it feels like hours but it isn't really". Staff collectively expressed they felt there were not always enough staff to meet people's needs.

On the first day of our inspection we were told, and observed, there were not enough care staff on duty. The impact of this was explained by one person who told us they could not have their shower because the staff had been too busy. Interaction between staff and people was task orientated, for example there was little time for staff to stop and talk with people. We heard call bells ringing for increased periods and staff were visibly stretched. On our second day, staffing levels had improved. From speaking with the registered manager and reviewing staffing rotas, we found action was being taken to ensure there were always enough staff on duty to meet people's needs.

The registered manager used a dependency tool which considered people's individual care needs and the staffing which was required. The registered manager explained that there were a number of care and nursing vacancies which had arisen, however recruitment was underway. The registered manager had an understanding of the impact on people when there were staffing shortages and in the short term was using agency staff to fill current vacancies. The same agency staff were requested to help ensure the consistency of care for people. Staffing rota's showed staffing was improving and where there were gaps, the registered manager had recognised this and was taking action.

People were protected by safe recruitment procedures as the registered provider had a policy which ensured all employees were subject to necessary checks which determined that they were suitable to work with vulnerable people. Checks were in place to ensure people were being cared for by nursing staff who were eligible to practice within the UK.

People's medicines were managed well to ensure they received them safely and nursing staff made sure people received their medicines at the correct times; records confirmed this. For one person, their care plan showed they required their medicine at a particular time to minimise problematic symptoms. The nurse told us about this person and demonstrated an understanding of the importance of administering medicines at the prescribed time. People's pain relief was monitored, and people were asked whether additional pain relief was required. We observed a nurse compassionately ask a person if they required any further pain killers. They gave the person time to respond and describe in their own words how they were feeling.

People's behaviour was not controlled by excessive use of medicines. On the day of our inspection the registered manager was meeting with a GP and pharmacist to review people's medicines. One reason for this review was to help ensure people were not over medicated. Medicines were reviewed and the outcome of medicine reviews were shared with the person and their family as necessary, to make sure the person was involved in any final decision.

The registered manager carried out a medicines audit to make sure medicines were being stored, administered and disposed of safely. We saw when a cream had been

Good

Is the service safe?

prescribed records in people's rooms were not always completed. We found this had not been highlighted on the medicine audit. The registered manager acknowledged this and told us that improvements would be made.

Requires improvement

Is the service effective?

Our findings

People's consent to care and treatment was not reflected clearly in care plans. For example, a document entitled "consent to share information for care delivery" had not always been signed by the person. This meant it was not clear to staff whether the person had consented. People's care plans also contained information regarding their mental capacity, however the form did not take into consideration people's ability to make some decisions which affected their life, for example choosing what clothes they would like to wear or deciding what they would like to eat. The registered manager was aware that people's consent and capacity needed to be assessed correctly and obtained to ensure people's human rights were not being breached.

We found the legislative framework of the Mental Capacity Act 2005 was not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care and support from staff who received an induction, training, supervision and appraisal. The registered manager explained the current induction was being adapted to take into consideration the Care Certificate which was being introduced in April 2015. This demonstrated the registered manager was aware of the change in legislation, and the impact on staff. The registered manager explained supervision involved practical observations, followed by feedback and reflective discussion. This meant staff were supported and could learn and develop in their roles.

People were supported by staff who had attended training applicable to their role, for example dementia and Parkinson's training. All staff expressed how passionate the registered manager was about training; comments included, "we do loads" and "the manager is hot on training". Some staff told us they would prefer more of a mixture of face to face training rather than mainly e-learning, and we were told training could be of a higher level, as some felt the content of courses to be too basic. External professionals felt staff were well trained and competent to meet the needs of people.

People were protected by the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). Staff received training; however the majority of staff did not have a basic understanding about DoLS. The registered manager told us she would look into this. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is required involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

We read in one person's care plan that a psychiatric nurse had been contacted to help assess a person's mental capacity. This showed the registered manager was aware of the legislation. We were informed that there were no DoLS authorisations in place and no applications had been made because no one was deprived of their liberty. However, the registered manager knew what the legal responsibilities were, but told us she always tried to alleviate depriving a person of their liberty by taking alternative steps.

Information about nutrition and high calorie diets was displayed for staff to read. This information was prominent in the catering area of the care home, which meant staff could read it easily during the serving of meals. Staff explained if they had any concerns about how much a person was eating or drinking they would speak with the nurse or registered manager.

Staff told us and records showed food and fluid was monitored when there was risk or concern about a person's nutritional or hydration intake. The registered manager used a malnutrition universal screening tool (MUST) to raise the awareness of a possible risk of malnutrition. The MUST tool triggered action, for example a referral to external health care professionals such as speech and language therapists, more frequent weighing or high calorie diets. However, for one person who had a chart in place, we found their care plan did not give a clear description about the reasons why, and about the action required of staff. As a result of this, we found gaps in documentation. It was not clear from the person's care plan or the charts in place, whether the person was receiving the amount of food and drink which was required.

People's care plans indicated when they were at risk of not eating or drinking enough. However, when this risk had

Requires improvement

Is the service effective?

been identified a care plan was not always in place to give direction and guidance to staff about how to meet the individual needs of the person. For example, for one person, their risk assessment had shown a change in the level of concern relating to their nutrition. However there was no care plan in place to indicate the action staff should take. This meant the person's care needs may not be met consistently.

The registered person had not taken proper steps to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe because the recording of people's nutrition and hydration requirements was inaccurate and care planning did not always reflect the care needed to meet people's needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9(1)(a)(b)(c)(3)(a)(b)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to help themselves to drinks which were available in the lounges or were offered by staff. Staff supported people who spent time in their room and required assistance to eat and drink. However one relative told us they felt their loved one was not supported frequently enough with drinks and showed us three full cups of cold coffee which had been left in front of them. We spoke with the registered manager about this and of the concern raised by the relative. Prior to us leaving, the registered manager had promptly investigated the concern which had been raised and taken action.

People were weighed on a monthly basis or more frequently if there was a concern; however we found some documentation had gaps without any explanations. This meant if a person was at risk of weight loss it may not be identified quickly. The registered manager agreed to address this immediately.

People could choose where they wanted to eat their meals, for example, people who preferred privacy ate their meals in their rooms, whilst others chose to eat their meals in the conservatory/dining room. People who required assistance were given support in a respectful and dignified manner.

People were complimentary of the food, comments included, "the meals are excellent, no complaints", and "the food is wonderful with quite a selection". One relative told us, "they [the people who lived at The Elms Care Centre] have a choice of three meals at mid-day and a choice for breakfast. If a resident wants anything specific they will get it. One resident asked for fish and chips and they brought it in from the local chip shop as it wasn't on the menu that day."

The chef explained they spoke with people individually each day; this gave people an opportunity to express a change in their likes and dislikes, they told us, "what the residents want we do try to provide". People were also able to give positive or negative feedback about the quality and choice of meals. The chef was aware of people's nutritional needs and explained about how any changes in nutritional needs were communicated. For example, the chef told us that one person was due to visit the dentist; they had been informed by the nurse that the person may require a different meal because they may be in pain. This showed there was good communication and flexibility to help meet people's individual needs.

People told us they were able to see their GP or other health care professionals and documentation confirmed this.

Good

Is the service caring?

Our findings

People told us staff were caring, comments included, "yes, they [the staff] are kind, respectful and listen to me, they do treat me with dignity", and "they are very kind, some are very thoughtful. They treat me with respect". People described how staff ensured their dignity was respected when staff provided personal care, we were told "when they wash me they talk and laugh with me, they treat me with respect and listen to me" and "they pull my curtains and close my door when I use the commode and when they wash me".

Staff spoke with and treated people with respect; staff took time to acknowledge people and their relatives. Relatives commented, "we have visited at various times during the day and we have always noticed that staff are attentive and caring to the residents", "when I arrived yesterday X had had an accident and the carer came to help, she treated X with care and dignity, she sorted it out in a very professional and caring way" and "the staff listen to X intently when she talks about hallucinations". However, one relative felt their loved one was not always treated with care and attention. They showed us that staff had not ensured their relative's glasses had been put on and hearing aids had not been put in. We spoke with the registered manager about this, they were already aware of other concerns which had been raised, and were taking action.

People's friends and relatives could visit at any time of the day; relatives were welcomed warmly by staff.

Staff were attentive to people, for example a film afternoon had been arranged. The staff made sure everyone was comfortable, people could hear, and drinks crisps and chocolates were offered. Staff were observant that one person may like to have a rest rather than watch the film as the person was going out to a concert later that evening. The person was asked and they agreed a rest would be good.

People, staff and visitors approached the registered manager, without hesitation. The registered manager explained they also worked on duty as a nurse, which meant people could regularly express their views. It also helped the registered manager to have a broad understanding of how people were feeling.

People's clothes were carefully labelled to help ensure people received their own clothes back after they had been laundered. People told us they had no concerns with the laundry service which was provided.

A recent survey had been carried out to obtain feedback from people. The survey gave people an opportunity to comment on areas of their care, such as their care plan, dignity and respect and access to external health care professionals. However, the results had not yet been collated or shared with people. People had not always had an opportunity to be involved in planning their own care to ensure it was delivered in a way that reflected their own choices and wishes. We discussed this with the registered manager who told us improvements were being made.

External professionals told us they felt staff were kind and caring. One professional told us they felt the staff considered all aspects of a person's care, for example their social care as well as their nursing care needs. All professionals spoke highly of the care which was delivered to people.

People's confidentiality was important; this was demonstrated by the registered manager who ensured the office door was closed when personal information was being discussed. Confidential personal information was not on display and was securely locked away.

Requires improvement

Is the service responsive?

Our findings

People had care plans in place which highlighted health care needs. However, care plans did not always demonstrate the care which was being delivered; the content was limited and did not always give clear descriptions. Care plans were reviewed by the team to make changes to people's care delivery as required, however, these reviews were not effective. For example, one person had a learning disability however their communication care plan did not provide details to staff about how to meet this need. Another person's daily records stated that the person had lost their glasses; however the person's communication care plan did not state that they wore glasses. For one person who needed support with memory and cognition, the person's care plan highlighted the concerns, but there was no guidance to staff about how to meet this need. People's care plans did not contain information about what their activity preferences were or their previous social history. The registered manager acknowledged improvements were required and, before the end of our inspection, had already started to commence action.

People's changing care needs were discussed amongst the staff to ensure important information was shared, this occurred during handovers; however, not all care staff felt the handovers were comprehensive enough. For example they felt nursing staff received more information than care staff, resulting in them not always knowing all information about people. The registered manager was aware of this and was taking action to make improvements.

Care plans did not always reflect the care being delivered and did not always involve the person. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9(1)(a)(b)(c)(3)(a)(b)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When there was deterioration in a person's health, appropriate action was taken and the recording of the action was clear. For one person who had recently been admitted to hospital the daily notes showed why and how this decision had been made, the people involved and the communication which had taken place with the person's family.

People told us there were a wide variety of social activities available, and we found the social activities which were offered promoted an ethos of living and enjoyment. One person was pleased to tell us they were going to the Methodist Chapel that evening to listen to a male voice choir. For one person who was registered blind they explained, "the staff order talking books for me that I receive through the post".

There were activities co-ordinators who worked seven days within the home, which meant people were able to participate in activities at the weekend as well as during the week. We saw people were encouraged to participate but also given the opportunity to decline which was respected.

One relative told us, "they do encourage X to do activities. Until recently X went out monthly to the local pub for a jazz evening. They do take residents out in wheel chairs that we've noticed. They have taken residents to the garden centre". Another relative told us staff had recognized their relative may be lonely living on the first floor so, following consultation, the person moved downstairs.

External health care professionals told us they felt the staff communicated effectively. One professional told us they felt the registered manager was open to ideas, suggestions and found sensible solutions to problems people were faced with.

People told us they felt they could complain and were confident their complaint would be listened to by staff and the registered manager; comments included, "I would be happy to talk to staff but I have no worries or complaints" and "I would speak to any of the staff with any worries or complaints but none at present". The complaints procedure was displayed in the entrance of the home. People were given a copy of the complaints procedure when they moved in and a copy was also in people's bedrooms.

The registered manager took a pro-active approach to the management of complaints. For example, during our inspection we shared feedback about a concern which had been raised; the registered manager immediately investigated the concern and took action. Documentation showed when a complex complaint had been raised, time had been spent investigating the concerns, to try and find an appropriate resolution for everyone. The recording of

Requires improvement

Is the service responsive?

complaints demonstrates how a provider has responded to improving the service for people. The registered manager had not been documenting verbal complaints but told us, in the future, this would occur.

Good

Is the service well-led?

Our findings

Staff meetings were held to give staff an opportunity to feedback and for the registered manager to share information. Staff had recently been asked to complete a survey about working at the care home; the results were going to be used to make any necessary improvements.

Staff told us they felt supported by the registered manager, and the common description of the registered manger was that they were "firm but fair". The registered manager spoke with staff in a respectful manner and staff approached them without hesitation. This demonstrated staff felt comfortable in their presence.

The whistle blowing policy which was in place assured staff if they were to report concerns it would be "without fear of reprisals". Staff told us they would not hesitate to report to the registered manager concerns about abusive practices.

There was a clear management structure in place and the deputy manager or registered manager worked at weekends. This meant people, relatives and staff were always able to speak with someone who had management responsibility.

External professionals told us they felt the home was well managed and felt the registered manager was competent, professional and had a good knowledge of people. A relative told us, "I am aware of the manager, she is very efficient…we can leave the home in the comfort that X is being well looked after and they will contact us if anything happens. We couldn't fault them at all".

There were links with the local community which meant people were still part of the community. For example, clergy visited the care home, local schools visited throughout the year and people were supported to attend social engagements.

Feedback from external professionals and documentation showed the registered manager worked well with other agencies, such as the local authority, commissioning and health care professionals to help ensure a joined up approach to people's care.

The service had notified the Commission of significant events which had occurred in line with their legal obligations.

The registered manager felt supported by the registered provider who visited monthly. We were told, in between these times, the registered provider was always on the end of the phone if required. The registered manager and staff told us the registered provider had invested, and was continuing to invest, in the care home. For example a new call bell system had recently been installed, which meant people who sat in lounges or who were vulnerable to falls always had a call bell in reach.

Audits help to identify if improvements are required, so action can be taken promptly. The registered manager had a continuous improvement register/plan in place which identified areas for improvement.

Falls and accidents were recorded to help enable the registered manager to identify patterns; results of these audits could then be used to facilitate changes, for example to staff levels, people's care plans, staff practice or the environment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Person-centred care Regulation 9 (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (1) (a) (b) (c) (3) (a) (b) (d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not taken proper steps to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe because the recording of people's nutrition and hydration requirements was inaccurate and care planning did not always reflect the care required to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Need for consent Regulation 18 (1) (a) (b) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them.