HC-One Limited

Elmwood Nursing Home

Inspection report

32 Elmwood Road
Croydon
Surrey
CR0 2SG

Tel: 02086894040
Website: www.hc-one.co.uk/homes/elmwood

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18 September 2017

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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 caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 12, 15 and 18 September 2017. The first day was unannounced.

At our last inspection on 2 August 2016 we found three regulatory breaches which related to staffing, the need for consent and quality assurance. Accordingly, the service was rated 'Requires improvement'. Following that inspection the provider wrote to us with their action plan which set out what they would do to meet these regulatory requirements.

Elmwood Nursing Home is a purpose built residential home that provides nursing care and support for up to 60 older people, most of whom were living with dementia. At this inspection 51 people were living at the service.

The service did not have a registered manager in post at the time of the inspection although the new manager had started the registration process. 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.

People's consent was not always obtained. Care records contained Best Interests decisions which stated that people were unable to communicate or make decisions whilst their assessments and care plans stated they could communicate and make decisions. We found that where a supervising authority had stated a person had capacity to make a decision and that a deprivation of their liberty had not been approved; the service had not amended care records to reflect this. Staff received training, appraisal and supervision but records of supervision meetings did not reflect what was discussed.

People were at risk of not having their needs safely met overnight because there were insufficient staff numbers available to provide care, support and supervision. People and staff were at risk of harm because care records contained inaccurate information about people's assessed mobility needs. Care records stated that people required one member of staff to support them to transfer whilst their assessments stated two staff were required to do so safely.

People's medicines were administered, recorded and stored appropriately. Staff were recruited using robust procedures that ensured they were suitable to deliver care. People at risk of choking, pressure ulcers and undernourishment had detailed assessments and care plans in place to support them. People were supported with nutritional assessments and received the support they required to eat and drink safely. People enjoyed the nutritious meals they received and healthcare professionals supported people whenever they were required.

People and relatives told us that staff were caring and kind. People and staff shared positive relationships. People's independence and dignity were promoted and their privacy and confidentiality were maintained.

Care records did not reflect person centred care. There was significant replication of information between people's care records which included the exact same wording for people's preferences. This included identical information about people's stated final wishes.

A range of activities were available for people to participate in support was available to prevent people from becoming socially isolated. Communication with relatives had been improved with the introduction of relatives meetings and the role of keyworker who liaised with them on an on-going basis. People's cultural and religious needs were identified and met and the service created opportunities for people to experience cultures other than their own. Complaints were addressed in line with the provider's policy which included a written response within the stated timeframe. The provider actively sought the views of relatives and people through meetings and surveys and responded to the feedback it received.

People did not receive a service were the quality assurance processes were robust enough to identify and rectify failings in care records. We found information had been duplicated across a number of people's care records which resulted in inaccurate information about people's needs, care and support.

The new manager had made a number of improvements to the service including redecorating the building, improving communication with relatives and increasing activities. The manager worked collaboratively with other agencies to improve the service people received.

During this inspection, we identified a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 safe. Staffing levels at night time were not appropriate and could not protect people from the risk of unsafe care.

Care records contained incorrect information about the support people required to transfer safely.

People received their medicines safely.

Staff were recruited through thorough and safe procedures.

People's health related risks were assessed and plans were in place to mitigate them.

Is the service effective?

Requires Improvement

The service was not effective. People did not always give their consent and the provider did not always act in accordance with the requirements of the Mental Capacity Act 2005.

Staff were supervised and appraised but records of staff supervision meetings did not always reflect the discussions which took place in them.

People received the support they required to eat well and to eat safely.

People had timely and on-going access to health and social care services.

Is the service caring?

Good

The service was caring. People and relatives told us that staff were kind and caring.

People were treated with dignity and independence was maintained.

Staff promoted people's independence and privacy.

Is the service responsive?

Requires Improvement

The service was not responsive. Information that should have been personalised was copied and replicated between different people's care records.

People were supported to participate in a range of activities.

People were supported by named members of staff called 'keyworkers' who maintained contact with people's families.

People we supported around their spiritual needs and offered the opportunity to experience other cultures.

The provider gathered the views of people and their relatives and acted upon them.

Is the service well-led?

Requires Improvement

The service was not well-led. The service failed to act upon the shortfalls detected in its audits.

The service did not have a registered manager but the new manager had commenced the registration process with CQC.

Relatives and staff were positive about the changes the new manager had made to the service.

The service was developing partnership working with other agencies.

Elmwood Nursing 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.

This announced inspection took place on 12, 15 and 18 September 2017. The first day was unannounced. The inspection was undertaken by one inspector, one specialist nursing advisor and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send to us about significant events that take place within services. We also reviewed the provider's action plan and we used this information in the planning of the inspection.

During the inspection we spoke with 14 people, eight relatives, the registered manager, deputy manager and administrator. We also spoke with 10 staff, the activities coordinator and the chef. We reviewed 10 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We reviewed 10 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted 12 health and social care professionals to gather their views about the service people were receiving.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2016 we found that the provider was in breach of regulation because staffing levels were not appropriate for the needs of people as they did not fully consider the dependency needs of people who used the service.

At this inspection we found that the provider had taken action to increase staffing levels during the daytime on all three floors of the nursing home, but the provider did not substantially change the staffing level overnight resulting in the risk that people's needs might not be met.

People were at risk of not receiving the level of support their needs required. Staff told us they were concerned for people's care and safety at night when there was one care staff and one nurse for up to 19 people per floor. One member of staff told us, "It takes two staff to reposition people so they don't get pressure sores. Who is supervising the other 18 people?" A second member of staff said, "Because of their health some people are bed bound. They need to be turned regularly to manage their skin integrity. These people are frail so repositioning requires the gentle touch of two staff or people could get hurt. We don't have enough staff to do this simple task as it should be done." A third member of staff told us, "There are seven people on this floor who, because of their dementia can show challenging behaviour. It takes two staff to calm them down and make them safe. When one person becomes challenging it can cause others to become challenging and then we are immediately overwhelmed."

People did not receive the supervision their needs required overnight. A fourth member of staff told us, "We have five people living with dementia who actively walk about on this floor. Their needs don't change at eight o'clock at night because the late staff have arrived. Do the maths: five active walkers plus eight people who require two staff at the same time to manage their personal care." A fifth member of staff told us, "People who are active walkers can pace for hour after hour at night. It's their right and it's a part of their condition. But we should be keeping an eye on them in case they fall or go into other people's rooms but often we can't because both the staff are giving care to someone else." Care records noted that people who actively walked were at risk of falling. One person' care records stated, "[Person's name] must be supervised when walking as they can become prone to falls when exhausted." We found there were insufficient numbers of staff deployed to supervise people effectively overnight.

Care records confirmed that the majority of people on each of the nursing home's three floors required two staff at a time to safely meet their personal care needs at night. On one floor 11 people required two staff to provide them with personal care because of their increased mobility needs. This included using a hoist to transfer people and supporting people by washing and redressing them. Additionally, care records showed that people required two staff to reposition them to provide pressure relief to sensitive areas and two staff at a time to manage behaviours which may challenge. We reviewed staff rotas and found that when two staff were supporting one person at night there was insufficient planning to ensure staff were available to safely meet the needs of other people.

The provider recognised there had been a staffing shortfall and told us they had taken steps to increase

staffing levels overnight. On one floor the provider had begun to trial a 'twilight shift' between 6pm and midnight the week before our inspection. But staff told us this measure was not sufficient. We found that such was the concern of day staff for the safety of people overnight and the workload of their colleagues working overnight that staff had implemented the practice of putting people to bed as early as 7pm. One member of staff told us, "Nights are impossible. One carer and one nurse could never wash, change, medicate and put 15 to 19 people to bed." Another member of staff said, "The nights [night staff] can't cope. We do what we can to help by making bedtime earlier for some." A further member of staff told us, "We have to put people to bed before the night shift starts because they are overwhelmed. They are burnt out. That's why they use so much agency which makes it even worse as you then have one nurse who knows people and one care assistant who doesn't."

Although there had been some improvement, this demonstrated a continued breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People were at risk of unsafe care because care records contained inaccurate information. We read 10 people's care records and found that half of them contained incorrect details about the support people required to safely transfer. People's care records included needs assessments which stated the support people required, care plans which guided staff as to how people's needs should be met and resident profiles which included a summary of people's needs and support. Resident profiles contained a photograph of people and were kept at the front of people's care records. We found five people's resident profiles which used the same wording to incorrectly state, "My personal care needs are one member of staff to assist me with all transfers." However, in the needs assessments and support plans for all five people it stated that they required two people to support them to safely transfer. This included two staff to support them to safely transfer from their wheelchair to the shower using a hoist. This meant people were at risk of harm if a member of staff followed the incorrect information in the resident profile when supporting a person to transfer.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

The number of safeguarding alerts raised in relation to the service had risen since the last inspection. There are on-going safeguarding investigations into these allegations. We will not refer to them in this report because the outcome of these is not yet known. The service's newly appointed manager told us, "We are changing the culture and attitude of the service towards safeguarding. I tell the team if we are transparent with the local authority and CQC then we can work together to keep people safe." Staff we spoke with had received training in keeping adults safe. They told us they understood the provider's whistle-blowing and said they would report any concerns about people's safety to an external agency such as the Local Authority or CQC should they believe the provider had not acted on the information of concern. However, the treatment of a member of staff alleged to have whistle-blown is currently the subject of an on-going investigation. The outcome of this is not yet known.

People's risk of experiencing avoidable harm was reduced by the risk management plans in place. Staff supported people to identify risks. For example, people were assessed for the risk of developing pressure ulcers by staff who used the Waterlow screening tool. The Waterlow screening tool looks at a number of factors which may identify risks to people's skin integrity including people's continence, mobility, skin type, build, and nutrition. Where people experienced pressure ulcers staff made referrals to the GP and tissue viability nurses and implemented a wound management plan which included supporting people to reposition and the use of pressure relieving air mattresses. However, when we reviewed one person's wound management records we found that photographs of their pressure ulcer were undated, some of the

images were blurred and they did not state where on the person the pressure ulcer was located. We brought this to the attention of the manager who arranged a group supervision for the service's nursing staff at which time the appropriate good practice in the management of pressure ulcers was clarified. Minutes were kept from the meeting and the five nursing staff in attendance signed to confirm they understood the provider's policy regarding the photographing, measuring and documenting of wounds. We found this person's care records contained notes regarding dressing changes at appropriate intervals and the improvement of the area concerned.

People's risk of choking was reduced. Staff carried out detailed choking risk assessments for people. These focused on people's difficulties swallowing, their frequency of chest infections, confusion, the speed at which they ate and any breathing difficulties. Where staff had concerns about the safety of people's swallowing they were referred to healthcare professionals. People with swallowing difficulties were supported with appropriately textured meals. For example, some people required their meals to by fork-mashable whilst others required kitchen staff to ensure their meals were pureed.

People who were at risk of malnutrition were monitored. To reduce people's risks of becoming malnourished staff supported them with regular assessments using the Malnutrition Universal Screening Tool (MUST). MUST assessments took into account a number of factors including people's health, height and weight to determine people's risk of becoming malnourished. We found that for people at risk of malnourishment staff supported them with fortified diets to increase the calorie intake throughout the day. Where people had experienced rapid and unplanned weight loss a referral was made to the GP to investigate the cause.

The provider ensured that the staff delivering care and support to people were recruited safely. Staff were only employed after successfully passing selection and vetting processes. The selection process involved submitting an application form and being interviewed by a manager. The vetting process included providing proof of identity, address and checks against criminal records. New staff completed a probationary period when their suitability to safely support people was confirmed by the manager.

People received their medicines safely. Nurses administered people's medicines in line with the prescriber's instructions. Medicine's Administration Records were completed accurately and audits of medicines were undertaken. We found one person's care records did not provide staff with information regarding a high risk medicine. We informed the clinical lead about this and the person's care records were immediately updated with an appropriate risk assessment put in place. People's allergies were stated clearly and prominently in their care records. Regular audits of medicines stocks, storage and records were undertaken by the manager and deputy. Additionally the dispensing pharmacist conducted audits of the service. Where actions arose from medicines audits we found these had been undertaken.

People and their relatives told us the environment of the service had improved. One person told us, "[The care home] looks very well, very nice." Relative told us, "The manager should be congratulated. He has really done the place up since he took charge." Since our last inspection the provider had taken action to improve the quality of people's surroundings. The communal areas on each floor, including the lounges, dining rooms and corridors had been redecorated. Lighting fixtures had been replaced and the service had a new lift. Chairs in the lounges had been re-cushioned and new bedside tables had been purchased for people's bedrooms. Nursing stations had been moved into larger areas on each level and the manager informed us that the service's entry system was due to be upgraded to enable staff within nursing stations to see who was at the door via a video system and speak to them through an intercom to improve the safety of people using the service.

People were protected from the risk of infection. Staff wore personal protective equipment (PPE) when delivering personal care. For example, staff wore single use gloves and aprons when supporting people to shower. The service had a domestic team which cleaned each bedroom and all communal areas each day and recorded its work in a housekeeping diary. A member of domestic staff told us, "By cleaning thoroughly, people's bedrooms smell nice and we reduce infection risks." Risk assessments were in place for the management of chemicals involved in cleaning the service. These included ensuring that rooms used to store chemicals were adequately ventilated. The manager carried out audits to ensure the home's cleanliness. These audits included a check of cleaning records and a visual inspection of the service. We found the home to be clean with no malodours.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection we found there were no specific mental capacity assessments recorded in people's care records and there were no best interest meeting records to support decision making where people lacked capacity. Consequently we found the provider to be in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider forwarded us an action plan stating the timeframe in which DoLS applications would be made for people and best interest meetings held.

At this inspection we found that mental capacity assessments had been undertaken and best interest documentation was in place. The provider had also submitted DoLS applications to the local authority. However, where DoLS had not been authorised by the Local Authority the provider had not amended people's care records to reflect this decision. For example, one person's mental capacity assessment records contained a statement from a healthcare professional that the person had the capacity to make a decision about where they lived but the person's care records continued to contain a best interest assessment by Elmwood staff that the person lacked the capacity to make this decision. In another person's care records, staff had written a best interest assessment in support of a do not attempt cardiopulmonary resuscitation (DNACPR) instruction. Within the assessment staff wrote, "[Person's name] is unable to communicate basic needs." This was contradicted within the person's end of life care plan which stated, "[Person's name] is able to make his wishes known as to what should happen to him should his condition deteriorate." Additionally, within their communicate care plan it stated, "[Person's name] is able to communicate their wishes and needs verbally to staff and is able to respond clearly when they are being spoken to." In both instances the provider did not seek or obtain the consent of a person who had capacity.

Although there had been some improvement, this demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Need for Consent.

Relatives told us that staff skills and knowledge should be improved. One relative told us, "I am not totally convinced that all the staff are as knowledgeable as they should be for the type of care they are providing."

Another relative told us, "I feel that some can still benefit from a bit more learning and understanding about the behaviour of dementia sufferers and interact a bit more with residents on a one to one basis." We checked staff training records which confirmed that staff in the nursing home had not received dementia training. We spoke with the new manager about this and he showed us confirmation of dementia awareness training scheduled to be delivered to staff by the Local Authority. Staff received regular training in core areas which included manual handling, first aid, fire safety and infection control. The manager retained details of the professional qualifications and registration status of nurses. This included the expiry and renewal dates for their registration with the Nursing and Midwifery Council.

New staff were supported through an induction process which included both classroom-type and on-line training in mandatory subjects. New staff shadowed experienced colleagues for a period in order to see how care was delivered and were observed when they began to provide support to people. During their induction period new staff familiarised themselves with people and their care records. New staff were issued with a handbook from the provider as part of their induction. This included a welcome pack, health and safety information, code of conduct, information about whistle-blowing and details about the service provider.

People received care from supervised staff. Staff received supervision from their line managers. We read the minutes of supervision meetings held by the new manager. We found these invited staff to reflect on their practice, looked at areas of improvement, changes taking place and staff training needs. The manager informed us that the model of one to one meetings he had held and recorded was being adopted by other line managers and would be used in all staff supervisions going forward.

People's communication needs were assessed and staff had guidance in care records on how to communicate effectively with people. For example, in one person's care records it stated, "Staff to speak slowly and let [person's name] answer in their own time." In another person's care records the importance of uncomplicated short sentences was emphasised. Care records also provided staff with guidance as to people's nonverbal communication. For example, a third person's care records said, "When [Person's name] is in pain he tends to do facial grimacing and appears very stiff." A member of staff told us, "You get to know people's facial expressions well. You begin to recognise what a look means, what a sound means. I know it sounds strange to say this but we see people every day and we recognise these little subtle things and we respond." We observed staff responding positively and confidently to people's facial expressions and body language throughout the three days of our inspection.

People ate well and told us they enjoyed their meals. One person told us, "The food is nice they give you a choice" another person said, "I like the fruits, the apple and grapes." We observed meals in three dining areas over two days. People were offered choices in what they ate. For example, for lunch staff offered people a choice between cottage pie, fish, halal food and a vegetarian dish. People sat at tables with linen table cloths and flowers. Napkins were bright to assist those with visual support needs.

People received the support they required to eat. The texture of food people were assessed to require was stated in care records. For example, some people had normal texture food or foods that were fork-mashable whilst other people had thick or thin pureed food. Care records also noted the support people required to eat. For example, some people required staff supervision or verbal prompting whilst others needed physical prompting or full support. The chef and kitchen staff received dietary notifications from team leaders as soon as people's nutritional needs changed. We also saw the chefs' records of people's likes, dislikes, allergies and cultural preferences. We read the chef's list of people who required their food to be pureed and saw that people received these.

People's health needs were met with the on-going involvement of healthcare professionals. People received

clinical support throughout the day by nurses employed at the service. A supporting GP practice did regular rounds of the service and referrals were made to health and social care resources whenever people required them. For example, staff made timely referrals to tissue viability nurses, dieticians, opticians and physiotherapists. This meant the provider ensured people's health needs were assessed by the appropriate healthcare professional for assessment and treatment.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. One person said of staff, "They smile, they are kind". Another person told us, "I like that they are kind". A third person said, "I would not like to live anywhere else." One relative told us, "Without exception, from our very first visit to the home, we have only ever experienced care and attention from everyone (management, office, nursing staff, activities co-ordinator, cleaners and the handyman)…I have only ever seen kindness, patience and encouragement towards my [family member]." A second relative told us, "I have found the staff to be caring and have seen them to be very patient with my [family member] and try to put her mind at rest when she feels lost." A third relative said, "I feel that on the whole the staff are caring, even though their shifts are very long and often seem to be quite full on." Whilst a fourth relative said staff were, "Smiling, friendly, calm and caring."

People and staff shared positive relationships. One relative told us, "[Staff] have a strong bond with people and we have no concerns about their care." We observed positive interactions between people and staff throughout our inspection. A member of staff told us, "Some people love singing and we encourage them to do so." We saw and heard people and staff singing on a number of occasions when people had spontaneously initiated it and also during planned group activities. Relatives told us they were made to feel welcome when they visited loved ones. Photographs of staff were on display around the service for people and relatives to see who would be available to provide care and support that day.

People were supported to maintain their independence. Care records noted where people required support or were independent. For example, one person's care records noted that they could drink independently whilst using a beaker but required the assistance of staff to use a cup or glass. Another person was supported to maintain their independence when eating food by staff cutting their food into suitably sized portions. One member of staff told us, "We support people to maintain their independence with personal hygiene and by encouraging them to wash the parts of their body they are able to. It is good for people's pride and emotional well-being. We encourage people to eat for themselves. If things are getting messy we support people to wear a dignity apron and support them to change afterwards."

People were treated with dignity and their privacy was respect by staff. One relative told us, "I feel that Elmwood staff in the main treat my father with dignity and respect." We observed staff knocking on people's doors before entering people's rooms. Staff addressed people by their preferred names. People were supported with assessments of their continence needs. This included people's views, preferences, medical conditions and support needs. People who wore incontinence pads were supported by staff to change them regularly throughout the day. Where saw that when people had been unable to reach a toilet in time staff discreetly spoke with them and supported them to change. By meeting people's hygiene needs staff promoted people's dignity.

The privacy of people's information was maintained whilst confidentiality had improved at the service. This was as a result of the nursing stations being relocated into larger facilities on each floor enabling staff to store people's records securely. Previously some records, including supplementary charts and records relating to people's diets were kept in communal areas. At the time of our inspection we found that all care

records were kept within locked cupboards in the nurse's stations and were not visible to people, relatives or visitors.

The manager and clinical lead informed us that none of the people receiving care and support at Elmwood Nursing Home were receiving end of life care at the time of our inspection, but noted that the service had in the past and would again in the future. At the time of our inspection the service no longer held the Gold Standard Framework Award for end of life care but was working towards alternative accreditation. One health and social care professional told us, "The home has been trying to complete an end-of-life care programme for a few years but without success. I do not think that is due to unwillingness on the part of individual staff nurses but workload and perhaps an unsupportive management structure." Staff received training from a beacon service in providing end of life care to people. This training was delivered to nurses, care staff and domestic staff. This meant all staff involved in delivering care and maintaining people's immediate environments had knowledge of good practice in supporting people through their end of life journey.

Requires Improvement

Is the service responsive?

Our findings

People had detailed needs assessments in place. These included assessments of people's mobility, personal care, communication, risks, physical health, behaviour, nutrition and skin care. A number of assessments had been informed by the involvement of external healthcare professionals including tissue viability nurses, consultants and physiotherapists. People had care plans and residents profiles in place which stated people's individualised preferences for how they wanted their assessed needs to be met. However, we found that there was significant word-for-word copying of text between care records. For example, we found four people's support plans around sleeping and resting each stated, "[Person's name] requires the assistance of the early staff to put them to bed as they prefer to go to bed early at about 19.00pm." We found that eight people had the same wording to describe their personal care needs even though in five of these eight cases the information was incorrect. We also read text which had been duplicated between people's best interest meeting records. The replication of text between people's care records meant that people did not always receive planned personalised care.

We reviewed four people's end of life care plans. We found three contained contradictory information. This included best interest assessments, which stated that people could not communicate their wishes around end of life care and, in contrast, their communication care plans stated that they had the ability to do so verbally and clearly. Additionally, we found that information which should have been personalised, unique to individual people and reflect their distinctive preferences for their final moments had been copied between documents. We were concerned that staff could follow what was stated in care records and may not carry out people's wishes.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.Person Centred Care.

A range of activities were available for people to participate in at the service. The service had an activities coordinator who relatives and staff described as enthusiastic. People were supported to participate in activities including, tea tasting groups in which people sampled varying flavoured teas alongside an assortment of biscuits and cheeses, indoor gardening when people painted flower pots and planted bulbs, movement activities including soft ball games and gentle exercise groups. People also enjoyed arts and crafts, singing, quizzes and board games. The service hosted movie nights and entertainers visited regularly. One relative told us, "During the summer residents spent a lot of time in the garden enjoying the fresh air and having entertainment on occasion, which was good to see and enjoy on visits." Activities which were previously presented to people in a written list format had been pictorialized so that people had images as well as words to help them make choices about what they did. Relatives and staff told us that people were supported to do more outside of the care home. This included using the garden for activities, picnics and barbeques as well as a trip by mini bus into a local town centre.

People who remained in their bedrooms were protected from social isolation. The activities coordinator supported people with individual activities including hair brushing, hand massages and reading as well as singing to and with people. Additionally, staff maintained close observation which were recorded in care

records. This monitoring was undertaken to increase people's social interaction and safety by, for example, supporting people to reposition to avoid the risk of pressure ulcers.

People were supported by the development of a keyworking system. A member of staff explained the role of a keyworker to us, "As a keyworker I make sure people have enough toiletries, that their clothes are folded and that their wardrobes are neat a tidy. I also keep in touch with relatives." Relatives told us that the development of the keyworking system had been positive. One relative told us, "Staff appear to know my [family member] well and their care is becoming more personalised… In our [family member's] room are details of their keyworker and [family member's] likes and dislikes." People had photographs of their keyworkers on their bedroom walls to help them to remember their key member of staff.

People's cultural needs were identified and met by the service. A member of staff told us, "We take our cue about meeting people's cultural needs from the relatives. For example, some people here are from the Caribbean and like cornmeal porridge and some people from India like vegetable curries." Another member of staff said, "The chef is really knowledgeable about foods from different cultures and the staff here are quite literally come from every continent around the world which is great for communicating in people's first languages." Staff also supported people to experience other cultures. Once a month the service held special events called 'monthly celebrations' which were opportunities for people to experience aspects of cultures from around the world. On the first day of our inspection there was an Hawaiian themed day in progress. Staff wore colourful necklaces and garlands in their hair. Tropical drinks were available. Previously the service had held Filipino, Indian, Nigerian and Caribbean days.

People were supported to participate in faith activities. Representatives from a number of religions visited people at the service. We observed a community church session in which five people, two staff and eight members from a local church congregation took part. People were given sheets explaining what was taking place and we saw singing, clapping and laughing throughout the session. These sessions took place fortnightly.

We received mixed views about how the service communicated with relatives, kept them informed and gathered their views. Some relatives were positive, with one stating, "The new manager has made it very clear that if we are unhappy with anything his door is always open for us to speak to him." Another relative told us, "There are regular relatives meetings which are well attended and I do feel that our views and concerns are listened to and acted on where possible. For example, I asked that [family member] have a female named carer rather than a male and this was changed very quickly." However, other relatives shared negative views about communication from the service. One relative told us, "I have had situations when my [relative] has had a pressure sore and [staff] did not let me know. On another occasion my [family member] was discharged from hospital and no one bothered to phone me." Another relative told us, "Nobody regularly asks me for my views or talks to me about how my [family member] is but I have received calls in the past when they had a fall to let me know, especially when [family member] had been taken to hospital to check he is okay." We found that the new manager had made significant improvements to the service's communication with relatives. These included creating relatives meetings, noticeboards around the service, and informal social events for people and relatives such as a barbeque, picnic and party and frequent direct telephone communication through keyworkers.

The provider had a clear complaints procedure in place. The manager told us, "We are being proactive with complaints. I tell relatives I have an open door policy and they can come to me anytime, not just when there is a problem. This way we aim to nip problems in the bud." We read complaints made since our last inspection. We found they were addressed in line with the provider's policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

The provider's checks of quality did not always identify and act upon shortfalls. Quality audits failed to detect the duplication of text between records. We found the exact same wording copied between different people's care records including end of life care plans, best interest meetings and people's profiles resulting in inaccurate and contradictory information. Within staff records we found identical minutes for different staff members' supervision meetings. This meant managers could not distinguish between the records of staff or maintain an accurate record of discussions with staff about their individual performances in their roles. Additionally, we found that records of these meetings did not always reflect what we were told took place in them. Staff told us that people's changing needs, the delivery of care, staff training and the support they required were discussed but the records of supervision meetings did not reflect this. For example, records of one staff member's supervision consisted of 39 numbered instructions including, "Do not flush sanitary towels or wipes down the toilet", "training must remain at 100% as they are mandatory", "do not store wheelchairs in the bathroom". The supervision records for another member of staff contained four questions: 'How are you feeling?' 'Do you feel supported?' 'Do you have something to tell me?' And 'Is there anything I can help you [with]?' To these questions the staff member was reported to have responding 'Good', 'yes', 'No' and 'Not at the moment'. The provider's quality audits failed to detect all of the concerns we found regarding the need for people's consent. This included best interests meeting records that contained inaccurate information and the requirements of the Mental Capacity Act 2005 not always being adhered to. We also found that quality assurance checks failed to identify and rectify shortfalls in staffing levels overnight when the planned number of staff deployed did not meet the needs people presented with. This meant that the provider's quality auditing processes were not robust enough to drive improvements in the care and support people received.

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

The service did not have a registered manager. However, a new manager came into post four months before our inspection. They were in the process of registering with CQC at the time of our inspection. Relatives spoke favourable about the service's new manager. One relative told us, "The enthusiasm of the new manager and many of the improvements he has made to date and plans mentioned have been very positive." A second relative said, "Since the new manager has taken over the home has improved 100%." A third relative said, "The management of Elmwood is now good since the arrival of a high performing manager. The manager has set clear goals and expectations for staff performance." Other comments from relatives included, "The new manager has worked very hard to make Elmwood a better home", "There have been three managers of this home this year and so it has been stressful trying to get problems sorted out", and "I am very happy with him."

The staff were mainly positive about the new manager and the management culture that was developing at the service. One member of staff told us, "There have been a lot of positive changes since the new manager arrived." Another member of staff said, "I feel supported and valued now, it has improved since the new

manager started." A third staff team member told us, "The nurses and carers really pull together and that is a really good thing." The manager arranged 'flash meetings' each day. These were meetings that were attended by department heads, nurses, senior carers, and the administrator. The manager used flash meetings to ensure important information was shared in a timely manner within the team. A number of staff were entrusted with the role of being champions for areas at the service. Champions were responsible for promoting good practice within the staff team in specific areas including infection control, nutrition, dementia and dignity. At the time of the inspection the manager was planning a long service awards night. The event was being arranged to recognise the staff who had supported people at the service for lengthy periods.

The environment in which people lived was monitored and improved. Records were maintained of checks undertaken by the manager and department heads of the home's safety and cleanliness. For example, we read in one audit that chopping boards in the kitchen were worn and an action plan directed that they be replaced. This was done. Records were kept of staff checks of air mattresses to ensure they had not deflated. These checks were undertaken to reduce the risk of people becoming stuck in, or slipping under the bedrails they were assessed as requiring. Clinical reports monitored people's pressure ulcers, weight loss, infections, hospital admissions and falls. The service operated a recording and monitoring system for accidents, incidents and complaints. Where actions were carried out these were monitored by senior managers from the provider organisation to ensure they were completed satisfactorily.

The manager worked collaboratively with others and was developing the network of relationships the service had. For example, the manager arranged a number of coffee mornings at which discharge coordinators from the local hospital were invited to attend. The service liaised with the local authority, a beacon hospice service and notified CQC of important events at 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 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing. The provider did not have procedures in place to deploy sufficient numbers of suitably qualified, competent and skilled staff to cover routine and emergency work at the service. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent. The provider did not always act in accordance with the requirements of the Mental Capacity Act and associated code of practice. Regulation 11(1)

The enforcement action we took:

A warning notice has been served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. The provider did not always do all that was reasonably practicable to mitigate risks. Regulation 12 (2)

The enforcement action we took:

A warning notice has been served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance. The provider did not operate effective auditing and governance systems. Regulation 17 (1) (2)

The enforcement action we took:

A warning notice has been served.