Elmsfield House Limited

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Inspection report

Elmsfield House
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 unannounced comprehensive inspection took place on the 9 May 2017. We last inspected Elmsfield House Limited on 30 December 2014 and 5 January 2015. At that inspection we rated the service as good overall.

Elmsfield House is registered to provide accommodation for up to 28 people older people. At the time of our inspection 23 people were using the service, some of whom were living with dementia.
The home is a Georgian property that has been extended and appropriately adapted for its present use as a care home. The home has a large garden with patio areas and ample car parking. It is set in a very rural location close to the village of Holme in Cumbria.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this inspection we found a breach of Regulation12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was because we found some risks associated with the delivery of safe care and treatment including the management of falls, weight loss and the safe use of some equipment had not always been recognised. Even when these risks had been identified they were not always recorded accurately or managed safely. Medicines and records relating to their administration were not consistently being managed in a safe manner.

In the event of an emergency evacuation having to be implemented we did not see that individual people had been assessed to ensure they could be evacuated safely.

We found some areas of the home required deeper cleaning and the external building housing the laundry was unclean and posed a risk to cross contamination. The high level of dust and debris behind machines contributed to an increased risk and was deemed to be hazardous should a fire occur.

We also found when accidents and incidents had occurred these had not always been reported to the appropriate authorities. Some of these incidents related to keeping people safe from abuse. We alerted this to the registered manager during the inspection and she took immediate action to inform the local safeguarding authority. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had not been protected from harm or the risk of harm.

We also found that some of the incidents should have been reported to us (CQC) but the provider had not

done so. We have addressed this later in the report under the domain of well led.

On the day of the inspection there were deemed to be sufficient numbers of staff but we observed times when staff were not always available when people most needed them. Staff had completed training that enabled them to improve their knowledge in order to deliver care and support safely. When employing new staff the necessary checks had been completed.

We observed good humoured and supportive interactions between staff members and people living at Elmsfield House. People living in the home were supported to access activities that were made available to them and pastimes of their choice. However records about people's participation in activities were not consistently completed.

Some care records we looked at did not contain all of the relevant and appropriate information relating to current health and care needs. This meant that information recorded did not always provide staff with accurate and up to date information about how to support individuals.

We have made a recommendation that records relating to care and treatment are consistent in providing accurate information to enable staff to follow the most appropriate plan of care.

Some areas of the auditing and quality monitoring systems established to monitor the safety and quality of the home were not always effective and needed to be improved. This was a breach of Regulation 17 Good governance 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 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?

Inadequate

The service was not always safe.

Not all risks associated with people's care and treatment had been managed safely.

Incidents including safeguarding people and accidents had not always been reported to the appropriate authorities.

The laundry posed a risk to people's health and safety.

The number of staff on duty was sufficient. The recruitment of new staff was done in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had received the relevant training to fulfil their roles.

People said they enjoyed the meals provided but some people said they would prefer more choice.

Where people had lost losing weight records did not always demonstrate how it was managed.

Is the service caring?

Good

The service was caring.

People told us they were very happy with the care at Elmsfield.

People were encouraged to be independent.

People wishes for how they wished to be cared for at their end of life had been planned for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information in people's care records did not always accurately

reflect people's needs.

People were supported in pursuing activities they enjoyed but these had not always been recorded.

People and relatives felt able to speak with staff or the registered manager about any concerns they had.

Is the service well-led?

Requires Improvement

The service was well always not led.

Systems were not always effective in quality monitoring and identifying the safety of the service provision.

Staff told us they had enjoyed working at Elmsfield and supported by the registered manager.

Notifications required by CQC had not always been made.

Elmsfield House Limited

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 was 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 unannounced comprehensive inspection took place on the 9 May 2017.The inspection team consisted of two adult social care inspectors and an 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 looked at the information we held about the service including information from the general public and the local commissioners of the service.

During the inspection we spoke with the registered manager, the registered provider, three care staff members, spoke with and/or observed 11 people who used the service and three relatives or visitors to the home. We observed how staff supported people who used the service and looked at the care and medication records for eight people living at Elmsfield House.

We looked at the staff files for people recruited in the last year. These files included details of recruitment, induction, training and personal development. We were also given copies of the training records for the whole care team.

We looked at records of maintenance and repair, the fire safety records, food safety records and quality monitoring documents. We also looked at how medication was managed and stored.

Inadequate

Is the service safe?

Our findings

During the inspection we found a bedrail in use without it being risk assessed for use or identified in the persons care plan. We found that the oversight and continuous management of the bedrail that was in use was not always formally recorded.

As part of this inspection, we looked at medicines records, storage, stock levels and care plans relating to the use of medicines. We looked at all the medicine administration (MAR) charts in use and in detail at the medication administration records belonging to eight of the people living in the home. We looked at how Controlled Drugs [medicines liable to misuse] and found they were stored appropriately.

The medicine administration records (MARs) we looked at, with the exception of three, had photographs in place and people's known allergies had been recorded on all. The service had systems in place for ordering, receiving and carrying forward unused medicines and returning unused medication. However, on the day of the inspection we found a range of medicines that were to be returned on the floor beneath a desk in the staff office. This is against national guidance and is unsafe as the medication could be misused.

We looked at the management of ointments, creams and lotions we found that these types of medicines had not always being recorded as having been applied by staff. We asked the team leader about the process for administering the prescribed creams and lotions. They explained that all creams were kept in people's bedrooms. Care staff were to apply prescribed creams during care and then record this on the medicine administration MAR charts. However, we found that this process was not being consistently followed. For example, one person was prescribed a cream to be applied daily but the MAR chart indicated that over a 12 day period it had been applied only five times. This meant that those records could still not be relied on to show that creams had been applied as prescribed. Additionally, all such prescribed items should be stored securely unless it has been assessed that it is safe not to lock them away.

We found the information to guide staff as to which creams to apply where and how was also not clear, so creams may not be applied correctly. For example on the MAR chart instructions were give as directed by district nurse but there was no information on what those directions were.

We found that the refrigerator temperatures, where medicines requiring refrigeration were stored, were being monitored. However, the room temperature of the area where other medicines were being stored was not being monitored. Medicines can become less effective if they are kept at the wrong temperature.

We saw that there was no information to guide staff to administer prescribed medicines, which were to be given "when required. It is important that clear guidance is recorded to ensure people are given theses medicines safely and consistently. This information was missing for a variety of types of medicines including strong pain- killers, medication for agitation and for constipation.

We noted areas where good practice could be improved. We saw that some medicine doses were variable but staff were not always making clear on the MAR what dose had been given. We also noted where

handwritten changes had been made to MAR charts but these had not been checked by another person to help ensure the amendments were correct.

Some areas of the home had not been kept clean or maintained in a manner that prevented the risk of infection including the laundry building. We noted that the dining room tables were not cleaned following breakfast and that the ceiling in the dining room had a number of visible cobwebs.

In the laundry building we found there was one door into and out of the laundry through which both clean and dirty linen was transported. Once washed the clean linen was dried and stored in the same room as the used dirty linen waiting to be washed. There was storage for laundered clothes on a rail and within individual baskets for clean clothes to be returned to people. Infection can be transferred between contaminated and uncontaminated items of clothing and laundry and the environments in which they are stored. Ideally, a laundry should be designed and organised to minimise the risk of recontamination of linen and to help ensure the protection of people living in the home and staff involved in the handling of used linen.

The laundry itself was not clean or well maintained. There were cardboard boxes that contained a variety of items covered over with a cloth. The walls were covered over in plasterboard that was porous and not easily cleanable. The floor covering was dirty and dusty and there were holes in the floor covering making it difficult to ensure these could be thoroughly cleaned. We looked behind the washing machine and drier and found dust and debris indicating this area had not been cleaned for some time. This also posed a fire risk in the event of a machinery malfunction.

The Department of Health has a code of practice and guidance about the prevention and control of infections, 'Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. By following the code, registered providers can show how they have met regulations. Registered providers must comply with this guidance and make sure they provide and maintain a clean and appropriate environment that facilitates the prevention and control of infections [Criterion 2 of the code of practice].
In the event of an emergency evacuation being required we did not see how this had been planned for each individual. Some people would require more assistance than others and we did not see that this had been assessed or recorded.

The above findings are a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 this was because risks associated with the delivery of safe care and treatment had not always been identified or managed.

There were five care staff, a cook, a cleaner and the registered manager on duty on the morning of the inspection. We saw that the numbers of staff available in the dining room during breakfast meant some people did not get their needs met in a timely manner. The team leader on duty was administering medication in the dining room and the other four care staff were busy assisting people to get up and dressed. Care staff only came into the dining room when they were helping people to the dining room. We observed one person who required assistance with eating and drinking had to wait up to 45 minutes before they were served with their breakfast.

We discussed the level of staffing available with the registered manager. They told us that there was sufficient staff based on the tool they used to calculate staffing requirements but did agreed that staff could be better deployed at key times such as meal times through the day.

We looked at the rotas and saw the core numbers of staff available on the rota were not always sufficient and this shortfall was occasionally covered by the use of agency staff. The provider was in the process of recruiting more staff. The numbers of staff on duty was determined by the dependency needs of people living in the home. The registered manager collated information about people's needs and used a tool to calculate the numbers of staff required on each shift. However we did not see that this tool included all of the time people required specific assistance from staff such as eating and drinking.

All of the staff spoken with expressed positive views of Elmsfield as a good and happy place to work. Staff told us they occasionally worked extra hours to ensure people received their care from familiar staff.

We saw that a number of incidents that had occurred with safeguarding concerns had been recorded but had not been reported to the appropriate authorities. We did not see any actions recorded to ensure that people were protected from reoccurrence of those incidents or acts. The Inspector requested during the inspection that this information was shared with the local authority safeguarding team. These incidents included physical assaults and other behaviours that may have caused harm to other by people who behaviours challenged the service.

This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had not been protected from harm or the risk of harm.

Requires Improvement

Is the service effective?

Our findings

People we spoke with who lived at Elmsfield House gave us mixed comments about the meals provided. One person said, "The food is mostly alright. There is not much choice we just get what is put in front of us. They will make us something different if we do not like something." Another person said, "The food is very nice the choice is good." We were also told, "The food is lovely the dinners are the nicest." We saw that meals were freshly cooked on the day of the inspection and there was a choice of two hot meals or a choice of sandwiches and three choices of pudding for lunch.

We observed staff members asking people what they wanted for their lunch and there was a menu board on the dining room wall. People with communication difficulties were shown the options available. We saw that the staff had more time over the lunch period to better support people. People were given time to eat their meal at their own pace and they were not rushed. We also observed people were offered more pudding if they wanted it. However during breakfast staff were not as readily available and some people did not get as much support.

During breakfast we observed one person was sat at the table asleep with toast in their hand. We saw from this person's care records they had experienced swallowing issues. However we did not see a specific care plan or risk assessment in place to inform staff on how to manage any risks associated with choking. We spoke with staff about this person having toast and staff were aware that this person required a soft diet.

We saw that most people had nutritional assessments completed to identify their needs and any risks they may have when eating. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well. However where one person had been identified as at risk of malnutrition and weight loss had occurred we did not see that actions taken had been recorded. We were told by the team leader this person had been referred to their GP and had commenced dietary supplements. We discussed this with the registered manager who identified that there was a need for written protocol for staff to follow should people lose weight.

Staff we spoke with felt that they were receiving appropriate training to assist them in their job, and could name a number of different training courses they had completed. We saw from records that staff had completed training when they started working at the home and completed refresher training in the recommended time frames. We saw that there was a training plan in place to cover the topic areas that some staff needed to be refreshed in. One staff member told us, "We are trained in first aid, dementia, etc. and the training is updated on a regular basis." Another staff member said, "I have had mandatory training before I started. I also had a couple of induction days before I started. In two or three months, I am doing my care standards course and then I will be starting my NVQ training."

The care staff we spoke with told us that they had regular team meetings and could speak openly with the registered manager to discuss any concerns. Staff said that they knew who they could contact should they require support out of hours. Staff also told us that they felt supported by team leaders and through formal systems such as supervision and appraisal.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called 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 the time of the inspection no one living at Elmsfield House had their liberties restricted.

Where people were living with dementia there was some signage to show people what different areas in the home were for. This was to help people with memory problems to be able to move around their home more easily and more independently. We saw that people had been able to bring personal items into the home and their bedrooms had been personalised with people's own furniture and ornaments to help them feel at home. We saw that a lot of people chose to spend time in private in their bedrooms if they wished or chose to. We saw that people could and did have their pets living with them.

Good

Is the service caring?

Our findings

People living at Elmsfield House and their relatives told us they were very happy with the care they received. One person said, "The care is very good." Another person said, "The staff are grand. We are all pals together. They are all very pleasant. It is a home from home almost." We were also told, "The care is very good, very good indeed. The staff are very kind and considerate very caring." A visitor told us, "The general care is fantastic. The staff are excellent, on the whole." Another visitor said, "The staff are very pleasant and the care is very good."

We observed staff knock before entering people's rooms. Staff took appropriate actions to maintain people's privacy and dignity. We saw that people were asked in a discreet way if they wanted to go to the toilet and the staff made sure that the doors to toilets and bedrooms were closed when people were receiving care to protect their dignity.

We saw, where appropriate, that the staff promoted independence in the people they were caring for. We saw that the staff gave people time and encouragement to carry out tasks themselves. This helped to maintain people's independence. One person who had their dog living with them was provided with appropriate accommodation to ensure they maintained their independence with direct access from their room to the outdoor areas. Staff took the time to speak with people and took up opportunities to interact and include them in general chatter and discussion.

Information was available about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

We saw that not all people's treatment wishes had been made clear in their records about what their end of life preferences were. Some care records contained information about the care people would like to receive at the end of their lives and who they would like to be involved in their care. This was to ensure people who could be involved with planning their end of life care were cared for in line with their wishes and beliefs at the end of life. During the inspection we discussed with the registered manager that a more consistence approach to end of life care planning would ensure people's wishes were fully noted.

Requires Improvement

Is the service responsive?

Our findings

People living and visiting at Elmsfield House had mixed opinions on the activities provided. One person told us, "Once a week we do baking or painting and we have singers mostly on a Sunday afternoon". Another person said, "We do them occasionally not very often". A relative we spoke with told us they had written to the home and made suggestions for other activities but at the time of the inspection they had not yet received any response. We looked at the records identifying what activities individual people had been involved in and we saw that these records had not been consistently completed. We discussed this with the registered manager during the inspection and she informed us that this area of record keeping had been highlighted for staff development.

People who we spoke with also told us they usually resolved any concerns directly with the registered manager or staff on duty. One relative who told us that their family was "In and out of the home all of the time" and told us, "I can't see any reason ever to complain about the care being offered".

Visitors we spoke with told us they had been involved in discussions about their relatives' care and where there had been any changes they had been informed by staff at the home. One person told us, "They always telephone when there is a change in my relative's care and/or medication".

Care plans were not always written in a person centred way. Person centred care planning is a way of helping someone to plan their care and support taking into account their individual preferences and what is important to them. We did not see that people had always been involved in their care planning. Where people could not easily make decisions for themselves we did not see that relevant others had been consistently consulted. Some care records did not contain relevant and appropriate information relating to current health and social needs. For example where someone's ability to swallow had changed. This meant that information recorded did not always provide staff with accurate and up to date information about how to support individuals.

We recommend that records relating to care and treatment are reviewed to be consistent in providing accurate information to enable staff to follow the most appropriate plan of care.

We could see in people's care records that the home worked with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). All of the staff we spoke with said that they enjoyed working at Elmsfield House and that it was a happy place to work and they felt they were supported. One person living at Elmsfield House told us, "The manager is pleasant and friendly."

During the inspection, we identified a number of incidents which under the conditions of registration with the Commissio, were legally required to be notified to us that had not been submitted. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration. This was a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

Although there were comprehensive systems in place to assess the quality and safety of the service provided in the home these had not been consistently effective when looking at the management of some areas of safety in the home. We saw from the quality monitoring checks done in the home that areas requiring actions to improve had been appropriately identified. However it was not always made clear in what time frame that those areas need to be improved by. We discussed this with the registered manager who assured us that this would be addressed to improve the current systems in place.

Maintenance checks were being done regularly and we could see that repairs or faults had been highlighted and acted upon. However even with a cleaning schedule and records relating to premises and equipment checks we found that there were some areas of the home that required deeper cleaning. The building housing the laundry facilities required immediate attention and this was discussed with the registered manager and provider during the inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective systems or processes implemented, for the purpose of the continuous monitoring of the service and the quality and safety of care that was being delivered. The systems that were in place failed to identify the areas of concern we found during the inspection.

As well as informal discussions with people and their relatives about the quality of the home, we also saw that regular resident and relatives meetings had taken place. These were for the service to address any suggestions made that might improve the quality and safety of the service provision.

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 This was because risks associated with the delivery of safe care and treatment had not always been identified or managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment This was because people had not been protected from harm or the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This was because the registered provider did not have effective systems or processes implemented, for the purpose of the continuous monitoring of the service and the quality and safety of care that was being delivered.