Elmcare Limited

Elmwood House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Elmwood House is a nursing home providing personal and nursing care to up to 32 people. The service supports adults with learning disabilities, including autistic spectrum disorder, associated mental health and physical disability needs. The home is split into four living areas across three floors, with communal lounges and dining spaces. At the time of our inspection, 23 people were living at the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people, respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People's care records did not always provide up to date information on risk for staff to support them safely. People did not always have access to specialist health and social care support as staff were not always guided on when this was needed. Medicines were not managed appropriately which meant people were put at an unnecessary risk of harm.

Incidents and accidents were not always effectively recorded or monitored. This meant action to prevent further risk of incidents or accidents was not always identified. Governance arrangements were not always effective to fully ensure the quality and safety of people's care.

Best practice guidance in relation to restraint was not always followed. The service did not always record when staff restrained people and there was no monitoring of restraint within the service in order to learn from the use of restraint and consider how it could be reduced.

People were not always supported within a well-maintained and clean environment.

Right Care:
People's care records did not always promote their care being delivered in a dignified way. There were improvements needed to the language used by staff to ensure people were always treated with respect and dignity.

The service had enough staff to meet people's needs.

Right Culture:
People were at risk of harm because of a lack of protection to prevent unnecessary restraint.

Staff did not have enough guidance to support people to manage their distress, anxiety, feelings and emotional reactions in a personalised way.

The management team were developing systems to improve the culture within the service, particularly to ensure documentation was completed to support people to achieve good outcomes.

The service enabled people and those important to them to be involved in their care planning. There were opportunities for people, relatives and staff to feedback on the running of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 28 June 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about safety, infection control and management of the service. As a result, we planned a focused inspection to review the key questions of safe and well-led only. During our site visit we observed concerns which related to the key question of caring, therefore a decision was made to open up the key question of caring within this focused inspection.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elmwood House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safety, safeguarding, recruitment, dignity and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Elmwood House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors, a pharmacist specialist 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.

Service and service type
Elmwood House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Elmwood House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We communicated with 5 people who used the service and 9 relatives about their experience of the care provided. Some people who used the service were unable to talk with us but used different ways of communicating including using sounds and body language. We spent time observing staff interactions with people.

We spoke with 14 care staff including the registered manager, deputy manager, clinical lead, nursing staff, care staff, domestic staff, kitchen staff and agency staff. We reviewed a range of records. This included 11 people's care records and 23 medicines records. We looked at 2 staff recruitment files. A variety of records relating to the management of the service, including some of the provider's operational policies were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we found people were at risk from unsafe care and treatment because the provider did not always ensure safe arrangements for people's medicines and the prevention and control of infection at the service. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

- Information about people's risks was not always up to date. For example, one person using the service had epilepsy. Their health care plan did not mention this. One person's medicine regime had changed, their corresponding care plan had not been updated to reflect this. This placed them at risk of receiving the wrong dose of medicine.
- People's care records did not always help them get the support they needed. Staff were not always provided with guidance on when to escalate concerns about people's health and wellbeing. Some people had consistently refused care and support, however staff had not always raised this with healthcare professionals. This placed people at risk of their health deteriorating.
- Positive behaviour support (PBS) plans were not always in place where required. This meant it was not clear how the service was supporting people, and to understand, and address underlying needs which may lead to individual's distress, or how staff were working to make the environment and support safe for people.
- When people displayed signs of distress, the service's policy was for staff to complete antecedent, behaviour and consequence (ABC) charts. These are tools used to record information about behaviour and help to understand what the behaviour is communicating. ABC charts were not consistently completed. This meant it was not clear how information about behaviour was recorded to help understand what the behaviour is communicating.
- Relatives felt improvements were required to ensure people were supported appropriately when they displayed signs of distress. One relative told us, "I don't know how they manage [person] if they get distressed." Another said, "I think staff should intervene a bit more."
- The environment did not always promote people's safety. One person showed us their bedroom and told us they had asked for some things to be fixed but this had not been done, such as a broken aerial which had been snapped at the socket. They also had a leak in their bathroom ceiling.
- Fire safety checks were not routinely completed. A fire door was found not to close fully. Not all people had a number on their bedroom door. This placed people at risk in the event of a fire.

Using medicines safely

● People did not always receive their medicines at the times they were prescribed or when they needed them.
● Prescribed medicines were not used effectively. Some prescribed medicines were used to manage people's behaviours. However, not everyone had a personalised PRN protocol in place and there was a lack of appropriate documentation or GP reviews to ensure the medicines were being used safely and in a person's best interests.
● Staff did not have access to all the information they needed in order to support people with their medicines in the best way.
● Records showed that training around the safe handling of medicines was out of date for some staff.
● Staff were not reporting medicines related errors or near misses in line with good practice.
● Staff were not following safe systems for managing medicines waste.

Preventing and controlling infection
● Not all areas within the home were clean. For example, within the laundry room there was a build-up of dust behind the washer and dryer. Some of the communal bathrooms were not clean. This increased the risk of infection.
● Not all areas within the home were well maintained to facilitate good infection and control procedures. Some areas of the home such as walls, doors, skirting and paint work were in a poor state of repair. This inhibited good cleaning practices and increased the risk of bacteria harbouring and infection spreading.

Risks to people were not always assessed and up to date guidance was not available to support people safely. The environment was not always safe, clean or well-maintained. The provider did not ensure the proper and safe management of medicines. This placed people at risk of harm and was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded following our inspection and confirmed ABC charts had been put in place and staff had been reminded on completing these. Audits of care plans had been started. The GP had been contacted regarding medicine reviews for all people. They also confirmed areas identified had been cleaned and fire safety concerns had been addressed.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were supported to receive visits in line with current government COVID-19 guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not protected from the risk of improper treatment. Some people at the service were sometimes restrained to administer their medicine. Best practice guidance in relation to the use of restraint was not always followed. This placed people at risk of harm.
● Records were not always completed following incidents of restraint. Medicine records showed restraint was used to administer medicines on occasions, however corresponding forms documenting the restraint were not always completed as required.
● Where records were completed, these did not contain full details of the use of restraint. For example, forms did not always identify whether re-focus techniques were used or whether any injury occurred. This meant it was not clear whether the restraint was carried out safely, or as a last resort.
● Incidents of restraint were not reviewed. Staff were required to complete restraint forms and put them within people's care files. The registered manager did not collate these forms, review them or monitor the use of restraint within the service. This meant there were no checks completed to ensure restraint was being used appropriately, safely and in line with best practice.

The use of restraint within the service was not always documented. Incidents of restraint were not monitored within the service. Best practice guidance in relation to restraint was not followed. This placed people at risk of being restrained unsafely, or unnecessarily. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded following our inspection and confirmed they had spoken with the provider's training manager to refresh staff practice in relation to restraint, including documentation.

Staffing and recruitment
● Staff recruitment processes did not promote safety. Robust recruitment checks were not always carried out. For example, full employment histories were not always obtained prior to the staff members employment.
● One staff member did not have a current Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Whilst the provider had completed a risk assessment whilst awaiting the DBS, this risk assessment was not comprehensive as it did not explore the person's full employment history, or reasons why their last two periods of employment working with vulnerable people was short.
● References were not always validated. One staff member's reference was provided without formal signature, or a verified email. No attempts were made by the provider to ensure the reference had been supplied by the previous employer. This meant the provider could not be assured the information about the staff member's previous experience was accurate.
● One person's application form noted they had no qualifications prior to starting employment. They had not yet completed all mandatory training as they were new to the service. We observed the staff member working independently during our inspection. This placed people at risk of receiving unsafe care.

Robust recruitment checks were not completed before staff commenced employment. This placed people at risk of harm. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded following our inspection and confirmed all references had been validated.

● The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Communication about people was not always positive. Staff did not always use respectful language which people understood and responded well to. During our inspection we overheard inappropriate conversations between staff members about people, in front of people.
- Written records were not always respectful of people's equality and diversity needs. One person's care plan referred to them as having 'mood swings' and being 'aggressive' 'destructive' and 'hostile'. Another person's care plan stated they had been given additional support hours to 'get them the attention they display behaviour for.'

Respecting and promoting people's privacy, dignity and independence

- People did not always receive dignified care. For example, restraint records for people at the service stated staff 'ran into the room to hold [person] on their bed'. One relative shared, "When we arrive impromptu, [person] has been unclean in the communal area."
- People's privacy was not always promoted. Personal confidential information was not always kept securely. For example, we observed people's medicines administration records (MAR's) left unattended and visible from the corridor through the clinic room window.
- People's clothing was not always labelled. Staff told us they guessed whose clothes belonged to who based on the size of the clothing. This increased the risk of people being put in clothes that did not belong to them, impacting on their dignity.

Supporting people to express their views and be involved in making decisions about their care

- People's decisions about how they wanted their care and support delivered was not always respected. For example, one person's care records said they wished to have their medicine between 10 o'clock and 2 o'clock, but medicine records showed it was not always given between these times.

Communication about people was not always respectful. People's dignity was not always promoted. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action and investigated the concerns raised about language used by staff.

- We observed some examples of compassionate care during our inspection. This included holding hands when people were upset and spending time singing with people. One relative told us about the compassionate support staff have provided a person following a bereavement.

● Most relatives described long standing staff members as kind and caring. One said, "Some staff have been there a while and are brilliant. Two in particular go above and beyond."
● We observed people making day to day decisions about how they wished to spend their time. For example, one person showed us video's they liked to watch on their electronic tablet. Another person told us about how they liked to spend time in their bedroom with their pets.
● Staff supported people to maintain links with those that were important to them. Most relatives felt involved in people's care and support.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found the provider's governance arrangements were not always effectively operated to ensure proactive, timely service improvement and related decision making for people's care and safety. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

- Governance processes were not always effective in helping to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. The systems in place to ensure good governance of the care provided for people were not effective in identifying the risks found during our inspection.
- Where audits had identified actions, these were not always completed. An audit carried out by the provider had flagged areas for improvement. The registered manager told us they did not feel the audit was an accurate reflection and requested another audit was completed. Another audit was completed by someone else within the senior management team. However, this meant the actions identified within the first audit were not completed, such as reporting concerns to relevant professionals when people refused intervention. This concern remained during our inspection.
- There was no oversight of medicine errors within the service. During our inspection, we identified medicine errors which had not been reported or investigated. A lack of system to report, record and investigate medicine errors placed service users at risk of harm.
- Oversight of accidents and incidents within the service was not effective. Analysis was minimal, only recording number and type of incident. This meant identifying measures to implement and prevent re-occurrence or risk of harm were not identified, placing people at risk of further harm.
- Systems to ensure oversight were not embedded. A daily walkaround was introduced for senior staff to check the environment, staff practice and any risk to people, however this was not completed daily as required.
- The provider's medicine's policies did not provide service specific guidance about the safe handling of medicines. This meant staff did not have an appropriate medicines policy to refer to and follow, therefore medicines were not always handled safely.

The provider's failed to monitor the quality and safety of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● Whilst the service had positive working relationships with a range of professionals, further improvement was required to ensure timely referrals were made to health care professionals where required.
● The provider had been supported by commissioners but had not always made timely improvements based on their recommendations. This impacted on people's experience using the service, and their safety.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager was aware improvements were required to ensure documentation was completed so people received consistent person-centred care which promoted good outcomes. Alongside a new clinical lead, they told us plans were in place to ensure responsibilities to complete documentation were understood by staff. These were yet to be implemented.
● Despite the concerns identified at this inspection, feedback we received from people's relatives was generally positive. One relative said, "They are getting there I think." Another told us, "All seems fine, I am happy with everything."
● Long standing staff members knew people well. One relative said, "[Staff members] know [person] well and all their little quirks."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Some processes to support people to express their views and be involved in the running of the service had been implemented, such as a monthly one to one meeting with key workers for people who needed additional support to communicate their views. However, at the time of our inspection these systems were not consistently used. This meant people were not always provided with opportunities to express their views.
● People told us they were able to be involved in decisions about their personal spaces. One person showed us how they had decorated their bedroom and a relative told us how a person had chosen their bedroom colours.
● Staff felt engaged with the service. There were opportunities for staff to feedback and they told us they felt listened to and supported in their roles.
● The provider sought feedback from relatives. Relatives told us they were sent questionnaires. One relative told us they were able to share feedback informally with the service, "We keep in touch with staff, and with management if we think anything needs looking at."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of compliance with duty of candour. We spoke with relatives who told us they were informed when things went wrong and were satisfied with the response received. One told us, "Management are quick to let me know if there is a problem now, and they will try and resolve it."
● The registered manager acknowledged our concerns at the inspection and immediately took action to address these.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Language used about people was not always respectful. People's dignity was not always promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust checks to ensure staff were safe and suitable to work with vulnerable people were not completed. This placed people at risk of unsafe care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Fire risks to people had not been identified, regular fire safety checks were not completed. The home was not clean and well-maintained. Care records and risk assessments did not contain up to date and accurate information to support people safely. This placed people at risk of infection and at risk of harm.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes in place to record and review restraints were either not in place, not in line with best practice guidance or insufficient. This placed people at risk of being restrained unsafely, or unnecessarily.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to monitor risks were either not in place or not effective. Policies and procedures were not always location specific or followed. This placed people at risk of harm.

The enforcement action we took:

Notice of proposal