Best Care Limited

Ellesmere House

Inspection report

Church Hill
Ellesmere
Shropshire
SY12 0HB
Tel: 01691 623657
Website:

Date of inspection visit: 6 and 7 August 2014
Date of publication: 20/01/2015

Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service

This inspection was unannounced which meant the provider did not know we were coming. We conducted this inspection over two days.

Ellesmere House provides accommodation for up to 28 people who require personal care. On the day of our inspection 21 people were living at the home. Most of the people living at Ellesmere House were living with dementia.

The home was last inspected on 19 April 2013. At this inspection the requirements of the Health and Social Care Act 2008 were met.

Summary of findings

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

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

We found that people's safety was at risk of being compromised in some areas. The management of medicines was not ensuring people were protected against the risks associated with medicines.

We found the home's infection control procedures were not meeting the regulation. Hazardous substances and equipment used in the home were not stored safely and could cause harm to people.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. This includes when balancing autonomy and protection in relation to consent or refusal of care or treatments. The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This includes decisions about depriving people of their liberty so they get the care and treatment they need where there is no less restrictive way of achieving this. Under DoLS providers are required to submit applications to a supervisory body for authority to do this. Staff had little knowledge of MCA or DoLS. Staff also did not know how to support people when they could not make their own decisions. This meant that people could be at risk of not having their human rights met and the service not acting in accordance with the law.

Staff were supported in their roles. However, we found that not all staff had received training which would help them meet the needs of the people who had dementia.

Where people had not given consent to their own care and treatment, relatives had consented on their behalf. However, there was no evidence to say why these people had not given their own consent.

We found that the current systems for quality assurance were not driving improvements to the home. We also found concerns during our inspection which the registered manager had not identified. People and their relatives were not fully involved in giving their opinions about the home. Although, quality audits were completed and issues identified, there was little evidence that these findings contributed to improving the service the home provided.

We found that the registered manager had not informed the CQC of two deaths that had occurred in the last 12 months. By law the registered manager must complete statutory notifications and submit them to the CQC for specific events.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People's medicines were not managed safely and the effectiveness of some medicine was not being monitored.

People were not protected against the risk of infection.

Staff did not understand the requirements of MCA and DoLS.

Inadequate

Is the service effective?
The service was not consistently effective.

Not all staff had received training to help them understand how to support people with dementia.

People's health and nutritional needs were met and staff supported people in a way that promoted their independence and dignity.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Staff did not always communicate with people effectively.

Staff did not understand how to support people when they could not make their own decisions.

Staff treated people with kindness, compassion and dignity.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

Where consent had been given by relatives there was no evidence to say why they had made decisions on that person's behalf.

People and relatives felt comfortable about raising concerns and complaints with the registered manager.

Requires Improvement

Is the service well-led?
The service was not well-led.

Quality systems had identified but were not driving improvements in the home.

People were put at an increased risk of receiving inappropriate care due to the registered persons not effectively monitoring the quality of service provided at the home.

People's and visitors opinions were not actively sought by the provider to help develop and improve the service the home provided.

Inadequate

Ellesmere House

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

The inspection team consisted of one inspector.

Prior to this inspection we looked at the provider information return (PIR). This document was requested from the provider and gave us their interpretation and evidence about how they were meeting the five questions. The five questions are, is the service safe, effective, caring, responsive and well-led?

Before our inspection we looked at statutory notifications and found that none had been recently submitted by the registered manager. By law the provider or registered manager must notify CQC of certain events, these are called statutory notifications. We spoke with the infection prevention and control nurse from the local NHS Clinical Commissioning Group and a contracts officer at Shropshire County Council. We used this information to help us plan our inspection of the home.

During our inspection we used the Short Observational Framework for Inspection (SOFI) because some people were unable to talk with us. SOFI is a specific way of observing care to help us understand the experience of people living at Ellesmere House.

During our inspection we spoke with one person who used the service and two relatives. We spoke with six staff and the registered manager. We also looked at four care records which included the assessment of people's needs, risk assessment and consent to care. We looked at records relating to the management of the home which included three staff files, medication records, audits and policies.

Is the service safe?

Our findings

We looked at how the home managed their medicines. We did this because the registered manager had stated on the provider information return that the home administered controlled medicines. A controlled medicine is a medicine that has extra security procedures in place.

We found that people's medicines were not managed safely. The registered manager told us the amount of medicine people received from the pharmacy was not recorded in their medicine records. Because of this we could not check whether the amount of medicine the service kept was correct. The registered manager informed us that no medicine audits or checks were completed. We saw one person's medicine was not stored safely and tablets had become free of their packaging. The tablets were at risk of contamination. We asked a staff member to take action and remove them. We also informed the registered manager of what we had seen. When we returned the next day we saw the tablets had been left as we had found them. This meant the registered manager had failed to take action to reduce the risk of harm to the person.

When we completed a check of the home's controlled medicines we found that two tablets were unaccounted for. A staff member and the registered manager could not tell us when these tablets went missing or why they were unaccounted for. The registered manager told us that no checks were completed by staff on any medicines held in the home.

We found some controlled medicines stored that had not been given to people for a year. These were PRN medicines. A PRN medicine is a medicine that is prescribed to be taken as and when needed. The registered manager told us that this was because people did not need these medicines anymore. They also told us they had not arranged for these medicines to be returned to the pharmacy even though they were no longer needed. We spoke with a staff member about how these medicines were managed and their effects monitored. They were unable to give us this information. This meant there was a risk that people's need for medicine was not being monitored effectively.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to our inspection an infection prevention and control (IPC) audit had been carried out by the local NHS clinical commissioning group (CCG) on 7 July 2014. The audit had advised the provider of a number of actions they needed to take to improve their infection control procedures. Some of these actions had been addressed prior to our inspection.

In the laundry room we found nine commode pots were stacked on the floor. These were visibly stained and at least two had an unidentified substance around the rim. Out of the nine commode pots only three had handles. Next to the commode pots an airer with clean clothes drying on it was touching these pots. Wet mops were found standing in buckets which meant they were unable to dry effectively. This meant storage arrangements were not in line with current best practice and posed an increased risk of harm to people who used the service.

We looked at how the service stored its hazardous substances such as cleaning products. We found a large store room which had no lock on the door and people living at the home could enter this room unrestricted. This meant the home was putting people at risk by not storing hazardous substances in line with current safe practice.

The registered manager told us they were implementing a new cleaning schedule a result of feedback given from the CCG visit. This would provide clearer information on the cleaning tasks that had been completed in the home. This was not in place at the time of our inspection. We found the current cleaning schedule that was in use was not providing enough information on how the home was cleaned effectively.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that no person living at Ellesmere House was being deprived of their liberty and they had made no applications to the local authority to do this. We spoke with four staff about their understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Only one member of staff understood what MCA was and none of them could explain what DoLS was. The purpose of the MCA and DoLS is to protect people who cannot make their own informed decisions to ensure they are not being deprived of their liberty by being restricted. This is especially important in

Is the service safe?

caring for people living with dementia who may not be able to make their own decisions. This meant there was a risk that staff may not act appropriately because they did not understand the legislation or how to put it into practice.

We spoke with one person who told us they felt safe living at Ellesmere House. They told us that staff knew what they were doing and they felt safe in their care. All staff we spoke with understood how to keep people safe and protect them from abuse. Although most staff had received training in safeguarding some staff we spoke with did not know who they could report concerns to outside of the home. This meant that if staff were not happy with the way the provider was dealing with their concerns they did not know who to speak with outside of the home to ensure people were protected.

Risks to people had been assessed and identified. This included risks associated with their mobility, nutrition and their risk of developing pressure sores. We saw plans in place for staff to follow. Staff we spoke with understood how to support and protect people where risks had been identified. Staff understood their responsibilities in relation to concerns they had about people's safety and to report this to the registered manager.

People were cared for by sufficient numbers of staff. We observed that the number of staff working were able to meet people's needs throughout our inspection. Staff told us they were happy with staffing levels and felt there were enough staff working on each shift to meet people's needs. One senior and three care staff were present during the day. The registered manager told us this was in line with their agreed staffing levels. The registered manager told us that three members of staff lived on site and could be called on to work if needed. They also explained that in the event of a person requiring more support, staffing levels would be reviewed and staff numbers increased if needed.

Is the service effective?

Our findings

All the staff we spoke with told us they felt supported by the registered manager. Support they received was through one to one meetings with the registered manager and team meetings. They told us they felt able to raise any concerns with the registered manager and they felt listened to. Staff were given the opportunity to gain professional qualifications and two staff told us they were currently completing their health and social care diploma.

We found that although staff had access to training, most staff had not received training that was specific to the people they cared for. Staff and the registered manager told us that most of the people who used the service had dementia. We found that although staff supported people who had dementia, they had little or no training in how to do this. Out of 15 care staff four had training in dementia awareness and three in Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had little understanding of how to ensure people's rights and wishes were respected if they could not make their own decisions. This meant that staff may not have the knowledge and skills to meet people's dementia needs.

We observed that people were supported to eat their meals either in the dining room or in the lounge and were given a choice of where to eat. Cutlery and aids were provided which helped people maintain their independence when eating and drinking. We observed care staff supporting people to eat and this was done with dignity and at the person's own pace.

When one person said they didn't want any lunch we observed a staff member spend time with them to offer other choices. After discussion with the person it was agreed they would try a smaller portion. This showed that the staff member had helped this person to be involved in making their own decision and listened to their views.

We spoke with the cook about the menus they provided. They said, "I cook what they (people who used the service) like to eat". They told us they varied the menu and provided a choice of meals every day. Food was ordered fresh up to three times a week which meant people received fresh fruit and vegetables. We looked at planned menus and saw food provided was nutritious and varied. The cook told us there were some people on diabetic diets. We discussed what food was provided for them and found these people were appropriately catered for.

When we spoke with staff they told us that people's health needs were met with visits from other health professionals. This included doctors, district nurses and chiropodists. This was confirmed by one person we spoke with. We asked this person whether they had access to the doctor or chiropodist when they needed it. This person said, "I only have to ask and it will be organised".

However, we found that following visits from health professionals people's care records were not updated. We found that one person had been seen by a district nurse and staff had identified a change to the person's care needs. This person's care record had not been updated to reflect this. When we spoke with the registered manager about this they told us that people's health changes were not recorded in their care records, only in a communication book. This meant that people's care records may not reflect their health needs or changes to their plan of care. Also that staff may not be aware of changes in a person's needs or following people's most up to date plan of care.

Is the service caring?

Our findings

We used our SOFI observation tool to observe how staff interacted and engaged with people. We observed that staff treated people with respect and dignity. They offered choice to people and spoke to them in a way that showed compassion and care.

We observed that people's needs were met in a timely manner. We saw that people were not kept waiting and they received support when they needed it, for example, for eating and drinking. This meant that staff had enough time to support people.

Most staff communicated effectively with people and maintained eye contact when they spoke with them. We observed that staff had a good rapport with some people but did not communicate well with all people. On one occasion we observed that a staff member's comment had not been understood by a person and they looked confused by what was said. The staff member left the lounge without offering any explanation to this person to ensure they understood what was said.

We observed that there was always one member of staff present in the lounge. However, for most of the time they sat at the far end of the lounge under the television set and did not communicate with any one. The registered manager told us that they always tried to have one member of staff present in the lounge. We saw that when people wanted to leave the lounge the staff questioned them about why they wanted to leave but they were not stopped from leaving. This meant there could be a risk that people's freedom to go where they wanted could be restricted.

Staff we spoke with understood how to support people to make day to day decisions relating to food, clothes, personal care and activities. Most staff had little knowledge on what they would do if people could not make their own decisions and how they would support them. This meant there was a risk that staff may not seek people's views and act on their decisions.

One relative we spoke with told us that staff always kept them updated on how their relative was. We saw that people and families were involved in people's care with regards to identifying their preferences and choices. This included whether they wanted a male or female carer and their preferences for music, TV and food. However, we saw some records where relatives had made decisions about people's care but it was not clear why they had done this. This meant that although people's individual needs were assessed, people may not always be involved in expressing their views about their own care and support.

Staff we spoke with understood the needs of the people they cared for. When they spoke about people they spoke with respect. Staff told us how they respected people's equality and diversity by offering choice and respecting their wishes.

Is the service responsive?

Our findings

We saw that some records relating to consent and people's capacity to make informed decisions were not consistent. One person had a 'do not resuscitate' order in place. This had been signed by a doctor and the person's relative even though the person had capacity to make their own decisions. We saw other records where decisions had been made by doctors and relatives but the person's care records indicated that they had the capacity to make their own decisions. People's capacity had not been assessed to clarify what decisions they could make and what they were able to give consent to. We spoke with the registered manager about this. They told us they were not aware of these inconsistencies in people's records. One staff member told us that all the people living at the home could make their own decisions. Other staff we spoke with were not able to tell us with any certainty who could make their own decisions.

We saw other records relating to consent which had been signed by people's relatives, such as consent to staff giving them their medicines and how their care was to be delivered. We found nothing in these records to indicate that these people could not agree and consent to their own care. This meant there was a risk that people's wishes may not be sought or respected and they may receive inappropriate care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with one person about what hobbies and interests they were encouraged to be involved in. They told us that staff played board games, bingo and dominoes with them. They said, "I have enough to do if I want to". We observed staff playing board games with two people. During our observations we saw that people who fell asleep in their chairs were left to sleep. Most people were not offered choices or encouraged to identify what they would like to do with their time to keep them stimulated or enhance their lives.

Relatives we spoke with told us staff supported them to maintain their relationships with their family members. They told us staff were friendly and 'looked after them' when they visited, offering them refreshments and respecting their privacy.

We spoke with one person and one relative who both told us they would feel comfortable raising concerns or complaints with staff. One relative told us they had not needed to make any complaints but had spoken to the registered manner about a concern they had. They told us they were happy with how the concern had been dealt with.

We saw in the reception area of home there was information available for people and visitors, informing them about how they could complain and who to. The person and relative we spoke with told us that they knew this information was available. They told us they would feel confident to follow the complaints procedure but would prefer to speak directly to the registered manager.

Staff we spoke with told us that if people or relatives wanted to raise concerns they would ask the registered manager to speak with them or pass on their concerns on their behalf. On the provider information return the registered manager stated that they had not received any complaints in the last 12 months. This was confirmed with the registered manager at our inspection.

Is the service well-led?

Our findings

The registered manager had identified a number of areas for improvement on the provider information return (PIR) they had sent to us. However, during our inspection we saw little evidence of these improvements being made or in progress. In the PIR the registered manager had stated a senior manager had completed two quality visits in the last 12 months and reports and actions were produced as a result of this. When we asked to look at these reports they told us they did not have them. The registered manager told us about plans they and the provider had to make improvements in the home. These were also identified on the PIR. At the time of our inspection we saw no evidence to suggest these plans were in progress. We found the lack of action by the provider and registered manager on areas they had already identified as needing improvement was placing people at risk.

We found that the current systems for quality assurance were not driving improvements to the home. Monthly audits were conducted by the registered manager and sent to the provider for action. These audits were for health and safety, the kitchen area, infection control and the meal service. They also completed a weekly 'walk through' inspection of the home to identify work required and maintenance repairs. The registered manager told us they spoke with the providers each week to raise concerns and issues with them but 'little got done as a result'. The registered manager could provide no evidence of actions completed as a result of these audits.

We found there were no effective systems in place to ensure the safe management of medicines including controlled and PRN medicines. The registered manager told us the only audit completed on medicines was by their pharmacy every six months. No checks were completed by the registered manager on quantities of medicines held or their effectiveness in meeting people's needs.

We found the provider's systems did not protect people from the risks that could arise from inappropriate standards of cleanliness and hygiene. Since the visit from the CCG the provider had appointed an Infection Prevention and Control (IPC) Lead but they had not yet assumed responsibility for the role. An IPC Lead is a person that is responsible for the service's infection prevention and control management and structure. The registered manager told us that they and the provider were aware of the concerns raised by the CCG but we saw little action taken as a result of this visit.

Throughout our inspection we identified concerns in other areas which showed a lack of effective management systems, for example records relating to changes in people's care needs and obtaining people's consent. This meant people may be at risk of unsafe or inappropriate care because there were no effective monitoring systems in place.

The registered manager was aware that all policies in the home were out of date. We saw policies which had not been updated since 2007 and made reference to legislation which had been replaced. We were told by the registered manager that it was the provider who wrote and issued these policies. In the PIR the registered manager had identified this as an area for improvement but we saw no evidence to show these were in the process of being updated. This meant there was a risk that staff and the registered manager were not following up to date policy guidance, legislation or best practice guidelines.

We found that people and their relatives were not fully involved in developing the service the home provided. The registered manager told us they spoke with relatives when they visited so they had the opportunity to make comments or raise concerns. Comment cards were kept by the front door for visitors to complete but we saw no evidence of how this feedback from concerns, complaints or comments was used to help develop the service provided. The registered manager told us they planned to introduce resident meetings and questionnaires as this had not been done previously.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager had stated on their PIR that two people had passed away in the last 12 months. At our inspection the registered manager told us that one of these deaths had been investigated by the local adult safeguarding team. The allegation of abuse was unsubstantiated following investigation. By law the provider or registered manager must notify CQC of certain events, these are called statutory notifications. CQC had not received any statutory notifications of these deaths or the associated safeguarding investigation. The registered

Is the service well-led?

manager told us they were aware CQC should have been notified. They told us the reason for not sending these notifications to CQC was due to computer issues, which had been resolved. This meant that the registered manager was not acting in accordance with their legal responsibilities.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us the culture of the home was to create a 'homely environment' for people. One staff said, "It is a homely home. We support each other. Residents are happy and we all get along". Other staff members we spoke with confirmed that staff worked well as a team. Staff told us they felt supported by the registered manager and had confidence in them dealing with any poor practice or concerns they had.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers There were no effective systems in place to regularly assess and monitor the quality of the service provided. The provider was not taking action on improvements that had been identified. Regulation 10 (1) (a) (b), (2) (a) (b) (111) (iv) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People, staff and others were not protected against the risk of infection because there were no effective systems in operation. Regulation 12 (1) (a) (b) (c), (2) (c) (i) (ii) (iii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Although arrangements were in place for obtaining consent not all people had consented to their care and treatment. Where relatives had consented on a person's behalf there was no evidence to show why this had been done. Regulation 18.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider had not notified the Commission without delay of the death of a service user. Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 (1) (a) (b) (3))