Care Quality Commission

Eldercare (Halifax) Limited

Elm Royd Nursing Home

Inspection report

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Ratings

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

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We inspected Elm Royd Nursing Home on 29 and 30 October 2015 and the visit was unannounced. Our last inspection took place on 6 August 2014 and found breaches of regulations in regard to staffing numbers and staff support and lack of effective quality monitoring.

Elm Royd Nursing Home is registered to provide nursing and residential care to up to 50 older people and people who may be living with dementia. This included seven intermediate care beds. These places were commissioned by the Calderdale Clinical Commissioning Group (CCG) and used to provide people with additional support on discharge from hospital, before they could return home; or sometimes as an alternative to a hospital admission. An external multidisciplinary team which included occupational therapists, physiotherapists and nursing staff were involved in supporting these placements.

Summary of findings

On the day of our visit there were 34 people using the service. This included three people receiving intermediate care.

There has not been a registered manager at the service in September 2013. The manager at the time of our visit had only been in employment at the service for one week. They told us they would be applying for registration with the Care Quality Commission. 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.

Staff had failed to recognise and report incidents within the home that could put people at risk. There were not enough staff available to maintain people's safety and staff did not have an awareness of the detail in people's care plans to make sure that the care they delivered was safe. The majority of staff had received training in safeguarding but this was not being out into practice. Accidents and incidents were not being monitored effectively. Systems for managing medicines in the home were not safe. There were some risk assessment in place and people who lived at the home had personal emergency evacuation plans in place. Systems for managing the spread of infection in the home were not always followed. We made safeguarding alerts in respect of four people living at the home following our first day of inspection and the manager of the home made a further four alerts.

Not all of the staff working at the home had received the induction and training they needed to do their jobs effectively. Agency nurses had not been adequately inducted and did not have an adequate understanding of people's needs. Staff were not working within the requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards and we had concerns that some people may have been unlawfully deprived of their liberty. Some of the people living at the home told us the food was good. However, people who needed support with eating and drinking and in maintaining good nutrition were not always getting the support they needed. Systems were in place to access community health care professionals as needed but we saw the advice they gave was not always followed.

There was little to support the needs of people living with dementia within the environment.

We witnessed some caring interventions but these were not consistent and staff frequently failed to recognise people's dignity and privacy needs.

Care plans had been developed with a person centred approach but this was not being continued into care practice. Staff were unaware of the content of care plans and we did not see staff refer to them during the two days of our inspection. One member of staff told us they had never seen a care plan.

We saw some activities being offered to people, mostly by the activities co-ordinator. However for people who were unable or did not choose to engage in the planned activity there was little to occupy or stimulate them.

Complaints made to the service were not managed in line with the complaints policy.

There was a lack of leadership within the home and audits of quality of service were not robust or effective. Environmental safety checks were up to date but staff had not reported potential safety problems such as the tipping of a hoist or exposed wiring in one of the bedrooms.

There was no auditing of complaints or accidents.

The provider had failed to make sure that notifiable incidents within the service had been reported as required.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 were not kept safe as there were not enough staff with the right skill mix who knew how to meet people's individual needs. Safeguarding incidents were not always recognised or reported.

Medicines management was not safe.

Care was not always delivered safely.

Inadequate

Is the service effective?
The service was not effective.

People's weight and nutritional and hydration needs were not monitored effectively, which placed people at risk of not receiving sufficient quantities of food and drink to maintain their health.

Staff lacked knowledge in how to meet their needs. Mandatory training had not been undertaken by some staff and was overdue for others. Induction for new staff was not thorough. Agency staff did not receive adequate induction.

Mental capacity assessments had not been made and Deprivation of Liberty Safeguards (DoLS) authorisations for people who may have been deprived of their liberty had not been sought.

People had access to healthcare services but staff did not always follow professional advice.

Inadequate

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

We witnessed some caring interventions but these were not consistent and staff frequently failed to recognise people's dignity and privacy needs.

We saw some indication that close relatives or advocates had been involved in constructing and reviewing care plans. However this was not consistent in all of the care records we looked at.

Requires improvement

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

Care was always delivered to meet people's individual needs.

Activities were provided however these benefitted only some of the people and others had little or no access to meaningful activities or social engagement.

Complaints were not managed.

Requires improvement

Summary of findings

Is the service well-led?

The service was not well led.

There was no registered manager. There was a lack of leadership and poor quality assurance systems meant people did not receive safe care.

Systems were in place to monitor the safety of the environment but there was some slippage in this area.

Requires improvement

Elm Royd Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 29 and 30 October 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who looked at medicine management and Mental Capacity Act (MCA) along with Deprivation of Liberty Safeguards (DoLS).

Our last inspection took place on 6 August 2014 and found breaches of regulations in regard to staffing numbers and staff support and lack of effective quality monitoring.

Before the inspection we reviewed the information we held about the home. This included information from the provider, the local authority contracts and safeguarding teams and the clinical commissioning group (CCG). On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

On the day of our inspection we spoke with eight people who lived at Elm Royd Nursing Home, three people who were visiting their relatives, 14 members of staff, the acting manager and the regional manager.

Some of the people we spoke with had complex care needs and were not able to express their views to us. We therefore spent time observing care in the dining room and lounges to help us understand the experience of all of the people living at the home

Inadequate

Is the service safe?

Our findings

We spoke with two people who were receiving care in the intermediate care unit of the home who both told us they felt safe at the home. However we found evidence of a number of situations in which people's safety was put at risk.

One person told us one of the other people living at Elm Royd Nursing Home regularly came into their bedroom, uninvited. They said the person opened their drawers and wardrobe and had also opened the door to the en-suite when they were on the toilet. They told us they had reported this to one of the nurses and had been told, "(Name) can't help it." Whilst we were sitting in the person's bedroom with them the person they had told us about came into the bedroom in a state of undress. This was an undignified, inappropriate and unsafe situation for both people.

We spoke with a visitor who said their relation had also been disturbed by the person coming into their room, closing their curtains and turning the light off. They told us they had initially addressed this with staff who said the person did the same to other people living at the home but they just said hello when the person entered their room. The person we spoke with was concerned because their relation was not able call for help or to turn their light back on and staff did not appear to recognise this as an issue. The person told us they had also spoken about their concerns with the area manager.

We saw the person who went into other people's bedrooms had an alarm on their bedroom door, which when switched on would alert staff they had come out of their bedroom. We saw the alarm was in the off position and could not have been switched on earlier in the morning as the buzzer did not sound when this person left their room and entered another person's bedroom. We tested the alarm and found it was in working order. This meant by the buzzer not being on staff had failed to protect this individual and other people living in the home.

We spoke with the area manager about this who told us that they had spoken with the clinical lead for the home who had said they were unaware of the situation with the person entering other people's rooms. However, we saw written incident reports of the person becoming involved in physical altercations with a person whose room they had entered which had been signed as seen by the clinical lead. We also saw several care records which detailed that the person had been going into other people's rooms. When we spoke to staff about this they said it happened frequently and they had reported it to the clinical lead. The area manager said they had not referred the matter to safeguarding but would do so after speaking with us.

We looked at accident and incident records and saw that whilst they were being recorded, they had not been analysed or managed to promote people's safety. For example we saw an accident report which said that a hoist had tipped over whilst a person was using it. The person using the hoist was not reported to have suffered any injuries but the report shows both staff involved sustained minor injuries in supporting the hoist and the service user. This was a serious incident which required immediate investigation. When we asked staff about this they said they thought the hoist had been taken out of use for a time. We spoke with the manager and the area manager about this. Both said they had not been made aware of the incident and the area manager said there had not been any maintenance checks of the hoist made. This incident had not been referred to safeguarding.

One person told us there was one member of staff they did not like and described them as abrupt and nasty. They also said the same member of staff had threatened to 'slap' them one night when they were assisting them to bed. The same person said they had told one of the nurses about this incident. We asked the nurse who said the individual had told them the member of staff was 'unfriendly' and they had said they would keep an eye on them. This incident had not been referred to safeguarding.

We spoke with a member of staff who told us that an agency carer had supported a person to use the hoist without another member of staff present. This practice could put the person at risk. The member of staff said they had reported the incident to the clinical lead. Again the incident had not been referred to safeguarding.

Failure to recognise and report these incidents was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

When we spoke to staff about safeguarding they were all able to tell us about what their responsibilities were in keeping people safe and we saw that the majority of staff were up to date with safeguarding training.

Inadequate

Is the service safe?

We made three safeguarding referrals following the first day of our inspection and the manager confirmed to us, following the inspection, that they had made a further four safeguarding referrals.

When we spoke to staff about safe use of hoists and hoist slings one staff member said they did not know which sling should be used for which person, they said "I just go on the size of the person." When we asked if the information about hoists and slings was in people's care plans, the staff member said "I've never seen a care plan."

This meant that people were being put at risk of unsafe moving and handling and use of equipment.

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

When we inspected Elm Royd in August 2014 we said that people's needs were not being met because staff were not responding in a timely way or there were not enough staff available. We said that improvements must be made

On this inspection we saw that staffing levels were arranged at nine care assistants and two nurses during the day. Staff were deployed to different areas of the home with one nurse for each of the two floors. The manager generally worked office hours during the week as did the home's administrator. The care team were supported by cleaning and kitchen staff and a person was employed to engage people in activities.

We saw that care staff were very busy and one's we spoke with said they struggled to meet people's needs in a timely manner. We observed long periods in lounge areas where staff were not available. We had to call for staff to assist on two occasions because people who lived at the home needed assistance and on another occasion had to offer reassurance to a person who had become distressed. On one occasion we pressed the call bell in a person's bedroom because we had found them to be in a state which required immediate attention from staff. After ten minutes one of the inspectors went to look for staff. They found a member of staff sitting immediately beneath the digital call bell information display which was showing the call bell had been activated. The member of staff did not respond to the call and we had to ask for someone to come to assist the person.

One person told us that staff were slow to respond when they pressed their call bell. We looked at some of the response times detailed on the electronic monitoring system for call bell response times and saw responses in excess of 8 minutes for that day. This meant that people could be put at risk because staff were slow to respond. We also found that some staff were unfamiliar with and had not been shown how to use the call system.

When we spoke with the area manager they told us that although staffing had been organised as a result of people's dependency assessments, the size and layout of the building had not been considered and they recognised that staff were not available to people as needed.

This was a breach of the Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for three staff members. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. We spoke with two members of staff who had recently commenced employment who told us they had not had any induction into their roles.

We found a number of issues in relation to infection control around the home. For example, a pressure cushion heavily soiled with faecal matter was left in a lounge area for several hours despite staff being in and out of the room at various intervals. This was only removed when we brought it to the attention of the area manager. We saw soiled and wet bedding on the floor in two people's bedrooms and found one person's ensuite to be heavily soiled with faeces. This was despite a member of care staff sitting in the person's room with them.

We found a toilet frame to have holes and tears in the plastic covering which meant the frame could not be adequately cleaned.

We also found a lack of appropriate toiletries in many people's bedrooms. When we asked staff how these people would have been supported to wash, they were unable to tell us.

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

Inadequate

Is the service safe?

Although we found some environmental safety measures had been put in place such as window restrictors and fire safety equipment, we found issues with the environment that could put people at risk. One person told us, "The carpet between my bedroom and bathroom is loose I have told them about it since I came in but they haven't done anything about it. My Zimmer frame gets caught on it." We looked in this person's bedroom and saw the carpet was coming out of the gripper and presenting a trip hazard. When we looked in this person's care plan we saw they had been assessed as being at high risk of falls. This meant no action had been taken to reduce the risk of this person tripping over the defective carpet.

In the lounge, we saw that because of the way furniture had been arranged, one person had to lift their walking frame above the height of the chairs in order to manoeuvre through the gap to leave the room. This was unsafe and could have caused them to fall.

In a bedroom we saw the plug sockets had come off the wall and tape had been used to try to secure them. This had not worked and the wiring to the sockets was exposed.

This was a breach of the Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service used recognised assessment tools for looking at care issues such as nutrition and tissue integrity and noted that, in some instances these risk assessments had been used to good effect. We also saw that people had personal emergency evacuation plans in place.

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We looked at medication storage and administration procedures at the service. We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw that all oral medicines were dispensed to the home in boxes or bottles to individual people.

However we saw the storage of medicines in the downstairs fridge were not secure. The fridge stored topical preparations and three bottles of liquid medicine. The fridge was kept in the downstairs lounge area with free access to people in that area. We saw the fridge remained unlocked throughout the morning despite the nurse accessing it on several occasions. We saw that storage of controlled drugs (CD's) was safe and that drug refrigerator temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures.

We saw that medicines were not always administered as per the prescribers' instruction. For example medicines to be administered before food were not being given as prescribed. On two occasions we saw a medicine administered after food when it should have been administered 30 to 60 minutes before food. We challenged the nurse before a third person was administered this medicine inappropriately. The nurse sought advice from a Community Matron who advised the medicine should be withheld until 30 to 60 minutes before lunch for all other people who were prescribed the medicine.

We saw as required (PRN) medicines were not supported by written instructions which described situations and presentations where PRN medicines could be given. Furthermore the recording of PRN medicines as required by the codes on the medication administration record (MAR) sheet were not being followed. For example, when PRN medicines were not required a letter 'N' was used to record the event, however the code on the MAR sheet defined the letter 'N' should be used if the person was nauseous. The MAR sheets therefore gave the appearance that many people were experiencing nausea. This had not been recognised as an issue.

During both days of our inspection we found that some people's medicines had run out. This included medicines which were essential to maintaining people's health. We noted that this had not been resolved by the end of our second day of inspection. This meant some people were not receiving their prescribed medicines.

We also found medicines in the trolley with no available MAR sheet. We found one person had been prescribed a cream to be administered twice daily. The cream had been dispensed and opened over five weeks before our inspection but visual inspection of the tube indicated negligible use of the cream. There was no MAR sheet for the preceding four weeks and no MAR sheet for the forthcoming cycle. The registered nurse told us they had no knowledge this preparation was required. We saw that the person's care plan detailed this cream with clear instructions as to when and where it had to be applied. The care plan recorded the medicine had been applied on only

Inadequate

Is the service safe?

two days. A pump dispenser of another cream dispensed to the same person at the same time appeared to be unused. We could find no record of its use either on a MAR sheet or in the care records.

On the second day of the inspection we found one person without a current MAR sheet although a MAR sheet had been in use with prescribed medicines on the previous 28 day cycle.

We carried out a random sample of 12 supplied medicines dispensed in individual boxes. We found that on all occasions the stock levels of the medicines did not concur with amounts recorded as received and administered on the MAR sheet.

We were told three people received their medicines covertly. This means the medicine was disguised, usually in food, so that the person did not know they were taking it. Covert administration of medicines must be done in accordance with the main principles of the Mental Capacity Act 2005 but we found this was not the case. In addition, we observed that where specific instructions were in place for covert administration, these were not being followed.

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

We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We looked at prescription sheets to see if medicines were used inappropriately to control people's behavioural issues. In discussion with the nursing staff and the scrutiny of the MAR sheets we were assured that use of these medicines was not the preferred method of addressing challenging behaviours.

Inadequate

Is the service effective?

Our findings

When we inspected this service in August 2014 we found that staff were not being provided with a formal support system to look at their individual practice and professional development. We said that improvements were needed. On this inspection all of the staff we spoke with confirmed that they had received supervision. The clinical lead told us that arrangements had been put in place for staff to receive supervision from their immediate senior rather than the manager conducting all supervisions.

When we looked at training records we saw that not all of the staff had received appropriate training. For example, the training matrix showed that six people, including one of the clinical leads had not received moving and handling (or safer people handling) training at all. We had observed two of these staff moving and handling people without supervision during our inspection. We also noted that one of the staff involved in a moving and handling incident using the hoist, had not had any training at all in this and the other person had not received updated training in the time schedule indicated on the training matrix.

We saw that of the staff who had received the training, eighteen were overdue for updates. The training matrix detailed that staff had not received, or were not up to date with other areas of training including fire safety, health and safety and nutrition and hydration. In addition, despite the service offering care to people living with dementia, less than half of the care and nursing staff had up to date training in this area. Not all staff, including the two clinical leads, had received training in safeguarding vulnerable adults.

We spoke with two new staff about their induction to the service. Both said they had not followed any induction programme and we were unable to find reference to induction, other than basic personnel details, in their files. One of the clinical leads also told us they had not received any induction. We saw that staff were unfamiliar with and unsure how to use the call bell system. This would be a basic requirement of an effective induction.

We saw that a large number of agency staff were being used at the home, this included agency nurses. Our observations of nursing practice showed that agency staff had not been adequately inducted and did not have an adequate understanding of people's needs. For example, the nurse had not looked at care plans for a person who was receiving covert medication and as such did not have the knowledge to comply with the pharmacist's instructions.

This was a breach of the Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When we inspected Elm Royd in August 2014 we raised some concerns in relation to how they could make sure that people living at the home were not unlawfully deprived of their liberty. The manager at that time said they were to look at the principles of the mental capacity act and work with the local safeguarding team.

At the beginning of this inspection the clinical lead told us that none of the people living at the home were subject to DoLS. We looked at the files of four people who had been diagnosed with dementia who demonstrated a significant degree of cognitive impairment. We could find no evidence of decision specific mental capacity assessments even though some care plans stated the person was lacking capacity.

We noted the provider had in place a number of methods which may constitute a deprivation of liberty. The front door was locked; internal doors within the building and the passenger lift were restricting free movement due to the use of digital locks with the code numbers unknown to

people. Sensor mats were available to alert staff if a person was vacating their bed. The main staircase was guarded by a gate to discourage access and we observed five bedroom doors were alarmed to alert staff if people were leaving their room. We had also noted the use of covert administration of medicines for three people without the proper assessments and safeguards being in place.

We were concerned these accumulations of restrictions being experienced by some people may amount to unauthorised deprivation of their liberty. We saw one person was being cared for on a one to one basis. Whilst the person was free to walk around the ground floor of the home their carer remained by their side and as such the provider was exercising complete and effective control over this person's care and movements. We had further concerns that other people were under continuous supervision and control and may not be free to leave. However there was no evidence to suggest people would be stopped from leaving should they choose to do so.

The manager assured us they would commence the process to assess the levels of restrictions people were subject to and take appropriate action to comply with the needs of the Mental Capacity Act 2005.

Whilst we saw some documentation in place for appropriate use of bedrails one person we spoke with had a profiling bed and they told us staff put the bed rails up at night, but they had asked them not to. The person did not want the bedrails on. We looked in their care plan it stated, "(Name) is prone to falling when in bed so their bed rails and bumpers need to be in situ when they are in bed." The person told us that because of the bedrails they were unable to get out of bed to use the toilet. We asked the nurse where the risk assessment was regarding the bedrails and they told us it should be in the care plan, but when they looked they could not find it. There were no accident reports of this person falling out of bed and there was no evidence to support the statement in the care plan about them falling out of bed. This meant bed rails were being used against the person's wishes. We also saw in one person's care records, that they had been "restrained" on two occasions. There were no incident reports relating to this and the restraints had not been reported.

This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager about the use of restraint which included the use of bed-rails. The manager demonstrated a good understanding of how inappropriate use of bed-rails may constitute unlawful restraint.

Two people who lived at the home told us that the food they received was good and we observed that the food served to people in the dining room looked hot and appetising. People in the dining room also had access to condiments and serviettes.

On the first day of our inspection we observed the serving of the lunchtime meal in the upstairs lounge. Meals were delivered to the lounge on an unheated trolley with a sheet of tinfoil over the meals. We observed twelve meals delivered on this trolley, the meals were for people in the lounge and people in their own rooms. No drinks were available on the trolley and people were not offered a drink with their meal.

We saw that a number of these meals had been pureed with each component pureed and served separately. This helps people who need to have their meal pureed to taste the individual components of the meal. We heard the care assistant instruct an agency care assistant to mix the food together before assisting one of the people in the lounge to eat. We asked the care assistant why they would mix the meal together. They said that it made it easier for the person to eat as it could be quite dry. There was no gravy available to add moisture to the meal. We asked the carer who had told them to serve meals in this way, they said they had never been given any advice about serving meals and said "We just have to do what we think." The care assistant went to say, referring to the agency member of staff "It's hard when you are left with someone who has only worked here a couple of times."

We observed the agency member of staff assist a person with their food, they did not speak to the person throughout the time they were assisting them and when food was spilled on the person's chin, they did not wipe it clean. We observed the same practice with two other people in the room.

We saw staff scraped the leftovers of people's meals into a container which had been placed on the floor in view of people still eating their meals.

Inadequate

Is the service effective?

Forty minutes after the meals were delivered to the room; staff were taking meals to people, when we asked staff to check if the meals were still warm, we found they were cold. Staff warmed the meals up in a microwave but only did this after our intervention.

On the second day of our inspection we saw two people had been served their meals in one of the downstairs lounges. Both people had their meals placed on small tables which they struggled to reach and therefore were spilling their food on their clothing and on the floor. One person who had appeared to enjoy the food they were able to pick up said "Oh I give up" and stopped trying to eat the meal. No staff were in attendance in the room. We asked the person if we could get help for them and they said "Well it's cold anyway." When staff did come to the room we told them what had happened and the staff member did offer to get the person another meal which they declined. We also saw some people struggle with their meals in the dining room, although some staff were in the room supporting other people, there was not sufficient support for all the people who needed it and we saw people did not get their full meals due to spilling large amounts.

We spoke with the chef who told us they aware of which people needed special diets and told us that they fortified the food served with cream, butter and yoghurt.

We looked at the care file for a person who staff had told us was at risk nutritionally. We saw from the care records that the person has been assessed as being at high risk of pressure damage and at high risk nutritionally. The care plan said that the person needed to have snacks throughout the day and a fortified diet. We observed the serving of drinks to this person during the morning and afternoon of the first day of our inspection and did not see the person being offered any snacks at all. We saw that this person had been assessed as needing to have their daily food and fluid intake recorded. We looked at the food and fluid intake charts for this person for the seven days prior to our inspection. There were no snacks recorded as being offered during that time and only three records of supper being offered. On one day no intake had been recorded at all. There was no overview of the daily charts. This meant that this person was not receiving the care their assessments and care plans had indicated they needed and there was no system in place to review their nutritional intake.

We looked at this person's weight records which showed unusually high weight losses and gains. For example the person was recorded as having gained eight kilograms in one month and then lost almost the same amount the following month. A later record indicated that the person had had gained almost three kilograms in two days. A referral had been made to the dietician for this person but this was two weeks after a weight loss of over 8kg had been recorded.

We saw similar anomalies in other people's weight records. For example one person was recorded as having gained over 5kg in one week and then lost 5kg in the following week, whilst two others were recorded as losing 5kg or more in one week. We asked the area manager if this had been reported as a possible problem with the scales and they said it had not and showed us the calibration report for the scales. There was no evidence that nursing staff had noticed the unusual weight changes or what they had done to address it.

We spoke with a visitor who showed us large amounts of nutritional supplements in their relative's room. The visitor told us that their relative had suffered weight loss before coming to the home and needed the supplements. They said staff had clearly not assisted their relative to take these supplements as the amounts had not gone down.

This meant that staff had not made appropriate assessments of people's nutritional needs and had not taken action to make sure people received the nutrition they needed, in a way that met their needs, to promote and sustain their health.

This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Elm Royd advertises as providing specialist care for people living with dementia, however we found little evidence to support this. Some of the toilets and bathrooms had good signage to indicate their use whilst others had no signage at all other than a number on the door. This made it difficult to differentiate between the toilets and bathrooms and people's rooms. Some people's bedroom doors had their names on whilst others didn't. There was nothing in place to help people living with dementia to navigate to their room. We did not see any provision to support or give

Inadequate

Is the service effective?

a sense of purpose to people who liked to walk around the home and we did not see any provision of items of interest such as books, magazines, games or craft items for people to engage with.

Staff appeared to struggle to engage effectively with people living with dementia. For example we saw one staff member lean over a person to take their apron off. The member of staff did this quickly and without speaking to the person. The person flinched and shouted, “Don’t hurt me”. When the member of staff told them they just wanted to remove their apron the person said “Well why didn’t you tell me then?” The person then became agitated and shouted at the staff member to go away. The staff member laughed and said to their colleague “she really doesn’t like me.”

We saw staff spending time with a person liked to walk around the home, however each time the person got up to walk, staff told them to “Come and sit down.” Staff did not make any effort to find out where the person wanted to go or what they wanted to do.

We also noticed that a number of clocks around the home showed the wrong time, this included two clocks in one person’s bedroom. In the lounge, a clock which was hung from the ceiling and showed the time on two faces was showing two different times. This did not support people living with dementia in their orientation.

Care records showed arrangements were in place that made sure people's health and social welfare was protected. We saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP’s, hospital consultants, psychiatrists, community nurses, speech and language therapists, opticians and dentists.

We spoke with a community health care professional who told us communication was a constant problem with advice given not always being passed on or recorded to ensure consistency of care. The matron did however say there had been some progress and improvement recently.

Requires improvement

Is the service caring?

Our findings

One person said, “Most of the staff are very good. The young ones are very good, if you tell them you have left something in your bedroom they will fetch it for you. There is just one I don’t like.” However the person told us they were unable to reach their light switch in their bedroom and said when they had to buzz for staff to turn it off they ‘growled’ “What do you want now?”

We spoke with two visitors one of whom told us they had faith in the staff and another who said they had no confidence at all in, particularly, the nursing staff and were removing their relative from the home.

We found people's needs were assessed and their care and treatment was planned yet care was not consistently delivered in line with their individual care plan.

We looked at people's care plans and found they included clear instructions to enable staff to carry out effective care. All aspects of people's personal and health care needs had been assessed. Assessment of people’s needs commenced before they arrived at the home. This assessment ensured the provider was certain they were able to meet people’s current needs. However when we spoke with care staff and agency nurses they were unaware of the detail recorded in people’s care plans. One member of care staff told us they had never seen a care plan and others told us they did not have time to look at them and felt they were for the nurses.

We witnessed some caring interventions but these were not consistent and staff frequently failed to recognise people’s dignity and privacy needs. Examples of this included a member of staff pointing at a person and saying to their colleague “Can you do her?” and staff asking each other “Who is watching the lounge?” referring to who was going to be available to people in the lounge.

We observed staff assist a person into the upstairs lounge in a wheelchair, staff then left the room without speaking to the person and returned approximately half an hour later with another person in a wheelchair. Staff then assisted both people to move from their wheelchairs into lounge chairs using the hoist. Whilst doing this one member of staff said to the other “I don’t know which chairs they go in.” We saw that staff failed to give the people using the hoist any reassurance and we had to intervene and ask staff to support a person who was becoming distressed as they had spun around twice in the hoist sling.

A further example of staff failing to show an understanding of people’s privacy and dignity needs was a lack of response to the issue of people being disturbed and upset by one person entering their and other people’s rooms and turning off lights and pressure relieving mattresses whilst they were in bed. We observed another person was regularly shouting and screaming. These behaviours were challenging and distressing both for themselves and those around them. We sat with a person for a short while who had been upset by these out-of-character behaviours and it was clear neither the cause of the distress or its effect was being recognised by staff. We looked at care plans which whilst recording the symptom did nothing to look for a cause. We could find no evidence these symptoms of dementia were being questioned as a sign of un-met need because the person could not communicate verbally.

We were alerted to one person who was in bed because of a strong and unpleasant odour coming from their room. The door to the room was open. We found the person in bed wearing only a vest had been incontinent of faeces and had spread it on them self and around the bed. When we eventually managed to alert staff to come and assist, they said loudly from the corridor “Just a minute, I have to go and get some gloves before I come in.” When the member of staff came to the room they did not speak with the person but said to the inspector “Was he like this when you came in?” This demonstrated a lack of regard for the person and their dignity.

We saw a number of examples of staff having failed to support people in meeting their dignity needs with regard to personal care. We saw people with unkempt hair, clothing not put on properly and in one case we saw a ladies jumper pulled up revealing that they did not have any underclothes on and their breast was visible. We saw toothbrushes hard and dry and in one case full of hair which would indicate that staff had failed to support people to brush their teeth. We also noted that a number of people did not have any toiletries in their rooms. Staff were unable to tell us how these people had been supported to wash that morning saying “The night staff got them up.” We saw people left for long periods of time with food spillages on their clothing and saw people being transported in wheelchairs with other people’s names on them. We saw incontinence pads left on a bookcase outside of one of the lounges and noted that people who did not take their breakfast in the dining room were served their porridge in polystyrene bowls.

Requires improvement

Is the service caring?

On both days of our inspection we saw personal and confidential records left out in areas where anybody living at or visiting the home could access them.

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some care records indicated where close relatives or advocates had been involved in constructing and reviewing care plans. However this was not consistent in all of the care records we looked at.

Requires improvement

Is the service responsive?

Our findings

We looked at seven care plans during our inspection. We found the care plans to have been developed with a person centred approach, with individual information on people's wishes in relation to how their care was provided. The care plans showed how people liked to spend their time and how they liked to be supported. The plan also showed what people or their relatives had told staff about what provoked their anxieties and inappropriate behaviours. We found that care plans concentrated on what people were unable to do rather than record what skills and abilities people retained. This was shown particularly in the way dependence was assessed and recorded. We saw care was directed towards what care inputs were needed rather than what people could do for themselves.

Whilst care plans were clearly defined we found on a number of occasions this was not being reflected in care delivery and therefore the person centred approach was not being continued into care practice. Throughout our two days of inspection we did not staff refer to people's care plans other than when asked to do so by ourselves.

We saw one person's care plan showed they liked to spend their day with other people in the lounge yet on the two days of our inspection we saw they sat alone. We also saw the same person was required to sit with their legs elevated yet we observed the person sitting with their legs down.

We saw one person sitting with their legs on a footstool. The footstool had been poorly positioned and their left calf was hanging off the end putting pressure on this area. We brought this to the attention of the nurse who pulled back the blanket and said their leg looked a bit red and that the person suffered with circulation problems. They said they would get the community matron. When we checked the following day to see if the community matron had been called, the agency nurse told us they didn't know anything about it. We looked at the handover sheet and saw it had been noted. However when we looked at the person's daily record, the problem had been documented but the agency nurse had not looked at the records in people's care files. The agency nurse said the community matron had been to the home but had left and asked us what we thought they should do. We told the agency nurse they should do what they thought was needed for the person. The agency nurse later told us they had been in contact with the person's GP.

We saw from one of the care plans we looked at one person had developed sores between their toes. They had been seen by the community matron and dressings had been prescribed. We could find no record to show when the dressings had been changed or any progress notes about the condition of the blisters/sores. The community matron had also asked for the person to keep their legs elevated. There was no footstool for them to use in the lounge and their legs were not elevated during our visit. We saw the person was a diabetic so foot care was very important. This meant staff were not following the advice given by the healthcare professional.

We saw one person assisted into the lounge with no footwear on. We saw staff move them with a moving and handling belt and drag lift. Later in the morning the person asked to go to the toilet. Staff went to get shoes after we brought to their attention the person was not wearing any. They reported to us the two pairs in their bedroom were unsuitable (one pair had no soles and the other pair had only half a sole and that their slippers could not be found. One carer said they were not prepared to stand the person without anything on their feet as there was a risk they would slip. This carer gained consent from the individual to use the hoist. The hoist was brought and we asked carer how they knew that hoist was suitable. They said they could see the person was not too heavy for it. We checked the person's weight record and found the hoist was suitable. We got the manager who agreed foot wear was not suitable as did the area manager. The area manager said it should not have got to the point where this person had no footwear. One of the carers said they would contact the family. We told the area manager it was not wholly the families' responsibility as it was staff from the home that saw the person on a daily basis. We checked with the administrator and there was money being held for this person. At lunchtime the activities person had been out and purchased a pair of new sandals. We do not think this would have happened without our intervention.

We saw another person should have been sat in a bespoke chair following an assessment by an occupational therapist (OT). We observed the person sat in a wheelchair until their relative arrived mid-afternoon and brought the matter to the attention of staff. We also noted this person should have had a roll in the palm of their hand to help prevent hand contractions and finger nails causing skin damage. The roll was not in place and neither was the cushion defined in the care plan to help provide support.

Requires improvement

Is the service responsive?

We saw in this person's care plan the outcome of an assessment conducted by an OT and physiotherapist. The professional advice recorded in a signed letter included the wearing of a leg splint during the day with staff checking the splint every 3-4 hours. We found the splint was not in place. However a hand written unsigned note was in the person's room dated after the first assessment which indicated a physiotherapist had said the splint should only be worn for 3-4 hours. Whilst the care plan was reviewed no-one had sought to clarify the clinical advice. This meant that staff were not following professional advice and where the advice was confusing , had failed to take further advice to make sure the person received the care they needed.

Early in the morning on the first day of our inspection we saw a person who staff told us should have been sitting on a pressure cushion but said the night staff had assisted the person to get up and had not put the pressure cushion in place. Staff tried to put a cushion in place but the person was resistive and therefore staff said they would get a pressure cushion when the person was assisted to the toilet. We returned frequently to the lounge where the person was sitting and did not see any evidence of them being supported to the toilet and a pressure cushion was not put in place at all during the day. This meant that the person's needs were not met on that day.

We saw some activities being offered to people, mostly by the activities co-ordinator. However for people who were unable or did not choose to engage in the planned activity there was little to occupy or stimulate them. We saw staff frequently change television channels or music without asking the people in the room if they wanted this or what they would prefer to watch or listen to. In the upstairs lounge we saw programmes for small children being played loudly.

On the second day of our inspection we saw one person sitting alone all day in their room. When we looked at their care plan it said that when the person was in their room they liked to listen to music. We did not see music provided at all throughout the day. The care plan also said to maintain or increase socialisation for this person. When we asked staff why they were sitting alone in their room, they said it was because staff training was taking place in the lounge they liked to sit in.

One person told us, "I hate it here it's like prison, I have done (number) weeks of my sentence. We do nothing just sit here all day." We looked in their care plan and saw recorded that they liked to watch television. We asked the person what they liked to watch and they told us any sport except boxing. We asked them if they had watched any of the rugby world cup and they said, "I didn't even see a ball being kicked."

On the second day of our inspection we saw a person had come to the home to provide entertainment to people. When we looked in at the entertainment we saw staff standing around the edges of the room with their arms folded rather that assisting and encouraging people to engage in the entertainment.

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

When we asked about how people were enabled to make complaints. One person said, "They (staff) would say I am always complaining. I do complain if I come across something not right and I tell them. No one takes a blind bit of notice though. I worry if I keep complaining I will stop getting any service whatsoever."

We asked the area manager if we could look at the complaints file. The area manager told us we could but said we would not find detail of recent complaints as they had not been documented or managed. We found this to be the case as no record had been made of two complaints we had been made aware of, one by a relative and one by a person who used the service.

This was a breach of the Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

The registered manager left Elm Royd in 2013. Since that time, for a period of months, there was an acting manager in post. They did not continue in that role but did continue to work at the service. At the time of our visit, a new manager had commenced employment but they had only been in post for one week. They told us they intended to apply to the Care Quality Commission for registration.

The area manager was present at the home for periods of time during both days of our inspection and they assisted with the inspection process.

When we inspected this service in August 2014 we said that the registered person did not have effective systems in place to monitor the quality of service delivery and said improvements were needed. The provider sent us an action plan telling us that there was a 'full, robust quality assurance audit now in place.'

We saw reports from provider visits from the previous and current month. Whilst these had been completed and issues had been identified, they did not appear to be have been followed up on. For example, the complaints audit was recorded as not having been completed on both visits and where issues with care plans had been identified in the October visit there was no evidence of any action plan to address this.

We did not see any evidence of recent care or medication audits and there was no overview of how the service was working within the requirements of the Mental Capacity act and Deprivation of Liberty Safeguards.

Environmental safety records were up to date and certificates of safety such as gas, maintenance of lifts and moving and handling equipment were all in place and up to date.

We saw that up until the end of the previous month, weekly hot water checks had been maintained. The area manager told us that the maintenance person had left the home and whilst cover had been organised from within the company these checks had not been completed during the month of our inspection.

We asked on several occasions during our inspection for a read out from the nurse call system. The area manager told us they were unable to provide this due to a technical problem. We therefore asked for this to be sent to us within the week following the inspection. This was not sent.

We did not see any evidence of analysis of accident and incident records, and on speaking to the area manager; we established that even serious incidents such as the hoist tipping over had not been reported appropriately within the company as per their own policies and procedures. However, this would indicate that accident and incident forms had not been looked at as part of the monthly quality visits.

When we asked the area manager about complaints monitoring, they told us that they knew it had not been completed and that complaints had not been managed in line with their own procedures.

We saw that some quality monitoring had taken place in the form of questionnaires sent to relatives of people who lived at the home. However we did not see any analysis of the results of this despite the survey having taken place several months prior to our inspection.

Staff we spoke with reported a lack of leadership within the home. Two recently recruited members of staff told us they had never been given any guidance in how to do their jobs.

We saw that some meeting had been held at the home for both staff and people who lived at the home and their friends and relatives. Residents and relatives meetings minutes recorded positive outcomes but these had been very poorly attended and the most recent one was dated April 2015. We saw a copy of a sign which had been put up saying the meeting scheduled for June 2015 had been 'Cancelled again due to poor attendance. 'This meant that people did not have the opportunity to attend the meeting. We were unable to understand how the meeting could be cancelled due to poor attendance in advance of the day of the meeting. We did not see any action plans in relation to issues brought up in staff meetings, including the issue of staff not having enough time to read care plans.

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

It is the responsibility of registered providers to inform the Care Quality Commission, by way of statutory notifications

Requires improvement

Is the service well-led?

of certain events that have taken place in the service. This includes reports of abuse of people living at the home and serious accidents. We found evidence of several events that had happened which the provider had failed to report.

This was a breach of Regulation 18(2) (a, e and f) of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not have effective systems in place to maintain standards of hygiene and infection control. Regulation 12 (2) (h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **All premises used by the service provider were not properly maintained. Regulation 15 (1) (e).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Service users' nutritional needs were not being assessed and reviewed to ensure they were being met. Regulation 14 (1) (4) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a)**

Regulated activity	Regulation

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 18 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person did not have systems in place to manage complaints effectively. Regulation 16 (1) and (2)**

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had failed to report notifiable incidents.**

This section is primarily information for the provider

Enforcement actions

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

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 Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to recognise and investigate any allegation or evidence of abuse. Regulation 13 (1) (2) & (3). Systems were not being followed to make sure that service users were not restrained or deprived of their liberty without lawful authority. Regulation 13 (4) (b)(c) and (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were being put at risk of unsafe moving and handling and use of equipment. Regulation 12 (2) (e) Service users were not protected by the proper and safe management of medicines. Regulation 12 (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) and (2) (a) & (b)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support and training to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).