Elmcare Limited

Elmwood House

Inspection report

Elm Street
Hollingwood
Chesterfield
Derbyshire
S43 2LQ

Tel: 01246477077

Date of inspection visit:
11 April 2023

Date of publication:
12 May 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Elmwood House is a care home providing personal and nursing care to 22 people at the time of the inspection. The service can support up to 32 people. The service is split into 4 different areas over 3 separate floors, the cottage, the lodge, the villa and the penthouse. People have access to communal lounges and dining spaces, as well as an outdoor area.

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

Right Support:
Medicines were not managed safely, which meant people were put at an unnecessary risk of harm.

Accidents and incident management was not effective. The system to review accidents and incidents to ensure lessons were learned had not yet been embedded. There was no analysis of themes or trends to identify how risks to people could be mitigated. This meant any changes in people's needs following accidents or incidents were not identified or reflected in their care records.

Since our last inspection, staff had worked with people to reduce the use of restraint. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced.

People were supported to live in a clean environment.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care:
The majority of people's care had been reviewed to ensure risks people might face were assessed. Where actions to mitigate risk were identified, staff did not always ensure this was carried out.

The service had enough appropriately skilled staff to meet people's needs and keep them safe.

Right Culture:
People were not always supported to lead inclusive and empowered lives because of the ethos, values,

attitudes and behaviours of the management and staff. Risks of a closed culture were not always identified so that people received support based on transparency, respect, and inclusivity. Records describing people or behaviour were not always written respectfully.

Feedback on the quality of support provided to people was sought, involving the person, their families, and other professionals as appropriate.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 7 January 2023).

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the management of accidents and incidents at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

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

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

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Elmwood House

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by 2 inspectors.

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

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

At the time of our inspection there was not a registered manager in post. The manager told us they plan on registering with CQC, but an application has not been received.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with 5 people who use the service. We spoke with 6 staff, including the manager, regional manager, deputy manager and care staff. We carried out observations of communal areas. We reviewed a range of records including 7 people's care records, medicine administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Since our last inspection, the provider had started to review and update all care plans and risk assessments for people using the service. However, there had been no reviews of accidents and incidents to see if people's needs had changed, which meant updates and changes in people's care and support needs had not been clearly identified or documented.
● One person's care plan which had not been updated to the new format, had handwritten notes which stated where thing's were no longer applicable. However, no further information on how they currently presented was recorded which meant staff did not have up to date guidance on how to support them.
● Where action to mitigate risk was required, records did not always demonstrate this was carried out. For example, one person required regular repositioning to support their skin integrity. Repositioning charts were not always completed to show this had been carried out. This placed them at risk of further skin breakdown.

● Improvements were required to ensure people were always supported in a safe environment. For example, we found exposed light fittings in one person's bedroom and unattended cleaning product in a communal space. This placed people at risk of harm.

Using medicines safely
● Medicines were not always stored, managed or disposed of safely. Medicines were kept in clinic rooms which exceeded the recommended temperature for safe medicine storage. Opening dates were not recorded on medicines. This increased the risk of reduced efficacy of the medicines and people being given out of date medicines.
● At our last inspection we found staff did not follow safe systems for managing medicine waste. During this inspection, medicines were not always disposed of in line with best practice guidance. We found a bin of medicine which was full and not sealed. Whilst we found no evidence people were at risk of harm, this meant medicine could be taken from the bin.
● Medicines were not always given in line with prescriber's instructions. For example, one person's medicine

administration record (MAR) noted they'd been given a sedative medicine which was prescribed on an 'as required' basis to manage agitation. However, the reasons recorded for the administration was because of a headache. It was not clear from the records why this person had been administered this medicine for a headache as their 'as required' protocol did not specify this was a potential sign of agitation

● At our last inspection we found staff were not reporting medicine related errors or near misses in line with good practice. During this inspection, nursing staff did not demonstrate knowledge on how to report medicine discrepancies. Feedback from the manager confirmed the clinical lead was responsible for reviewing this information, however when they were not in work this was not checked in their absence. This placed people at risk of receiving unsafe medicine administration.

The provider failed to ensure risks to people were identified and mitigated. Medicines were not managed safely. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately and addressed all environmental concerns. Medicines were moved to a cooler room and staff were reminded to check temperatures.

● At our last inspection we found people were not always protected from the risk of fire. At this inspection we found fire safety checks were now routinely completed and recorded, and people were protected from the risk of fire.

● A new system to monitor people's healthcare needs and support staff on recognising when people may need clinical intervention was in the process of being rolled out.

● Positive behaviour support (PBS) plans were now in place for people to help staff understand people's behaviours. These were in the process of being reviewed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the provider was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

At our last inspection the provider had failed to ensure robust recruitment checks were carried out before staff commenced employment. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The provider followed safe recruitment practices. This included the provider obtaining at least two satisfactory references and Disclosure and Barring Service (DBS) checks, for all new staff prior to them starting work. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There was enough staff to meet the needs of people safely. This included staffing for peoples commissioned one to one support. People told us staff came to help them quickly.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure effective systems and processes were in place to record and review restraints, this placed people at risk of being restrained unsafely, or unnecessarily. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Staff understood their responsibility to report accidents and incidents, but sufficient information was not always recorded to allow lessons to be learned. For example, body maps were completed with no further information on how any marks or bruising may have been caused.
● The system for recording accidents and incidents was under review by the manager following feedback from the local authority, to ensure sufficient information was provided to ensure action could be taken quickly to mitigate risk to people. This had not yet been embedded.
● Some people using the service had their medicine administered via intramuscular injections and sometimes required restraining by staff to ensure this was administered safely. Since our last inspection, the use of restraint had been reduced and staff utilised less restrictive methods to support people to have their medicines, only reverting to restraint as a last resort.
● Records of restraint were now completed fully, appropriately, and reviewed by senior staff. This meant there was clear records and better oversight of the use of restraint within the service. This reduced the risk of people receiving improper treatment.
● People told us they felt safe living at Elmwood House. Staff had received safeguarding training and the provider was meeting weekly with the local safeguarding team to discuss open safeguarding referrals and actions required.

Preventing and controlling infection
● At our last inspection, the environment was not always clean. At this inspection, improvements had been made and the service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had arrangements for keeping the premises clean and hygienic.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

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

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to ensure effective systems and processes were in place to monitor risks. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The systems in place to ensure good governance of the care provided for people continued to be ineffective and failed to identify the risks found during our inspection. For example, a recent medicines audit had achieved 100% compliance, despite areas of medicine management found to be unsafe by inspectors.
● Oversight of accidents and incidents within the service was not effective. At our last inspection we found the system to analyse accidents and incidents was not effective. At this inspection there was no system in place to review and analyse accidents and incidents at all. Managers had begun to collate all accident and incident forms but were having to review these retrospectively. This meant measures to implement and prevent reoccurrence or risk of harm continued to not be identified, placing people at risk of further harm.

● Since our last inspection, the provider had implemented a service improvement plan, however this did not clearly prioritise areas for improvement. We found whilst quick fixes had been put in place, such as buying artwork for the home, actions which had impact on people's safety had not made sufficient progress which left people at risk of harm. For example, analysis of accidents and incidents.
● Systems to ensure consistent oversight were not embedded. For example, a daily report had been introduced by the clinical lead to check for medicine errors, however they were on leave during our inspection, and this had not been completed in their absence. This meant any errors would not be identified in a timely manner.
● As systems and processes to ensure oversight were not in place or embedded, information was not always shared with relevant stakeholder's support people's quality of care. Authorities fed back that information had not been shared with them until they had identified it themselves during quality assurance visits. For example, the lift had broken on 3 occasions, and this had not been passed on to commissioners. This demonstrated a lack of transparency.
● Whilst the provider was receiving support from partner agencies including the local authority and

integrated care board to improve the safety of the service, their own systems and processes had not identified these areas for improvement until raised by these agencies. This meant timely improvements to the safety and quality of the service had not been made.

The provider failed to ensure governance systems were identifying risks to people using the service and timely and effective action was taken to drive improvements at the service. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● A positive culture was not always promoted within the service. Disrespectful terminology was used to describe people or incidents. For example, we reviewed accident and incident forms which referred to one person as "a biter" and one which described one person's signs of distress as displaying "absolutely disgusting behaviour" and "a disgusting outburst." Managers overlooked the potential impact on people's equality, diversity and human rights needs as these concerns were not identified through their review process. The provider responded to these concerns and assured us this would be addressed by additional training.

● We received mixed feedback from people using the service regarding their experience at the service and relationships with staff. One person said, "Yes I like living here." Another shared they were hoping to move out. We asked one member of staff to introduce inspectors to one person, but they told us "It's probably best I didn't as [person] doesn't like me."

● The manager was aware improvements were required to ensure the culture within the service was positive and inclusive. They explained they planned to address this by meeting with everyone once they were settled in the role to understand how they can improve relationships.

● Staff did not always engage with people in a way that met their emotional or social needs. During our inspection, staff were observed to be task orientated, for example ensuring people had meals or supported to dress and completing paperwork.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Whilst the manager displayed an understanding of duty of candour, the lack of system to review accidents and incidents had meant they were not always aware of when things went wrong. This meant duty of candour had not always been acted on.

● At the time of our inspection, the manager told us they had not been aware of the legal requirement to notify CQC of significant events which occurred at the service until recently. The manager had been in post since the beginning of the year which meant significant events which had occurred during this time had not been reported at the time. The manager was in the process of reviewing and submitting these retrospectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had opportunities to be involved in the running of the service. People were supported, including those with protected characteristics, to have their say on different aspects of the service during resident's meetings. A "you said, we did" board had been implemented, which showed how feedback was used to make changes in the home, such as buying new furniture as requested by one person.

● The manager sought feedback from relatives, visitors and professionals and was in the process of reviewing this feedback.

● Staff had various opportunities to engage with the running of the service, through supervisions and meetings. The manager had sent out surveys to request their feedback and was in the process of reviewing this feedback.
● People had links to local community resources and were supported to access these. For example, local supermarkets and entertainment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people were identified and mitigated. Medicines were not managed safely. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure governance systems were identifying risks to people using the service and timely and effective action was taken to drive improvements at the service. This placed people at risk of harm.