Shaw Healthcare Limited

New Elmcroft

Inspection report

St. Giles Close
Shoreham By Sea
West Sussex
BN43 6AT

Tel: 01273466500
Website: www.shaw.co.uk

Date of inspection visit:
28 June 2018

Date of publication:
23 August 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 28 June 2018 and was unannounced. New Elmcroft is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

New Elmcroft is situated in Shoreham, West Sussex and is one of a group of homes owned by a national provided, Shaw Healthcare Limited. New Elmcroft accommodates 60 people across separate units, each of which have separate bedrooms with ensuite shower facilities, a communal dining room and lounge. There were also gardens for people to use and a hairdressing room. The home provides accommodation for older people, those living with dementia and people who require support with their nursing needs. At the time of the inspection there were 49 people living at the home. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection the home was rated as Good. At this inspection we found the evidence continued to support the rating of Good. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Most risks were assessed and managed well. There had been several incidents whereby people had accessed areas of the home that had the potential to cause them harm. Preventative measures had immediately been put in place, such as installation of locks to the doors. One of the doors to the sluice toom, which had a key pad lock installed, had not been closed. There was a potential that a person could access the room and cause themselves harm.

External healthcare advice had not always been implemented by staff. Two people had been assessed as needing to have their drinks thickened to minimise the risk of choking. Neither of the people were provided with thickened drinks. One of these people began to cough on an un-thickened drink and there was a potential that they could have come to harm as there were no staff with the person when this occurred. These incidents were immediately fed back to staff who ensured that the people's drinks were thickened.

People told us that staff made them feel safe. They felt that there was sufficient staff, that they were well-trained and knowledgeable to meet their needs and assure their safety. People and staff were aware of the importance of raising concerns about people's wellbeing and safety. People were protected from abuse and made aware of their right to complain. Incidents had been reflected on and practice changed in response.

People were protected from the spread of infection. Registered nurses and external healthcare professionals ensured that people's heath was maintained. Medicines were provided when people required them. People

told us that they were confident that staff would summon assistance if their health condition deteriorated. There was a coordinated approach to people's healthcare. People received good need of life care.

People had a positive dining experience. They told us that they were happy with the food and had access to drinks and snacks throughout the day and night. One person told us, "Food is okay, helpings are fine, it is enough for me".

People were asked their consent before being supported and were involved in their care. People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. Staff demonstrated respect. People's privacy and dignity were maintained and they were supported by staff in a sensitive and dignified way. People told us that they felt well-cared for. They spoke fondly of the staff and person-centred practice was evident. One person told us, "I get on well with all the staff. They are nice".

The environment provided spaces for people to enjoy time on their own or with others. There was a fun, lively and welcoming atmosphere. People had access to a varied range of stimulation. Activities, external events and entertainment was available for people to enjoy. One person told us, "There are lots of entertainers that come in. We have quite a bit to do".

People and relatives were complimentary about the leadership and management of the home. They told us that the home was well-organised and that the registered manager listened and acted upon their ideas and suggestions. Systems were monitored to ensure they were effective. Staff were appropriately supported and involved in decisions that affected their work. Partnership working with external organisations and healthcare professionals ensured that good practice was shared.

Further information is in the detailed findings below.

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 home has deteriorated to Requires Improvement.	**Requires Improvement**
Is the service effective? The home has improved to Good.	**Good**
Is the service caring? The home remained Good.	**Good**
Is the service responsive? The home remained Good.	**Good**
Is the service well-led? The home remained Good.	**Good**

New Elmcroft

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.

The inspection took place on 28 June 2018 and was unannounced. The inspection team consisted of two inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held, as well as feedback we had received. We used information the registered manager sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted one healthcare professional for their feedback. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 28 people, seven relatives, three visitors, seven members of staff, two visiting healthcare professionals, the registered manager and the operations manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and electronic medicine administration records (MAR) for twelve people, four staff records, quality assurance audits, incident reports and records relating to the management of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We observed people in the communal lounges, their experiences during lunchtime and the administration of medicines. Following the inspection, we contacted a healthcare professional for their feedback.

Requires Improvement

Is the service safe?

Our findings

People told us that staff made them feel safe. One person told us, "I am safe because the staff make sure I am, supervising me in the bathroom so I don't fall". Another person told us, "They make sure we are safe by weighing up risks before we do it". However, despite these positive comments, we found areas of practice that needed improvement.

Most risks to people's safety had been assessed and managed well. There had, however, been several incidents whereby people had been able to access areas of the home that had the potential to cause them harm. These included a boiler room and a sluice room. In addition, one person had accessed an unsecured fire escape and had been found in the grounds of the home without staff support. Although no long-term harm was caused to people, measures should have been taken to ensure that the doors to these areas were secured to ensure people's safety. After the incidents immediate action was taken to ensure that the doors were secure, such as the installation of locks and key pads. Although there was a way of securing the doors to prevent people from accessing the areas, we found the door to the sluice room open. There was a potential that a similar incident, to that which had previously occurred, could have occurred again if a person was to have entered the room. This was immediately fed back to staff who secured the door, however, is an area of practice in need of improvement.

People were not always safeguarded from harm as external healthcare professional's advice had not always been followed by staff. Two people had been assessed by a Speech and Language Therapist (SALT). They had recommended that their drinks be thickened due to swallowing difficulties and to minimise the risk of choking. Records showed staff had been provided with guidance about the amount of thickener to add to people's drinks. Observations showed that thickener had not been added to either person's drinks. One of the people began to cough whilst drinking an un-thickened drink and there was no staff with the person to ensure their safety. The person was unharmed, although there was a potential that the person could have choked. These incidents were immediately fed back to staff who ensured that both people's drinks were thickened in accordance with the guidance. This is an area of practice that needs improvement.

People were provided with medicines to maintain their health. Medicines were administered by registered nurses and trained staff, who had their competence regularly assessed. There were safe systems in place to store, dispense, administer and dispose of people's medicines. People told us that they were happy with the support provided and received their medicines on time. There had been historical incidents whereby one person had not received their medicines in a timely way. This had been reflected on and changes made. One nurses told us that they set their alarm to alert them to the times when medicines needed to be administered. Records showed that there had been improvements to the timeliness of medicines.

People were safeguarded from abuse. Robust pre-employment checks ensured that staff employed were suitable to work in the health and social care sector. Registered nurses all had current registrations with the Nursing and Midwifery Council (NMC). Staff understood their responsibilities to safeguard people from harm. Appropriate referrals had been made to the local authority when incidents had occurred. Advice and guidance provided by the local authority had been listened to and complied with. Staff were mindful of

potential situations when people displayed behaviours that challenged others. They used distraction techniques and monitored people to assure their safety. People were made aware of their personal responsibility to ensure their safety. Records of a resident's meeting showed that people had been made aware and reminded of the need to raise concerns about their safety.

There was sufficient staff to meet people's needs. People told us that staff were busy, yet available when they called for assistance. Consideration was made of staff's skills and levels of experience. Less experienced staff worked alongside the more-experienced to develop their skills and receive support and guidance.

People were protected from infection. Staff responsible for handing food had received appropriate food handling training. The home was clean and staff were provided with appropriate personal protective equipment to minimise the spread of infection. Staff disposed of waste appropriately to minimise cross-contamination.

Good

Is the service effective?

Our findings

At the previous inspection on 20 March 2016, one person had experienced unplanned weight loss and this had not been identified by staff. This was an area of practice in need of improvement. At this inspection improvements had been made.

People's needs were assessed prior to them moving into the home and on an on-going basis. Care plans were specific to people's assessed needs and provided staff with advice and guidance about how to support people appropriately. People's risk of malnutrition was assessed on an ongoing basis and appropriate action taken. For example, for people who were at risk of losing weight and becoming malnourished, they had access to fortified food and drinks which were monitored daily. In addition, the frequency in which they were weighed increased and advice had been sought from external healthcare professionals when there were concerns.

People had access to sufficient quantities of food and drink. People had access to snacks and drinks throughout the day and night. Comments from people included, "We have a choice every day and sometimes we have a cooked breakfast" and "I like the meals, I get what I like". People could invite their family and friends to join them. A relative told us, "For me the meals are excellent and value for money". Care plans identified people's cultural and religious needs and support was adapted to ensure that people's beliefs were respected. For example, people's cultural needs were respected when providing food. People had a pleasant and sociable dining experience. People could choose to eat their meals in the communal dining rooms or in their own rooms and told us that their wishes were respected.

People told us that they had confidence in staff's abilities. One person told us, "I think staff are well-trained". A relative told us, "They are very knowledgeable and tale a real interest in the well-being of their charges". Staff received a comprehensive induction and had access to on-going learning and development to ensure that they could meet people's needs. Links were maintained with the local authority, external healthcare professionals and local colleges to promote and share best practice. The registered and deputy manager gave talks and learning sets at staff meetings to update staff's knowledge. Registered nurses had access to courses to enable them to retain and develop their skills to ensure people received the most up-to-date and appropriate treatment.

People's healthcare needs were assessed and met. There was a coordinated approach to people's care. Registered nurses provided nursing support to people residing on the nursing units. There were links with external healthcare professionals to maintain people's health for those residing on the residential units. People had access to GPs and told us that they had faith in staff's abilities to recognise when they were not well. One person told us, "No question they would get the GP in. I go out to the dentist when needed and see a chiropodist". Regular routine visits from GPs and healthcare professionals enabled people to discuss their health. When people required the assistance of external healthcare professionals, referrals had been made in a timely manner. An innovative approach to monitor people who had complex, long-term health conditions had been introduced. This was a joint initiative between the provider and the local GP surgery, the results of which were monitored by community nursing teams. A handheld device was used to monitor

people's health. If people showed signs of their health deteriorating, intervention could be offered in a timely way before any conditions escalated. This reduced the risk of strokes or further disease.

People's needs were met by the design, layout and adaptation of the home. People also had their own rooms that they could use if they wanted to have their own space. People could choose to enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather. People were supported to independently mobilise around the home and technology, such as call bells, were available for people to use if they required assistance from staff. Themed areas supported people to orientate around the building and this was assisted by photographs or memory boxes alongside some people's bedroom doors. A relative told us, "This place is fine for my relative's wheelchair. The doorways are large and there are many open spaces".

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People's consent was gained before staff offered support. One person told us, "I am asked before carers attend to me, they ask if I am happy for them to do so". The registered manager had made appropriate DoLS applications. Those that had been authorised by the local authority sometimes had conditions associated to them. The registered manager had worked in accordance with these to ensure that people's needs were met and they were not being deprived of their liberty unlawfully.

Good

Is the service caring?

Our findings

People told us that staff were caring. Comments included, "I get on well with all the staff, they are nice" and "They are friendly towards me".

People were cared for in a kind and compassionate way. One person thought staff were caring as, "They always have time to chat". Relatives were equally positive, one told us, "My relative is treated with courtesy and dignified behaviour at all times, you cannot fault the carers". Another relative told us, "Nothing is too much trouble". People were treated with kindness and sensitivity. One person was showing signs of apparent anxiety. The registered manager took time to speak to the person, offering reassurance and distracting them by spending time in the garden looking at the plants. The person was reassured and was visibly calm following this interaction.

People and their relatives could express their needs and wishes. People were involved in their care. One person told us, "Staff do talk to me about my care". People's life history, their hobbies, interests and preferences had been gathered and recorded in people's care plans. Staff were provided with guidance as to how to support people according to their expressed needs and wishes. Regular resident and relative meetings, as well as surveys, enabled people and their relatives to make suggestions and have an input into their care. People were made aware of advocacy services when they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

People were treated with respect, their privacy and dignity maintained. Staff took time to explain their actions before offering support and fully involved people in their care. People could choose the gender of the staff that supported them and confirmed that this was listened to and respected. Staff were discreet and sensitive when assisting people with their personal care needs. Attention was paid to people's individuality. For example, some people wore jewellery or had their nails painted in a colour of their choice. 'Dignity day' had been celebrated. A notice board had been decorated with cut-outs of butterflies and people had written about what dignified care meant to them.

People's privacy, with regards to information that was held about them, was maintained. Records were stored in locked cabinets and offices and conversations about people's care held in private rooms.

People's differences were respected and staff adapted their approach to meet people's needs and preferences. Diversity was respected with regards to people's religion and this was documented in people's records. People could continue to practice their religion. One person had accompanied their family to a religious festival and this had been respected by staff.

Independence and the retaining of skills was valued and promoted. A visitor told us, "They are encouraged in every way, they motivate the residents by involving them in decision-making about food or activities".

People could maintain relationships with those that were important to them. One person told us, "No

restrictions on my family visits". Friendships had developed between people as well as with staff. People and their relatives told us that they could visit at any time and were made to feel welcome and our observations confirmed this. One person had enjoyed a Birthday party where they had invited family and friends to celebrate with a Barbecue and a cake. People had access to telephones and Wi-Fi to enable them to stay in touch with their family and friends.

Good

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to changes in people's needs. Records showed that when people's health needs had changed that referrals had been made in a timely way to ensure people received appropriate support. Relatives told us that they were kept informed of changes to their loves one's care. A relative told us, "They do ring with news of my relative, like if they are unwell".

People's care was person-centred and specific to their needs. People and their relatives had been involved in devising care plans. Care plans documented people's likes and dislikes and contained information on their health. Regular reviews provided up-to-date information and reflected people's current needs. People were aware of the complaints procedure and were supported by staff if they needed assistance to make their feelings known. Concerns that had been raised had been used as opportunities to learn. For example, one person had experienced a slight delay in receiving their medicines. Staff told us that they now set an alarm to notify them of the exact time the medicines are due.

People told us that there were lots to occupy their time. Fundraising events took place to raise additional funds that could be used to provide stimulation. A varied range of group activities and entertainment was provided and people told us how much they enjoyed this. People were observed making cards, singing along to music and enjoying ice-lollies and ice-creams. There was a fun, sociable and lively atmosphere. For people who preferred to spend time in their room, more sedate activities were provided, such as reading, listening to music or talking with staff. A visitor told us, "I came in one day and was very impressed. A resident who was in bed was making a pizza for their lunch. They were assisted by a carer who had arranged the crust and the resident was placing the topping and ingredients of their choice. It was amazing to see this activity taking place in a bedroom".

People were encouraged and able to maintain relationships and links with the local community. External event and trips out were provided to meet people's needs. One person had a love of swimming and staff had supported the person to go to the local swimming pool and out for a takeaway meal. They had told staff that this had made them 'Feel alive again'. Another person used to serve in the military. They explained that they had suggested to the registered manager about an activity. They told us, "They invited the RAF Chaplain and the local Air Training Corps are coming to mingle with us. It was my suggestion, it is amazing how the manager listens and acts on suggestions if they are feasible". A wish list was displayed which detailed people's wishes. People had suggested things such as going to the pub, watching the Sound of Music and having some Kentucky Fried Chicken. Once people's wishes had been fulfilled these had been ticked off on the board.

People's right to have information provided in an accessible manner was respected. The registered manager ensured people's communication needs had been identified and met. People's care plans contained information on the most appropriate way of communicating with people. One person experienced difficulties verbally communicating. Staff enabled the person to express their needs in their own time and confirmed their understanding by writing words on a white board. This enabled the person to communicate effectively. Information could be created in such a way to meet people's needs, for example, in accessible

formats to help them understand the care available to them. People had access to technology to summon assistance from staff. Call bells and sensor mats alerted staff to people's need for assistance. One person told us, "Staff are very good, they come as quick as they can when you call them".

People were provided with good end of life care. People were able to plan for the end of their lives. Records showed that people's expressed wishes and health needs had been met. There were links with local hospices and community matrons to ensure staff were provided with appropriate advice and guidance. The registered manager subscribed to the End of Life care hub (Echo). Echo is an NHS service that provides advice and support and access to specialists and equipment. Measures had been taken to ensure that the necessary equipment and medicines were available in anticipation of people's health deteriorating. People's comfort was maintained. A thank you card had been received from a relative of a person who had passed away. It stated, 'They were happy and content with you and that gave me peace of mind'.

Good

Is the service well-led?

Our findings

People were complimentary about the leadership and management and spoke highly of the registered manager. One person told us, "I think the staff work together quite well and the place seems well-organised". Another person told us, "It seems to be run well". Comments from relatives included, "The registered manager is approachable and does listen and does try to sort issues out" and "The registered manager speaks to my relative most days, they often chat. They are excellent and make sure everything is up to scratch".

New Elmcroft is one of a group of services owned by a national provider, Shaw Healthcare Limited. It is a purpose-built building with accommodation provided over two floors which are divided into smaller units of ten single bedrooms with unsuited shower rooms, a communal dining room and lounge. The home had a registered manager. A registered manager is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. There was a management hierarchy which enabled staff to be supported and supervised by either registered nurses or team leaders who worked alongside them to meet people's needs. In addition, there was a deputy manager and the registered manager. An operations manager also regularly visited the home to conduct quality assurance audits and to offer support. The management team were experienced and held appropriate management or nursing qualifications.

The provider's values of 'Happiness, Wellness and Kindness' were central to the care people received and were embedded in staff's practice. Staff strived to ensure that people had a good-quality life. There was an open and transparent culture. People and their relatives told us that they were kept informed about people's care and the running of the home. Regular newsletters provided people and their relatives with updated information and informed them of events and activities that had been held at the home. One newsletter had reminded relatives about people's care plan and the importance of their involvement within them. Regular meetings and surveys enabled people and their relatives to provide feedback and share their views. One relative told us, "Any issues are acted upon". Staff told us that the management team were accessible and supportive, that they could share ideas and suggestions. There was an emphasis on continuous improvement and learning. When care had not gone according to plan or concerns had been raised, these were shared with the staff team in meetings to provide encouragement and improve practice.

Quality assurance processes ensured that a good oversight of systems and processes remained. Regular audits were conducted by members of the management team and action plans devised when improvements were required. Records showed that when issues that needed to improve had been identified, appropriate action had been taken in a timely manner. The local authority undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live. The provider and registered manager were aware of their responsibilities to comply with registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

There was good partnership working to ensure staff learned from other sources of expertise and people

received coordinated care. There were links with the local authority and healthcare professionals. In addition, there were links with other registered managers from the providers other homes. This enabled the sharing of good practice. The registered manager kept up-to-date with changes in practice. They had arranged for the chefs to attend updated training with regards to the preparation of food for people who required a soft or pureed diet. This had been due to changes in the recommended consistency of these types of foods.