The Elms Residential Home Limited

The Elms Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Elms Care Centre is a residential care home providing personal and nursing care for up to 18 people aged 65. At the time of inspection five people were living at the service.

People are accommodated in one building split across two floors. There is a shared lounge and dining area. There is also a garden area people can access.

People's experience of using this service and what we found
People were not safe. People did not receive care and support required to meet their needs or keep them safe.
Staff did not have the skills, knowledge or support to identify people's health was deteriorating and did not seek medical intervention in a timely manner. This meant people were exposed to unnecessary risks and harm that may have been avoidable.

The service did not manage a COVID-19 outbreak effectively. Staff who were COVID-19 positive continued to work at the service despite having COVID-19 positive test results. Senior management and the provider knew this was happening. Consequently all 12 residents and most the staff contracted COVID-19.

The service was not well-led. There was not a registered manager at the service, and the provider had limited interaction with the service. This meant there was no clear leadership or oversight of the service, and limited opportunities to improve the quality of care people received.

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 19 December 2020).

At this inspection enough improvement had not been made/ sustained, and the provider was still in breach of regulations.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about management of the COVID-19 outbreak. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with people's safety and management of the service, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

You can read the report from our last inspection, by selecting the 'all reports' link for The Elms Care Centre on our website www.cqc.org.uk.

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

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Before our inspection activity had concluded the provider served notice on the five people living at the service. Clinical assessments of people were then undertaken on the same day as inspection due to concerns for people's health and safety. This led to three people being moved to hospital and two people being moved to another home over a two-day period. Local authority staff were brought in to the service due to staff failings to provide the care and support people needed. The provider then cancelled their registration.

We have identified breaches in relation staff use of Personal Protective Equipment (PPE) management of COVID-19, assessing people's care needs and seeking medical intervention in a timely manner, ensuring people received medicines safely, and how the service was managed and led at this inspection.

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

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This meant we would have kept the service under review, however, the provider cancelled their registration.

For adult social care services, the maximum time a service would be in special measures for would usually be no more than 12 months.

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

The Elms Care Centre

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 Care Act 2014.

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
The inspection was carried out by one inspector.

Service and service type
The Elms Care Centre 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.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

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.
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.
We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff including a permanent and temporary care worker, a cook and the covering manager. We also spoke with the provider.

We reviewed a range of records. This included three people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at three staff files in relation to recruitment and staff supervision. We also reviewed additional policies and procedures, training records and quality assurance records. We also liaised with the local authority regarding their concerns and involvement.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure risks to people's safety was reduced and did not ensure people received medicines safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. It was not evident at inspection enough improvement had been made and the provider was still in breach of this regulation.

Preventing and controlling infection

- COVID-19 positive staff continued to work at the service. The provider had sought advice from Public Health England, but government guidance to ensure COVID-19 positive staff were self-isolating had not been followed. This meant people and staff continued to be exposed to contracting and transmitting COVID-19 unnecessarily.
- The provider failed to effectively manage the COVID-19 outbreak. Government guidance, policies and procedures were in place, but staff failed to consistently follow them which placed people and staff at risk of contracting and transmitting COVID-19. The service experienced a significant COVID-19 outbreak which led to all residents contracting the virus. Seven people died of COVID-19. Most of the staff had been infected with COVID-19 and eventually self-isolated which meant agency staff were used as there was not enough staff available to care for people.
- The provider failed to ensure staff received consistent Polymerase Chain Reaction (PCR) testing for COVID-19 at the time of the COVID-19 outbreak. At the time of inspection staff had not received a PCR test for over a week and had only used Lateral Flow Tests (LFT). This was not in line with government guidance around testing. This meant people and staff may have continued to be exposed to the risk of contracting and transmitting COVID-19.
- Staff did not safely and consistently use PPE. Staff were observed moving between areas of the service such as the kitchen and between bedrooms of COVID-19 positive people without changing PPE or washing or sanitising their hands. This meant people and staff were exposed to the risk of contracting and transmitting COVID-19.
- People were not always safely barrier nursed. We observed a person who was COVID-19 positive with their bedroom door open. We also viewed daily records which stated people who were COVID-19 positive were moving around the service and spending time in communal areas rather than being supported to self-isolate in their bedrooms. This meant people and staff were exposed to unnecessary risk of contracting and transmitting COVID-19.
- Used PPE was not safely disposed of. Yellow bin bags were hung from rails and placed outside bedroom doors. This meant used PPE from COVID-19 positive people was exposed which could have transmitted the virus. This was raised with the covering manager at the time of inspection who rectified the concern and

placed bins with lids around the service.
● People did not have COVID-19 specific care plans. This meant staff did not have the appropriate guidance and information to provide safe care and support to people.
● Cleaning was not completed adequately. Delegation of cleaning duties was not prioritised and there was no contingency in place to ensure cleaning continued whilst cleaning staff were self-isolating due to COVID-19. Cleaning schedules were not robust and failed to evidence high touch point and deep cleans specifically for COVID-19 were being completed. Cleaning products used were not always adequate or appropriate for COVID-19 viruses.

Systems and processes to safeguard people from the risk of abuse
● People were not safe. People's basic care needs were not being met, and staff were neglecting them. Staff did not identify their practice was poor and there was no mechanism in place to monitor the care people received as there was no managerial support or oversight.
● There was a whistle blowing policy in place and staff had contacted partnership agencies and CQC to alert them to poor practice taking place at the service. Staff had acted with courage to speak up and seek support for people who were being subject to poor care and exposed to risk due to poor management of the COVID-19 outbreak.

Using medicines safely
● People were not always given their prescribed medicines. Medication Administration Records (MAR) showed one person had not received any medicines for a whole day. Another MAR evidenced one person had not received some of their prescribed medicines. There was no information recorded stating why this had occurred and no evidence to suggest support was sought from a GP. This meant people may have experienced adverse health effects which may have been avoidable.

Assessing risk, safety monitoring and management
● People's health needs were not met. Staff failed to identify people's health was deteriorating and failed to seek medical intervention in a timely manner. For example, three people were assessed as approaching the end stages of their lives, but staff had failed to identify signs of this.
● People did not have their needs and risks assessed and managed. Care plans and risk assessments were not all current and not reflective of people's current presentation. This meant staff did not have the necessary information and guidance to allow them to safely meet people's needs and risks.
● Daily records were not accurate or informative. Staff had implemented a system of recording during the COVID-19 outbreak which was not robust or fit for purpose. For example, people's fluid intake was not accurately recorded, and staff were unable to tell visiting nurses when people had last had a drink or how much they had consumed. This meant there was no mechanism for staff to monitor people's hydration and resulted in all five people being dehydrated. Staff failed to identify concerns and seek support from health professionals in a timely manner.

The provider failed to ensure people were safe; that their care needs were identified, and medical intervention was sough; that people were protected from the risk of infection and COVID-19 and failed to ensure people received medicines in a safe and appropriate manner. These are all breaches of Regulation 12(1) Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staffing and recruitment
● There was not enough staff. Agency and covering staff were introduced during the COVID-19 outbreak and living in the service as there were not enough staff able to work. There was no evidence temporary staff had completed an induction, any training or received a robust handover to ensure they were aware of the care

needs and circumstances of the people living at the service.
● Training records showed not all staff had completed all training relevant to their roles. Evidence was provided after inspection demonstrating a list of COVID-19 training offered, but there was insufficient evidence all staff had completed the training. A staff member told us they had not received any training on the use of PPE and said they applied "common sense" when using it. Assurances were not provided staff had the appropriate skills, knowledge and experience to provide safe care and treatment to people living at the service.

The provider failed to ensure sufficient numbers of adequately trained and experienced staff were available to provide the care and support people required. This is a breach of Regulation 18(1) Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● Staff had been recruited safely. Recruitment records of three staff were viewed showed staff had undertaken a recruitment process and received checks with the Disclosure and Barring Service (DBS).

Learning lessons when things go wrong
● It was unclear how lessons were learnt or how they were shared with staff when things went wrong. From our inspection there was no assurance or evidence to demonstrate lesson learning and debriefs took place.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

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.

At our last inspection the provider had failed to ensure management systems were effective to minimise risks to people's safety. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had not been enough improvement made at this inspection the provider continued to be in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The culture of the service was not open and transparent. Whistle blowers had raised concerns about COVID-19 positive staff continuing to work at the service. Partner agencies and CQC then explored the concerns raised.
- There was a blame culture within the service. Following the inspection, we observed and were told by the staff onsite they had been blamed for the service closing down at the team meeting, rather than the management team and provider taking responsibility and accountability for the failings of the service. We were also informed by the local authority of whistle blowers who had raised concerns the provider had blamed them for not doing their jobs and allowing people to die of COVID-19.
- The service was not well-led. One staff member told us, "Managers come and go." This meant there was a lack of consistency and leadership at the service. During the COVID-19 outbreak the manager was ill with COVID-19 and was absent from the service. The manager and area manager provided telephone support until a covering manager started at the service, but this was not sufficient to support the service which was in crisis. The provider failed to ensure adequate management and staffing support was put in place. The running of the service had fallen to the seniors who a staff member told us, "Had been brilliant and had been hands on to bring the service through the outbreak."
- Staff were supportive of one another. Positive and supportive interactions between staff were observed during inspection.

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

- There was not a registered manager at the service. A manager was in post and an application to register with CQC had been submitted. However not all relevant information had been provided.
- Audits were inconsistent and ineffective, they did not evidence how shortfalls had been addressed. For

example, concerns were highlighted around staff performance due to training gaps but there was no evidence concerns had been addressed. This meant staff could be providing care in areas they were not competent placing people at risk of avoidable harm.

● Issues raised at our previous inspection were still not addressed. For example, large amounts of personal files and confidential documents were found piled up in a cupboard. Amongst the paperwork were care plans belonging to people from another service. The provider had failed to ensure improvements were made and failed to ensure people's private information was stored appropriately, and in line with General Data Protection Regulation (GDPR) principles.

● Audits and quality assurance processes were in place but not robust at identifying what actions needed to take place to make improvements. While some improvements had been made to care plans for example, enough change had not been made quick enough to provide assurances people were safe and the service was well-led.

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

● Relatives received information about their relatives. Staff were observed having telephone conversations with relatives of people who had died. Staff were compassionate and tried to assist relatives with questions they had.

Working in partnership with others

● There was not a positive working relationship with the GP. The service raised concerns around the lack of support from the GP surgery during the COVID-19 outbreak. The concerns raised are being explored with the GP surgery.