HC-One Limited

Elmwood Nursing Home

Inspection report

32 Elmwood Road
Croydon
Surrey
CR0 2SG

Tel: 02086894040
Website: www.hc-one.co.uk/homes/elmwood

Date of inspection visit:
23 October 2018
26 October 2018
29 October 2018

Date of publication:
30 January 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13, 26 and 29 October 2018. The inspection was unannounced.

At our last inspection in March 2018 we found Elmwood Nursing Home to be on breach of five regulations of the Health and Social Care Act. These breaches were in relation to safe care and treatment; dignity and respect; staffing; consent and poor management. As a result of these findings we rated the service 'Inadequate' and placed Elmwood Nursing Home into 'Special Measures'. At this inspection we found the service to be in continued breach of all five regulations and identified breaches of two further regulations. The additional breaches were in relation to protecting people from abuse and notifying CQC of incidents were people had been harmed.

Elmwood Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 accommodates up to 60 people across three floors. 35 people were living in the service at the time of the inspection.

The service did not have a registered manager in post. However, a new manager had been appointed at the service and they were in the process of registering with CQC. 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.

People continued to be at risk of unsafe care and treatment because care records continued to contain inaccurate information about people. The incorrect details in care records included the wrong textures for food and consistencies of drinks for people who were at risk of unsafely swallowing. Care records showed that people were at risk of pressure sores worsening because dressings were not changed as frequently as prescribed. People were not adequately safeguarded from abuse and improper treatment because the provider failed to notify the CQC and Local Authority when people had been harmed. This prevented the appropriate level of investigation from being carried out. The provider continued to deliver nursing care to people without directly employing nurses to manage care to people on each floor.

People were not always treated in line with the principles of the Mental Capacity Act 2005. Care records continued to provide staff with incorrect information about people's capacity and ability to communicate. Staff were not receiving regular supervision or appraisal but they did receive on-going training. People accessed healthcare professionals whenever they needed to and the service provided people with nutritious meals.

Staff did not always demonstrate care when supporting people. People who were living with dementia were left for lengthy periods in their wheelchairs in the centre of communal areas in view of others, instead of being transferred to armchairs alongside them. When these and other people became upset they did not

receive the care and reassurance they required. In general, people's dining experience continued to be poor. People were left unattended for long periods at dining tables without explanation and staff spoke very little to people as they served and supported them. However, staff providing one to one assistance to enable people to eat, did so with kindness and sensitivity.

People's care records, whilst more personalised than those we reviewed during previous inspections, continued to contain inaccurate information. When people's needs changed they were not always reflected in care record and daily care records were not always completed appropriately. The service was responsive and creative in meeting people's spiritual needs and people identified to be approaching the end of their lives continued to be supported compassionately.

The service continued to be inadequately managed. This was the fourth consecutive inspection at which we have found the provider to be in breach of regulation related to good governance. The provider organisation had failed to improve the overall quality of service people received. This prevented people from receiving their care and support in line with fundamental standards. Quality assurance audits and processes identified a number of the issues we found during our inspection but failed to address shortfalls. This included a failure to improve people's dining experience and to make safeguarding referrals.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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.

During this inspection, we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The provider has remained in continuous breach of safe care and treatment regulation for three consecutive inspections.

People continued to be at risk of unsafe treatment because care records continued to contain inaccurate information about people's mobility and swallowing.

People were at risk of pressure sores worsening because dressings were not changed in line with care plans.

The provider prevented a thorough investigation of incidents where people may have experienced abuse or improper treatment by repeatedly failing to report people's injuries in line with safeguarding procedures.

Staff were recruited using robust procedures.

Medicines were administered by trained staff and were stored safely.

Is the service effective?

Requires Improvement

The service was not always effective. Care records contained inaccurate information regarding their communication and mental capacity.

Staff did not receive regular supervision or appraisal.

People had access to healthcare services and were visited by healthcare professionals.

Staff served nutritious food to people.

Is the service caring?

Requires Improvement

The service was not always caring. People were left for long periods without receiving staff attention.

People were not always supported appropriately and reassured

when they became anxious.

There was very little interaction with, or care shown towards, people when dining.

People receiving one to one support to eat were supported respectfully and their dignity was maintained.

People and relatives told us the staff were caring.

Relatives were made to feel welcome when they visited.

Is the service responsive?

Requires Improvement

The service was not always responsive. Whilst care records had become more personalised they continued to contain inaccurate information.

Care records were not always completed resulting in gaps in recording.

Care records were not always updated to reflect people's changing needs.

The service supported people around their spiritual needs.

People were supported compassionately during end of life care.

Is the service well-led?

Inadequate

The service was not well-led. The provider's quality assurance processes continued to be inadequate and failed to bring the service out of regulatory breach.

The provider failed in its legal duty to notify the CQC of serious incidents in which people were harmed.

The service did not have a registered manager or deputy manager in post.

Agency nursing staff continued to be in change of all three floors of the nursing home.

Staff and relatives thought the service had improved and expressed confidence in the manager.

The service received input and support form external agencies.

Elmwood 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 checked 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 unannounced inspection took place on 13, 26 and 29 October 2018. It was undertaken by three inspectors, one nursing specialist advisor and one expert 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 this inspection we reviewed the information we held about the service, including the statutory notifications we received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We reviewed feedback and quality monitoring undertaken by the local authority along with an internal audit of the service undertaken by the provider organisation. We used this information in the planning of this inspection.

During the inspection we spoke with seven people, five relatives and one visiting healthcare professional. We spoke with three agency nurses, three maintenance and housekeeping staff and six care staff. In addition, we spoke with the manager, clinical lead, chef, Wellbeing Coordinator, area quality director and regional quality director.

We reviewed 15 care records including risk assessments and care plans, 10 medicines administration records, five wound care plans and six staff files. We checked accident and incident records, safeguarding information, minutes of meetings, complaints and compliments and we reviewed the provider's quality assurance audits. We also checked health and safety, fire safety, food safety and infection control practices at the service. Throughout the day we undertook general observations and used the short observation framework for inspection (SOFI) in the main lounge. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection we contacted five health and social care professionals for their views regarding Elmwood Nursing Home.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2018, and at the inspection prior to that in September 2017, we rated the provider 'Requires improvement' when we asked the key question, 'Is the service safe?' We found the provider to be in breach of regulation at both inspections. People were placed at risk of receiving unsafe care and treatment because care records contained incorrect information, which if followed by staff could result in harm to people. Additionally, at our last inspection we found that people at risk of pressure ulcers were not always supported in line with their care plans.

At this inspection we found that people continued to be at risk as a result of inaccurate care records regarding their mobility, moving and handling needs. For example, one person had care records which stated, "[Person's name] is no longer mobile and relies on the support of two staff and a Zimmer frame for all transfers." However, elsewhere in the same person's care records we read, "[Person's name] transfers themselves from chair to chair or bed to chair and vice-versa." This meant there was a risk of staff who were unfamiliar with people reading the wrong information and delivering unsafe support to people.

People remained at risk of choking when eating. Just as we found in our September 2017 and March 2018 inspections, care records continued to contain contradictory and inaccurate information relating to the texture of food people required to enable them to swallow safely. For example, one section of one person's care records informed staff that a person required a "Fork mashable" diet but elsewhere within their care records it stated they required a "thick puree diet." Another person's care records stated in different sections that they should be supported to have, "A soft diet", "A fork-mashable diet", and a "A normal diet." This contradictory information prevented staff from clearly understanding either the risks to the person or the support they required. The provider's failure to present staff with clear guidance in care records meant people were at risk of choking.

People continued to be at risk of developing chest infections as a result of drinking unsafely. People identified to be at risk of liquids entering their airway as they drank, were assessed by healthcare professionals. These assessments resulted in directions as to the consistency of fluids people should drink. By adding a thickening agent to drinks such as water and tea the risk of people accidently inhaling fluid and developing chest infections can be reduced. However, as was the case at our last inspection we found evidence of contradictory information in care records regarding the consistencies of people's drinks. For example, within one person's care records we read guidance to staff that the person could have "normal fluids". However, this was contradicted elsewhere in their care records where a healthcare professional was reported as stating the person needed thickener for fluids. This conflicting information placed the person at risk as the guidance offered to staff was inadequate.

People who had experienced pressure ulcers were at risk of not receiving the care and treatment prescribed. For example, one person had been issued with pressure relieving boots following assessment by a tissue viability nurse. When we checked we found the person was not wearing their recommended boots and staff did not know where they were. People's care records stated the frequency with which their pressure ulcers should be cleaned and new dressings applied by nurses. We reviewed people's wound charts and found

people did not always have their wounds treated in line with their care plans. For example, one person's wound care plan stated that dressings should be changed every four days. However, records showed that on five occasions dressings were changed every six or seven days and on one occasion nine days lapsed between staff signing to confirm the person had their wound cleaned and dressed. Another person had clear instructions in their care records directing staff to change the person's dressings, "Twice weekly, every Wednesday and Saturday." We reviewed their records and found one occasion in which staff had not signed to confirm that dressings had been changed for 15 days. Because of the failure to complete wound care records we could not be assured that people's dressings were being changed in line with care plans. This meant people were at risk of infection and a deterioration of their pressure sores.

These issues demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Safe Care and Treatment.

People were not protected from the risk of abuse and improper treatment. The provider failed in its duty of care to appropriately report serious incidents in which people had experienced harm. We reviewed care records and found that one person had been admitted into hospital with a grade three pressure ulcer. A pressure ulcer is diagnosed as grade three where there is full thickness skin loss leaving a deep crater but the tissue surrounding the wound is undamaged. In a letter to the service a concerned healthcare professional instructed the care home to raise a safeguarding alert with the local authority and to inform the CQC. The service did neither. In another example, a person had bruising four centimetres in length along their forehead with discolouration beneath one eye. Staff did not know how this injury had occurred and the service did not make a safeguarding referral to the local authority or inform the CQC. In a further example, we saw a person with plaster cast on their arm on the first day of our inspection. We reviewed their care records and found the person had experienced a fracture wrist. The provider sent a notification to the CQC on the day of our inspection, which was seven days after the fracture occurred, but only after we had enquired about the person's injury. The service had not informed the local authority safeguarding team. Our concerns regarding the provider's failure to make safeguarding referrals were heightened by a local authority enquiry substantiating a finding of neglect against the provider in April 2018. This was in relation to person who developed a grade four pressure ulcer. A pressure ulcer is diagnosed as a grade four where there has been extensive skin destruction and damage to surrounding areas which may include muscle, tendon and bone. We insisted that the service inform the local authority's safeguarding team about these incidents and confirm to us that they had done so before we finished our on site inspection.

This is evidence of a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

Notwithstanding our findings, people and their relatives told us they felt Elmwood Nursing Home was safe and that people receiving care and support were safe living there. One relative told us, "I can't fault the place. I have absolutely no worries about my [family member's] safety whatsoever." Another relative said, "I never leave here worried how staff will treat my [family member]."

Staff were deployed in enough numbers to meet people's needs. However, relatives continue to express concerns at the level of agency staff used by the service. One relative told us, "There's far too heavy a reliance on agency staff and these staff often lack the necessary experience and skills and, of course, don't know the residents". Another relative said, "There have been recent improvements and there is increased staff morale but the weekends can present staff issues".

At our last inspection we found that the nursing home did not have any nurses employed to manage nursing care on each floor. At this inspection we found that all of the nurses deployed during the daytime, night time

and at weekends were agency staff. The service manager informed us that the agency nursing staff were booked for block periods so they could become familiar with people's needs and the clinical lead overseeing them continued to be directly employed. The manager was confident that recent recruitment efforts by the provider would soon result in nurses being appointed to permanent positions at the care home.

People were protected by the provider's robust recruitment processes. Before joining the service and being allowed to deliver care and support, staff were interviewed and background checks were carried out. Checks included taking up two references, confirming the identities of staff and the outcome of checks by the Disclosure and Barring Service (DBS). The DBS checks criminal records and lists of individuals barred from working with vulnerable adults. This information enables providers to make safe recruitment decisions.

Care records noted people's support needs and preferences around taking medicines. Staff completed medicine administration records [MAR] charts to confirm people had received their prescribed medicines. We checked people's MAR charts and found they had been completed appropriately with no gaps or omissions in recording. MAR folders contained large, clear, up-to-date photographs of people to ensure the right medicines were administered to the right people. People's allergy status was stated on the front of their MAR to alert staff. Medicines stocks were kept in a locked room and the temperature of the room was regularly checked to ensure medicines remained safe. Medicines in use were stored appropriately in medicine trolleys that were locked and fixed to walls.

Maintenance and housekeeping staff undertook a range of checks to ensure the environment of the care home was safe. For example, checks of people's profiling beds included examining the motors, controls, bumpers, air flow pumps and space around them. Other checks included a visual inspection of plugs and sockets and a physical check of running water temperatures from people's hot taps to protect people against the risk of scalding. To reduce the risk of legionella bacteria making people sick, the provider had a programme of flushing through water systems. By flushing toilets and running taps in bedrooms that were unoccupied, staff prevented bacteria from multiplying and spreading in still water. Maintenance and housekeeping staff maintained records of these checks and actions. Records were also maintained of the daily and weekly deep cleaning around the service, which included people's bedrooms.

The service stored chemicals for use in cleaning which could be dangerous to people. We checked how these chemicals were stored and found them to be held securely in locked facilities to which people did not have access. Chemicals for cleaning and laundry were subject to checks throughout the day. These audits were undertaken by the head of housekeeping, recorded and double checked by the manager. This meant people were protected from the risks associated with potentially hazardous materials.

Staff were trained and prepared to respond to a fire emergency. Fire drills were undertaken involving staff who worked in the day and at night to practice evacuation procedures following a fire alarm activation. A 'grab box' was situated at reception for staff to collect as part of their evacuation plan. The grab box contained torches and high visibility vests, a first aid box, a floor plan of the care home, the contingency plan for evacuation and important contact telephone numbers. This meant people's safety was enhanced by the readiness of staff to react to a fire and subsequent evacuation.

People were protected from the risks associated with unhygienic practices during personal care and food preparation. Staff wore gloves and aprons when supporting people with personal care. They disposed of this personal protection equipment after each use to prevent the spread of infection between people. In the kitchen staff wore hairnets in addition to gloves and aprons and prepared different foods on colour coded chopping boards to prevent cross contamination. Staff monitored the temperatures of refrigerated, cooked

and served foods and followed a detailed cleaning programme for the kitchen which included surfaces, appliances and the interior of food storing areas.

Requires Improvement

Is the service effective?

Our findings

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).

At our last three inspections we found that people were not always treated in line with the principles of the MCA. This was because some people's care records contained contradictory and inaccurate information about their communication and capacity. At this inspection we found people's care records continued to contain contradictory and inaccurate information about their communication. For example, one person had care records in place which stated they, "Lacked capacity" and "Cannot express themselves verbally." This information was incorrect as the person spoke with us on several occasions during our inspection. Another person had care records which stated in one place that they had "No capacity to express themself". However, within their care records it was also stated that they were able to make choices about their care with staff support. This meant people with capacity to make decisions were at risk of being denied their right to make them by staff who were informed by inaccurate and contradictory care records.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Need for Consent.

At our 2017 inspection we found that staff were not in receipt of regular and appropriately recorded supervision. This was a breach of regulation. At our March 2018 inspection we found that staff were receiving supervision which were recorded in detail but they were not receiving appraisals. This was a continuing breach of regulation. At this inspection we found the provider remained in breach of regulation because evidence could not be presented to show staff were receiving regular one to one supervision in line with the provider's policy, although records showed some staff had received appraisals. Staff we spoke with told us they knew regular supervision was planned for them but this had not yet happened. Staff also told us they had not been through an appraisal process. This meant staff were not appropriately supported and evaluated as they delivered care and support to people.

This is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Staffing.

People were supported by staff who were trained and had been inducted into the service. Staff undertook training in key areas including safeguarding, safe people handling, equality and diversity and infection control. One member of staff told us they found the training in the use of hoist equipment particularly useful. Staff training was delivered in person by trainers and on line through e-learning. There was a facility at the service for staff to train online. The room had two computer terminals and printing facilities. Headphones

were available to assist with audio tasks and concentration. All new staff completed mandatory training within their first week of starting at the service.

People were provided with nutritious food, a balanced diet and encouraged to drink plenty. One person told us, "I eat better here. The food is good." The dining areas on each floor were bright and clean. There were flowers on each table and contrasting colours were used for table clothes and place mats. This supported the visual needs of people living with dementia and sight loss. A changing daily menu was offered. Staff gave us examples of people being given alternatives if they asked for something not on the menu which included food from varying cultures.

Staff supported people to access healthcare services. Care records showed that people received input from a range of healthcare professionals. We spoke with one healthcare professional who told us that the service were timely in contacting them when people's needs changed. Staff maintained a record of healthcare professionals' involvement with people within their individual care records which enabled people's progress to be monitored. Staff had information about people's health needs. For example, we read guidance in care records regarding signs to be aware of that people diagnosed with diabetes may be becoming unwell. The signs staff were advised to be aware of included increased urination at night, increase thirst and recurrent infections. Staff were also told what action to take to effectively support this changing health need.

The service continued to be fully wheelchair accessible. Elmwood Nursing Home was purpose built and can be accessed by people using wheelchairs. Moving and handling equipment such as hoists were available to assist people. Lifts enabled people to move between floors and the entrance to the building was step free. The garden was accessible to people and garden furniture was arranged for people who wished to spend time there. There were lounges and dining areas on each floor and an activity day room for people to access

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated the care home 'Inadequate' when we looked at the key question, 'Is the service caring?' This was because staff spoke to people in an impolite way, lacked respect towards people during mealtimes and failed to protect the dignity of people who had been incontinent. Accordingly, we found the service to be in breach of regulation.

At this inspection we found that people were not always treated with dignity and respect because staff were not always attentive and communicative. People living with dementia were sometimes left for lengthy periods without staff interaction. For example, staff supported one person into the lounge in a wheelchair and left them. The person was not supported to transfer to a more comfortable and appropriate arm chair, like the other people in the room, for one hour and 40 minutes in full view of others. In another example, we saw a person become increasingly agitated when staff did not transfer them from a wheelchair to a lounge chair. Staff did not respond appropriately as the person became visibly and audibly anxious and did not explain why the person had to wait so long, instead telling them, "Yes I know you want to sit down. Just wait." Similarly, we saw staff fail to respond and reassure a third person who was saying they wanted to, "go home". This person became increasingly distressed but was ignored by staff. In a fourth example, we recorded a one hour and fifteen minute time lapse between staff interacting with another person.

Following our last inspection, where we observed poor practice and a lack of care around mealtimes, the provider had supported staff to undertake 'Dignity in dining' training. This involved training staff around the need to focus on welcoming people to the dining area, helping them relax, the need to offer and help with choices and to prioritise a good mealtime experience for people. At this inspection we observed people eating at lunchtime on all three floors. We saw people were sitting at their tables for up to twenty minutes without being served food or spoken to by staff. Generally there was little interaction between staff and people. We observed one staff member who stayed silent throughout the whole lunchtime period and didn't speak to any people. Some people who did not receive prompting, support, or encouragement ate very little. This meant people continued to experience a lack of care when dining together.

We also observed a number of people who required one-to-one staff support to eat their meals. We saw that staff stayed with those people throughout the meal, speaking to them in a respectful and caring manner, maintaining eye contact and encouraging them to eat their food. Staff informed people about what was on the fork they were presented with and chatted with them throughout their meal.

Staff did not always support people in ways that promoted their independence. For example, one person's care plan stated that they sometimes ate independently, but they were not given this option as their food was placed out of their reach and a member of staff came to feed them. On another occasion, a member of staff repeatedly lifted a glass of fruit juice to a person's lips so they could drink, which was not part of their care plan and we observed the same person drinking independently when staff were not with them.

Whilst the service had made improvements it continued to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Dignity and respect.

Notwithstanding our findings above, people and relatives were generally positive about the staff and the service. One person told us, "The staff are good." A relative said, "Some of the regular staff are wonderful." At times during our inspection we saw staff acting at times in kind and gentle ways towards people. For example, whilst walking along a corridor we overheard one person who was readying themselves to leave their bedroom, ask a member of staff, "Do you think I look nice today?" The member of staff responded, "I think you look lovely." The person asked, "Are you sure?" To which the member of staff said, "Definitely. 100%". We observed the person emerging onto the corridor smiling. We noted from our conversations with staff how they showed concern for people's wellbeing and spoke about people in a caring and meaningful way. We read care records which gave staff guidance on being caring towards people. One person's care records directed staff to, "Ensure [person's] feet are covered so they don't get cold." Another person's care records said, "Should [person's name] have a restless or unsettled night, offer plenty of reassurance and support [them] to get comfortable." Within a third person's care records we read the instruction to staff, "[Person's name] to be reminded that they should not hesitate to use the call bell."

People's care records contained personalised information. This included information that was important to people such as when, where and to whom they were married as well as their age at the time. One person's care records stated, "[Person's name] enjoys listening to music however doesn't like it too loud", going on to note the person, "Will clap their hands and tap their feet" to indicate their enjoyment. Another person's care records noted the importance they placed upon talking with staff. We read entries in this person's daily records noting the, "Chat time" they had shared with staff. Some of these entries also included information about the topics the person and staff had conversed about.

Relatives told us they were made to feel welcome when they visited the service. One relative said, "I think the new manager understands how important it is to get relatives on board. He makes the point of talking to us personally and he arranges meetings for us." Another relative told us that staff offered them a drink when they visited and, "Respect our privacy yes, but pop their head round the door every now and then to make sure everything's alright." The manager had ordered a post box for the service with the intention of supporting people to write and send cards and letters to loved ones. People and relatives were reminded of upcoming events. There were notice boards near the communal lounges on each floor. These displayed clear and colourful posters advertising upcoming events. Among the events advertised were dates for the Christmas pantomime, the next relatives' meeting and when the chiropodist would be visiting the service.

Requires Improvement

Is the service responsive?

Our findings

At our last two inspections we found Elmwood Nursing Home required improvement when we looked at the responsiveness of the service. This was because some care records were inaccurate, contained gaps in recording and were not personalised.

At this inspection we found that people's care records continued to contain inaccuracies. These inaccuracies included conflicting information about whether one person's diabetes was type1 or type 2. Another person's records contained the contradictory information that they required normal food and pureed foods. We also found that people continued to have gaps in their care records. For example, no entries were made into one person's care records related to their personal care on three separate occasions. Another person's elimination records were not completed for eight consecutive days. This meant that we could not be assured that staff were delivering care and support in line with people's care plans.

Care records did not always reflect people's changing needs. For example, one person sustained a fractured wrist one week before our inspection but their care plan had not been updated. This person's care plan stated that they were able to perform several tasks independently, such as moving around in their wheelchair, which would be difficult or impossible with a broken wrist. Another person's care plan stated that they were able to walk with a frame and move independently from chair to chair, but a short update on the back of the care plan added that they were now unable to mobilise without a wheelchair and required use of a hoist to move between chairs. This meant staff did not have accurate guidance in care records to respond effectively to people's changing needs.

Care records did not always provide staff with the guidance they required to support people responsively. For example, one person's care records noted they may become anxious but did not direct staff how to respond and support the person when this happened. We saw this person become agitated on three occasions during a two hour period without staff intervention. In one instance the person became very distressed on realising they did not have a personal item with them. The person became increasingly distressed until staff brought the item to them twelve minutes later.

Care plans contained personalised information about the support people needed to complete personal care tasks such as bathing and eating including the equipment they needed to use, their likes and dislikes and their preferred routines. For example, one person's care plan noted they liked, "Staff to take their watch off and place it on the side table whilst they have a bath or shower." Another person's care record noted they preferred to wear blouses and trousers rather than dresses and skirts. However, people did not always receive the support their care plans said they should. For example, one person's care plan stated in two places that they did not like fish but that person received fish for lunch, which they ate. This indicated either that the person's care plan contained incorrect information or that they were not receiving food that was appropriate for them.

The service was responsive to people's spiritual needs. The service supported people to maintain links with their faith communities. Church of England, Seventh Day Adventist and Catholic representatives attended

the service and met with people. Shortly before our inspection the care home hosted an interfaith religious service. This service of thanks giving was designed to bring people together around the core values shared between faiths. The interfaith service included Christian prayer, Islamic poetry and Hindu meditation.

People had memory boxes by their doors to help them identify their rooms. These contained recent as well as old photographs of people. The service did this in line with research informed good practice which identified that people living with dementia may recognise and relate to pictures of themselves when they were younger as opposed to photographs of themselves now. Memory boxes also contained items of individual significance to people. For example, one person had playing cards to reflect their love of card games. Another person had a printed statement which said, "I love to be pampered, l especially like when I get hand massages and my nails done."

Staff offered people a variety of activities. One person's care plan stated that they loved singing and records showed they had participated in several singing sessions in the last month as well as a number of other activities. The service had an activities co-ordinator who led people in activities including Singalongs, bingo, painting, ball games, baby-doll therapy, board games, card games, dominos, puzzles, hand massage. Where people preferred to spend time in their own rooms this was referenced in care records and the support required was stated. For example, one person's care records stated, "[Person's name] enjoys staying in their room enjoying their own company. Staff had guidance in care records to regularly spend time taking with the person in their bedroom and to ensure their television was tuned to the channel of their choice."

The provider had a complaints policy in place which could be used by people and their relatives. Additionally, people and relatives had the opportunity to raise concerns directly with the manager at his weekly surgery or residents' and relatives' meetings. Complaints were investigated and responded to in line with policy.

People were supported compassionately as they approached the end of their lives. People were supported by healthcare professionals when they were identified as being on the end of life pathway. This included the involvement of palliative specialists from a beacon hospice. People's end of life care planning included their wishes for the dying phase of their care. These were gathered in a booklet entitled 'Remembering together'. This booklet also stated how people would like their cultural and spiritual needs to be met and their preferences for funeral arrangements. The service supported people to remember their friends who had lived in the service and who had died. The service won an award from the provider organisation following the development of its remembrance garden which contained the names and photographs of people who had died over the previous three years. People were supported to use the remembrance garden for reflection whenever they chose.

Inadequate

Is the service well-led?

Our findings

At our last inspection of Elmwood Nursing Home we found the provider's leadership to be inadequate. This was because the provider did not fully implement its improvement action plan, there was uncaring practice, quality audits failed and the service was in breach of five regulations. At this inspection we found continued failure to make significant improvements. Checks of quality remained inadequate because they failed to correct the shortfalls the provider's audits identified and the service was in breach of seven regulations.

At this inspection we found the provider's quality assurance processes continued to fail to adequately address the shortfalls we found at our September 2017 and March 2018 inspections. For example, in the 'Safe' section of this report we refer to a person whose care records provided conflicting information as to their food texture and moving and handling needs. This is the third consecutive report in which we have highlighted these concerns in relation to this person. The service used a 'Resident of the day' format to review people's care records. These were signed to confirm that each section of people's care records were checked. We read this person's 'resident of the day' check which incorrectly confirmed that the care records were accurate. This meant that despite audits being undertaken, one year and one month after we highlighted the contradictory information in this person's care records to the provider, the errors remained.

The provider organisation failed to respond appropriately to the findings of its quality assurance processes where shortfalls in the nursing home were identified. For example, senior managers conducted an in-depth audit of the service and identified that safeguarding referrals should have been referred to the local authority. However, when the service failed to raise safeguarding alerts, the provider organisation failed to take action and ensure safeguarding referrals were made. This meant there was an inadequate response to shortfalls at both the care home management level and provider management level. In another example, an audit by provider level managers identified that people were not experiencing a positive dining experience. Senior managers observed staff failing to appropriately support people around meal times. The failings observed included staff not speaking to people and not providing sufficient support around people's independence. We found the same failings when we inspected the service one month after the provider's audit. We have reported what we found in the 'Caring' section of this report. This meant the provider's quality assurance processes did not always lead to improvements for people despite senior managers being aware of failings.

The service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Good Governance.

The provider failed in its legal duty to notify the CQC of significant events in which people had experienced harm. We found evidence that elderly and frail people had experienced bone fracture, pressure ulcers and facial bruising. Had we been aware of a grade three pressure ulcer occurring at the service we would have assessed the risks to people and determined if an inspection should have taken place sooner. Our assessment of risk would have taken into consideration the April 2018 finding by the local authority that an allegation of neglect against the provider had been substantiated after a person developed a grade four pressure sore. By failing to submit timely notifications the provider prevented the CQC from carrying out our

regulatory function to monitor and make sure people received safe care.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

At the time of our last inspection the service did not have a registered manager in post. Nor did the service have a deputy manager or any nurses deployed. This continued to be the case at this inspection. However, the home manager was in the process of applying to register with the CQC and we were told a deputy manager would be starting shortly. The service had a clinical lead who was a nurse with experience of working at the service. All of the staff we spoke with expressed their support for their home manger. One member of staff told us, "Their management staff is a definite improvement." A second member of the staff team said the manager was, "Very hands on", whilst a third member of staff, commenting on improved team work and communication, told us, "The team is really coming together."

The manager used praise to encourage the staff. We read compliments received by the service, These included thank you messages from relatives for the care their loved ones had received over the years, an appreciation from a relative for making their family member so happy and another thanking staff for their kindness and for the relief of knowing their family member was in safe hands. We also read a compliment from a relative made via a website which reviews care homes. The manager shared these positive messages with the team and thank you cards were displayed on a compliments noticeboards on each floor.□

The manager promoted communication through the team. Staff were supported to attend team meetings. We read the records of three team meetings which showed the manager and staff discussing issues such as people's personal care, record keeping and risk assessments. The manager held daily flash meetings. These meetings were attended by heads of departments who each provided an update on events and plans within their area or responsibility. The manager used flash meetings to ensure all of the senior staff were aware of developments regarding people's care and support, housekeeping, catering, maintenance, administration and activities. Flash meetings were also used to determine the leadership's priorities for the day and to discuss any scheduled appointments. Additionally, the manager and clinical lead conducted twice daily walk rounds. This involved a physical tour and inspection of the building. During walk rounds checks were made of people's changing needs, the home environment and infection control measures in place.

Relatives told us their level of involvement at the service had improved. The manager arranged regular meetings for relatives to attend. We read the records of one relatives meeting. These showed discussion around issues such as leadership developments, staff recruitment and behaviour, the findings of CQC's last inspection report and activities for people. Seven relatives responded to the providers most recent survey of their views and experiences of the service. All of the respondents described their overall impression of the care home as 'average', 'good' or 'excellent'. None described Elmwood Nursing Home as 'poor' or 'very poor'. The survey enabled relatives to make direct comments and we read positive remarks such as, "All staff and nurses are very good at their jobs", and negative responses including, "Home requires permanent staffing as a matter of urgency." The manager held a weekly surgery at the care home. This was an opportunity for people, relatives and staff to "pop in and chat" informally or to discuss matters of importance if they chose. The times of the manager's surgery meetings were highlighted on the noticeboards around the service.

The provider gathered the views of staff. Staff were encouraged to complete an on-line survey. 100% of staff who completed the survey agreed with the statement, "I would report an incident of abuse I witnessed or if I had concerns." 75% of respondents confirmed they were, "Happy at work." When asked whether they agreed with the survey statement, "The team work together to deliver kind care to residents", 42% agreed

whilst 42% disagreed. The manager told us that feedback from staff was reviewed to see where improvements were required. A member of staff told us, "[The service manager] listens to staff. I'm sure he wants to make everything better."

People benefited from the provider's partnership working. In 2017 the Local Authority placed the Elmwood Nursing Home into 'Provider Concerns'. This process involved close monitoring and increased scrutiny of the service by the local authority and an increase in support to the service from health and social care professionals. The significant support offered by the local authority included quality monitoring, attendance at relatives' meetings, guidance around care and support practice. Additionally, the local authority and its partners offered training to Elmwood Nursing Home staff. For example, during the week before our inspection, 10 staff attended a training session on pressure ulcer prevention and management delivered by the local authority's care support team. This meant the service had access to support and guidance on managing and delivering good care and support to people.