Burlington Care Limited

The Elms

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 11 and 12 September 2017 and was unannounced on the first day.

The Elms is registered to provide care and accommodation for a maximum of 37 older people, some of whom may be living with dementia. Communal rooms consist of a sitting room with a small quiet area at one end, a further smaller sitting room and a dining room. There is also a small seated area in the entrance and another in a walkthrough area near patio doors which leads out to a courtyard. The service has a large lawn at the front of the house and a car park. Bedrooms, bathrooms and toilets are located over three floors accessed by a passenger lift. Most bedrooms are for single occupancy but there are also some bedrooms for shared use. The service has good access to local facilities and amenities. At the time of the inspection, there were 34 people living in the service. We were told two people also attended the service for day care.

The service 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 on 27 and 28 April 2017, we judged the service as 'Requires Improvement'. This was because we had concerns about recruitment processes potentially placing people who used the service at risk. There were also concerns that we had not received notifications of incidents which affected the safety and welfare of people who used the service.

Prior to this inspection, we received information of concern regarding the safety of medicines management. There were some safeguarding investigations underway from January 2017 which related to potential shortfalls in the delivery of care; these were still on-going and being undertaken by the local authority. There were also some concerns about the number of accidents and incidents which occurred in the service. We decided to complete a focussed inspection to look at medicines management and to see how risk was assessed. Due to the number of concerns and level of risk found during the inspection, we changed the focussed inspection to a full comprehensive inspection.

The concerns identified during the inspection resulted in us finding the provider in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches included, management of the service, providing person-centred care, not maintaining privacy and dignity, the management of medicines, cleanliness and infection control, identifying and managing risk, good governance and staffing.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures' and the provider must take action to improve and sustain the improvements. 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 registered 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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

We found concerns with how the service was managed and governed. Audits had been completed but these had not been effective in identifying shortfalls and ensuring that lessons could be learned and practice improved. There was also a lack of analysis regarding accidents and incidents and improvements were needed in the investigation reports requested by the local authority.

There was a lack of robust risk management; areas of risk had not been identified and there was a lack of systems to check on-going concerns. This related to the environment, equipment used in the service and people's individual risk assessments. This had placed people at risk of potential or actual harm.

We found infection prevention and control had not been managed appropriately. Areas of the service and some equipment were not in a hygienic state. This placed people at risk of infections.

There were concerns with the safe and proper management of medicines. This had led to some people not receiving their medicines as prescribed and there was a lack of guidance for staff when administering 'when required' medicines. There was also a poor system of stock control that led to large amounts of wastage.

We found there was insufficient staff on duty during the day and not enough domestic staff at weekends, although recruitment was underway for this. The shortages of staff had impacted on support provided to people at meal times and observation of communal areas at specific times of the day to prevent accidents and distract people whose behaviour could be challenging. It had also resulted in a lack of staff attention to people's personal belongings; this in turn had impacted on people's dignity.

People who used the service had assessments and care plans but these did not always contain the most up to date information about their needs. This meant care could be overlooked and placed people at risk of receiving care that did not meet their needs.

People's health care needs were met and they had access to community health care professionals who visited the service to provide treatment and advice.

We found people's nutritional needs were met although one person did require more active support from staff. People liked the meals provided and there was plenty to eat and drink.

There were activities provided in-house and monthly outings were arranged. Some people benefitted from the activities more than others and we have made a recommendation about sourcing specific activities for

people living with dementia and having a designated member of staff.

We found staff had access to a range of training and they said they felt confident when supporting people. Supervision and support arrangements were in place, although staff told us this had not been as good as expected recently.

The provider had a complaints procedure and people felt able to raise concerns. Complaints were logged by the registered manager.

There had been improvements in the documentation of staff recruitment. The new staff recruitment record we looked at had full employment checks in place.

Following the inspection, we received an action plan formulated by the regional manager which showed us that all the shortfalls we identified during the inspection had been taken seriously by the provider. We will continue to monitor the service and complete a further inspection to check out progress with the action plan.

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.

Not all areas of risk had been identified in the service which meant people who used the service were placed at risk of potential or actual harm.

There were areas of the service which needed a deep clean to ensure people were protected from the risk of acquiring health care related infections.

The system to manage medication was not effective as some people had not received their medicines as prescribed, staff did not always have clear guidance on administration and stock was not controlled appropriately.

Although staff were recruited safely, there were shortages of care staff during the day and domestic staff at weekends. There was no activity co-ordinator.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had acted within the mental capacity legislation and safeguards were in place to protect people when they lacked capacity to make their own decisions. However, there was an inconsistency regarding capacity assessments and best interest decision recording for the restrictions some people had.

People had access to health care professionals for advice and treatment.

People's nutritional needs were met although one person needed more support with their needs. Better organisation at mealtimes was required. The menus provided people with choice and alternatives and the meals looked well-prepared.

Staff had received training in a range of subjects; however, there were instances when staff practice demonstrated shortfalls in specific areas such as infection prevention and control. There were differing views from staff about how effective management

support had been recently.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed examples of positive interactions and caring support provided by staff. However, there were concerns identified in some staff actions and how they looked after people's personal belongings which affected people's dignity, comfort and wellbeing.

Relatives described staff support in very positive ways.

We observed people's privacy was respected. However, an issue with a hole in a toilet door caused by the removal of a lock, could compromise privacy.

Some people's personal records were not stored securely.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People had assessments and care plans of their needs, but these lacked important information about how care was to be delivered in a person-centred way.

Staff had not always responded to people's changing needs in a timely way which potentially impacted on their safety and wellbeing.

Although there was an activity programme to provide stimulation and occupation for people, not everyone was able to benefit from this and more tailored activities for people living with dementia were required.

The provider had a complaints procedure and people felt able to complain.

Is the service well-led?

Inadequate

The service was not well-led.

There were concerns about the general management and oversight of the service, which meant audits had not captured shortfalls in order for these to be addressed in a timely way. There had also been gaps in communication between senior managers.

There had been a lack of oversight and supervision of staff competencies in specific areas such as medicines management.

There was a failure to analyse information in accidents, incidents and complaints which meant lessons were not learned in order to improve the service.

Meetings and surveys had taken place which helped people who used the service, their relatives and staff to express their views.

The Elms

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 inspection took place on 11 and 12 September 2017 and was unannounced. The inspection team consisted of one adult social care inspector, an inspection manager and a representative from the local authority safeguarding team.

The service had been inspected in April 2017 and prior to that inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the PIR to help in the planning of this inspection. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with three people who used the service and five relatives. We received feedback from two other relatives when they next visited the service and found we had completed an inspection. We spoke with the registered manager, the regional manager, the registered provider, one team leader, four care workers, one of whom was a senior, a domestic worker and a catering assistant. We also spoke with visiting health professionals which included a psychiatrist, two community nurses and a podiatrist.

We looked at nine care files for people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 15 people, daily notes of care provided and monitoring charts for behaviour, nutritional intake

and weights. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits and complaints management. We completed a tour of the environment.

Inadequate

Is the service safe?

Our findings

There were a number of areas within this key question where we had concerns.

We found there was a lack of oversight regarding the management of risk. This related to the environment but also to the actions of staff when caring for people. We saw workmen were carrying out decoration work in one of the corridors near the entrance. However, we observed the workmen left equipment unattended. The loft hatch was left hanging down, reels of electrical wire and large screwdrivers were left unattended on a window sill, there was a folded ladder leant against a wall, a bedroom used to place decorating equipment such as opened tins of paint and brushes was unlocked and electrical wires were exposed from light fittings. There was no risk assessment that addressed the work taking place during the inspection so people who used the service had limited access to the area. Some bedroom windows were a sash-type and the upper window did not have restrictors, which meant they could be opened wide enough for a person to exit. There was an abundance of used cigarette ends in the flower beds in the courtyard; no ashtray or bin had been provided and at best this was unsightly and at worst a risk to people who used the service.

We observed five people sitting at the dining table in wheelchairs that did not have footplates. Pushing people in wheelchairs without their feet placed on footplates could cause injuries to their feet and ankles. There were walking frames in people's bedrooms that did not belong to, and had not been assessed for, the occupants. One person had a bedrail in place which was unsafe to use; this was removed during the inspection. We observed people had access to plastic gloves, which were an ingestion risk. One person living with dementia was later found with one of the gloves on their hand walking around the service.

There were individual risk assessments in place for people whose behaviour could be challenging to themselves and other people who used the service. However, these did not always contain full information about triggers, the actual behaviour, what distraction techniques worked, what approaches staff were to use to minimise the risk of the behaviour occurring and what to do to protect people when it had occurred. People who had bedrails had a risk assessment but these were to state bedrails were required. They did not assess the person's suitability for them and whether they could present a trap hazard or were the least restrictive option for people.

Not assessing risk and doing all that is practicable to mitigate risk was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

We found not all people had received their medicines as prescribed. Out of the fifteen medication records we checked, administration errors had occurred for two people and there was a possible error with a third person, which was difficult to confirm. One person was prescribed a pain relief patch to be administered every 72 hours but staff had been applying this every 96 hours. Staff were unaware of the error and told us they had always administered the patch in this way. Another person had been administered one tablet a day for two days instead of the prescribed two tablets per day. The third person's medication administration record (MAR) was blank for 19 days for one of their medicines. Staff were unsure why this had occurred and

confirmed it was prescribed for the person; staff thought this may have been a recording error and they had forgotten to sign the MAR. The pharmacist confirmed the medicine had been dispensed into the monitored dosage system.

Some people were prescribed medicines to be taken when required (PRN) or they had a variable dose which required a judgement from the staff based on people's needs in relation to pain or agitation. We found staff did not have guidance about PRN medicines or those with a variable dose to assist their rationale for decision-making.

The medicines trolleys were dirty and splashed with spillages of liquids on the sides. The wheels and casings were ingrained with dirt and food and the container for the collection of medicines pots had items of discarded food in them.

We looked at medication returns records for the last three months. The returns book recorded the name of the person, the type, strength and quantity of medicine, the name of the staff completing the record and the signature of the pharmacist receiving it. The reason why medicines were returned was missing from several pages of the records. The records indicated that stock control was not managed effectively and large amounts of medicines were returned each month and then reordered rather than carried forward to the next MAR. This was an expensive and wasteful practice.

A joint police and safeguarding investigation is currently underway regarding irregularities in the disposal of medicines. This will be reported on when it is completed.

Not ensuring the safe and effective management of medicines was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

Medicines were stored safely in a treatment room and there was a fridge for those that required cold storage. Those medicines which required more secure storage were held in a designated, lockable cupboard. The temperature of the room and fridge were recorded to ensure this remained at an appropriate level. A health professional told us they had found the treatment room was locked at all times.

We found areas of the service were not clean and posed an infection control risk. There was an odour in the entrance and in two of the downstairs bedrooms. Seven of the downstairs bedrooms had small smearing of faeces on specific items such as bedheads, door frame, a toilet floor and seat cushions. A toilet also had a smearing of faeces on the flush button and a hand rail. There were other items in bedrooms, bathrooms and toilets that needed to be cleaned such as people's shoes, commode pans, a cushion, a pillow, a sheet and a blanket. Domestic staff had not followed guidance regarding the use of colour-coded mops for specific areas and the same mop had been used to clean bedroom floors, toilets and bathrooms. Some bedrooms had cushioned flooring and some of these were tacky when walked on. Several bedrooms had wardrobes and bedheads where the covering was peeling off which meant they were difficult to keep clean. Bedrail protectors were stored under beds which harboured dust. The linen room had items such as spare quilts stored on the floor, which also harboured dust.

We observed two people had bare feet resting on pressure relieving cushions; there were no records to show the cushions were thoroughly cleaned each day. Hand wash in toilets was stored on a ledge close to the floor and would not be safely accessed by people who used the service and the light pulls were dirty.

We decided to stop the environmental check and the regional manager spoke to staff during the inspection

and started a thorough clean of each bedroom, bathroom and toilet.

Not assessing the risk of and preventing, detecting and controlling the spread of infection was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

We looked at staff rotas and found there were five care staff (one of which was a senior) on duty in the morning, four in the afternoon and three at night; the registered manager worked Monday to Friday during normal working hours. These numbers of care staff on duty during the day were insufficient to safely support people's needs, especially as there were also two people who attended the service for day care. The registered manager did not have a tool to assess the care staffing levels although they told us this was being developed by the provider. The registered manager said they staffed the service to the levels which appeared right.

There had been a large number of accidents and incidents that had occurred in the service, several of these were un-witnessed. There were 35 recorded in April 2017, a reduction to 29 in May 2017, a further reduction in June 2017 to 10, but this could not be sustained and had increased to 21 in July 2017 and 31 in August 2017. A response to the rise in accidents and incidents in April 2017 was to ensure a member of staff was in the communal areas especially on the late shift and they were to observe for triggers and other anxious behaviours. However, in discussions, staff told us this was very difficult due to the various tasks they had to complete and the dependency levels of the people who used the service. Staff said, "We are struggling to meet service user's needs" and "Care staff are having to do domestic work at weekends, and in the evenings we have to do laundry; it takes us off the floor."

We observed the lunchtime experience for people who used the service and who sat in the small sitting room. There were several people who required more staff support than was available in order for them to eat their lunch whilst it was hot. Staff were too busy to notice the signs that people needed more support. When asked if the service could make improvements, one health professional said, "Help with feeding at regular intervals." Comments from other health care professionals were, "There is not enough staff" and "On occasions I have needed help and was told there was not enough staff on the floor so I have had to wait." Two relatives said they felt the service required more staff as they [staff] never had enough time for people.

We observed several care staff interacting with people and on the whole this was carried out in a sensitive way. However, there were long periods when no staff entered the small sitting room; more activity was going on in the main sitting room where more able people were seated.

We saw two domestic staff worked five mornings a week and a member of staff worked in the laundry seven mornings a week. We queried why there was no domestic staff at weekends and the registered manager told us they were currently recruiting an additional domestic to fill those hours. On one occasion a member of domestic staff took a day off on the Friday so they could work on Saturday. However, given the cleanliness issues we found during the inspection, it was important that domestic cover was recruited quickly or backfill arrangements with other staff put in place.

Not ensuring there was sufficient staff on duty at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

On a more positive note, catering staff were available seven days a week to cover breakfast, lunch and the evening meal. Maintenance personnel were available for 12 hours a week and an administrator for 20 hours

a week.

There were positive comments from relatives about the service such as, "We looked at a few homes and knew when we came here, it was the one", "The home is safe and secure where not just anybody can get in or out", "I feel he is safe here which provides me with peace of mind" and "My dad is safe and well."

In discussions, staff were clear about how they safeguarded people from abuse. They had completed safeguarding training and could list the different types of abuse and describe the signs and symptoms which may alert them to concerns. They also knew who to contact if they had concerns and all said they would raise them straight away.

Staff recruitment was looked at in detail at the last inspection in April 2017; there was an issue regarding the documentation of discussions following positive indicators on disclosure and barring service documents, which included a criminal record check. The registered manager told us these would be discussed with the member of staff and a judgement made as to whether employment would take place. The outcome of the discussion would be recorded in their personnel file should they be offered employment and additional supervisions held to check initial progress in the service. We looked at the personnel file of one new member of staff and found employment checks had been carried out appropriately.

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. In discussions with staff, they were clear about the need to gain consent prior to carrying out care tasks. They said, "We ask people what they would like to do" and "We ensure they have choices; it's their home." Staff described the actions they would take if someone declined care and spoke about returning at a later time and a different member of staff offering support. We observed staff offering people choices at mealtimes and showing them two different dishes of dessert.

One health professional told us that when they visited, they had observed a 'small number of staff' ask people where they would like their treatment to be performed.

We found there was an inconsistency regarding the completion of documentation for restrictions such as bedrails and sensor mats when people lacked capacity to agree to them. This was discussed with the registered manager and regional manager who told us they would audit the care files of people this applied to and check capacity assessment and best interest decision-making records were in place. Some people had capacity assessments and best interest decisions regarding admission to the service, but other people who lacked capacity did not have these records in their files. The regional manager told us they would contact the local authorities and obtain any MCA records they had about admission decisions.

People can only be deprived of their liberty so that they can 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider and registered manager were working within MCA and had made appropriate applications for DoLS to the local authority. They maintained a record of who had a DoLS authorised and who was awaiting assessment by health and social care professionals to complete the process.

We found people's health care needs were met and staff contacted community health professionals in a timely way. Staff recorded when health professionals visited the service and what treatment or advice they prescribed. Records showed people had access to GPs, psychiatrists, community nurses for physical and mental health needs, dieticians, podiatrists and opticians. We saw staff contacted emergency care practitioners when required. Health professionals confirmed staff contacted them in a timely way. Comments included, "I was contacted quickly when the service user deteriorated", "Yes, they [staff] are very proactive" and "They are very good and take on board all advice on pressure area care and documenting any issues or deterioration." One health professional did comment that junior staff required more training regarding moving and handling and the completion of fluid monitoring charts.

We found people's nutritional needs were met although one person required more active support with their food and hydration needs; the person had been referred to the dietician. People's weight was monitored although we saw some anomalies and the registered manager was to check these out to ensure the accuracy of them and take action if required. We saw the service had achieved bronze status for their application of 'Nutrition Mission', a local initiative to monitor and react when people's nutritional needs were at risk.

Menus provided people with choices and alternatives and we observed staff provided people with good portions at meal times. Catering staff had information about special diets There was some re-organisation of mealtimes required to ensure people had more support and weren't disturbed or distracted during their meals by the administration of medicines or people with anxious behaviours. People told us they liked the meals provided for them and said they had enough to eat. Relatives told us they were also happy with the food and that staff knew how to look after people. Comments included, "The food is always very good and there is always enough to go round" and "Its good food."

Training records showed us what had been completed and when it was due for an update. We saw staff had completed training considered as essential by the provider such as safeguarding, fire safety, moving and handling, dementia awareness and health and safety. Staff had also completed other training relevant to their roles such as safe handling of medicines, first aid, MCA and DoLS, food hygiene, person-centred care and end of life. Some staff had also completed low level physical intervention training over one day in 2016. However, it was unclear what the course content was and whether it covered the arm holds described by staff when we spoke with them about managing difficult and challenging situations. Staff said, "A lot of us have done the NAPPI training" and "We covered low level restraint." The regional manager was to check this out.

Following the inspection, the regional manager told us staff were to update infection control and medicines management training as a priority.

One member of staff had just completed a 'train the trainer' course for moving and handling so would be able to ensure new staff in the service received this training straight away and updates could be completed quickly. Staff told us they felt training was sufficient for them to support people's needs. We noted limited training in the health conditions which affected some people, for example diabetes. The registered manager told us they would obtain information about this so staff would have some guidance. On a visit to collect some documents a few days following the inspection, we saw a notice board in the entrance had an excellent display about diabetes and how it is managed in pictorial and written format.

Staff told us they had received supervision and appraisal and this covered areas such as problems they had, discussions about people's care and what they had to improve on. Medicine competency assessments had been partially completed for some staff but these were to be reviewed and re-done. There were some negative comments about how supported staff felt at present and these were discussed with the regional manager to address.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us staff were friendly and provided support when they needed it. Comments included, "I think the staff are very nice" and "Yes, they do look after us."

Relatives said, "My mum seems okay", "I have no issues; she's fine and looks well" and "The staff are always available and are really polite and caring. They are also very kind to the residents." One person contacted the Care Quality Commission following the inspection and told us staff were fantastic, had done a lot for their relative and went over and above to support them.

Health professionals said, "They always seem positive and caring", "They are all very helpful and friendly to the district nurses" and "I have only witnessed a positive approach."

Despite the positive comments from people who used the service, their relatives and health professionals, we found some areas of staff approach and attention that required improvement. For example, we found people's belongings were not looked after properly and there was a concern that their dignity could be compromised. We found a commode pan with a person's soiled underwear in it in one of the toilets. There were shoes left in bathrooms, one pair was soiled with faeces and odd shoes were found in bedrooms. We saw some people walking about the service without their footwear; when this was mentioned to staff, they collected their shoes and slippers and supported people to put them on. Some people's bedrooms were not as clean as required and some of their belongings such as toothbrushes had not been cared for. Staff had also not taken due care of people's medicated creams and lotions as we found these were not always stored in the bedroom of the person they were prescribed for.

A relative commented, "There was an issue with a lot of their clothes going missing and things ending up in her wardrobe that don't belong to her; we think we are on top of it now after speaking to the home."

There was also a privacy concern; the lock had been removed from a toilet door and the hole this left enabled people to see into the toilet. The regional manager contacted us following the inspection and told us this had been addressed.

We saw some people's bedrooms were very personalised and they had decorated them with pictures, photographs and ornaments to make them homely. However, other bedrooms in sharp contrast, were stark and did not provide any stimulation for the occupant. The regional manager told us they would discuss this with relatives and see if items could be brought in to make these bedrooms more homely in appearance.

We observed some people who used the service required more support at meals times to promote their dignity. When support was provided to people, we saw staff sat next to people and assisted them at an appropriate pace and in a kind way. However, we saw one person, unnoticed by staff, drinking juice from half empty, used beakers, which had been placed on the trolley to be returned to the kitchen. One person entered the small sitting room and sat next to another person; they took their rice pudding dessert and started to eat it with their fingers. This made a mess on the person's clothes and the table. Initially this went

unnoticed by the two staff in the room until one brought the person a spoon. Staff still didn't realise the rice pudding belonged to the other person until raised by the inspector. One person ate all their main meal and spent several minutes scraping the gravy with a knife which was left on their plate. We asked staff if the person was indicating they wanted second helpings so staff brought them another plateful of food which they started to eat. However, staff also brought their dessert at the same time so the person was diverted to eating that. They then alternated between both first course and the dessert.

We observed staff frequently brought desserts to people's tables and left them whilst people were still eating their main course. This meant the desserts would be cold by the time they ate them. We saw one person had a small table in front of them to eat their meal off whilst sitting in a comfy chair, rather than at the dining table. Whilst this respected the person's choice about where to have their meal, the table was not positioned properly. The person had to lean forward continually and struggled to eat their lunch, which was not an appropriate seating position for them.

We saw more thought was required regarding the administration of medicines during lunch. We observed this practice disturbed people's lunch experience and meant they took tablets and liquids in the middle of eating their meal. It is recognised that some people may require their medicines before food but this would only be a very small number and most would require them after meals. The large medicines trolleys were in the small sitting room making it look very cramped and it meant a member of staff was busy with administering medicines for the whole lunchtime period instead of providing assistance to people.

Not ensuring people's dignity was maintained was a breach of regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

We reported our observation findings to the regional manager and provider and they assured us this would be addressed with staff.

In discussions with staff, they described how they maintained people's privacy and dignity, and how they ensured people were able to make their own decisions. We overheard staff provide people with choices at lunchtime and when requested, they fetched items of clothing from bedrooms for people. We saw care files contained people's preferences which showed us they or their relatives had been involved in providing information for them.

There were notice boards which helped to provide people with information such as activities, meals and the names of staff. The notice board in the entrance could detail who was on duty with their photographs rather than listing the names of care staff. The board wasn't accurate on the first day of inspection. There was a service user guide, which provided people with specific information about the service and what they could expect; this was on display in the service. There was also a quarterly newsletter which provided information about fund raising events and how much money was raised, planned activities and dates of meetings.

People's personal and confidential information was not always stored in line with good data protection. Some people's care files were stored in a cupboard in the dining room, which was not secured. The registered manager told us care files were usually stored in their office which had a key-code lock; they could not account for why some care files were in the dining room and told us they would ensure this cupboard had a lock fitted.

The remaining care files and staff records were stored securely and computers were password protected. The provider was registered with the Information Commissioners Office, which was a requirement when

records were held in a computerised form.

Inadequate

Is the service responsive?

Our findings

People who used the service told us they would talk to staff if they had complaints. They said, "I would tell someone, my daughter or the girls" and "Yes, I would tell someone if I was unhappy."

Relatives told us they would complain to the registered manager if they had any concerns. One relative said, "They understand my dad's needs very well and I have no concerns." Another relative commented, "They do have good activity sessions but a lot of them [people who used the service] have high needs with dementia. My relative's needs are not as high so she doesn't have enough stimulation; she needs more conversation and there's not a lot of this between residents. There doesn't seem to be any support for individuals who require this level of support."

We saw people who used the service had assessments of their needs and risk assessments completed. Some care plans contained sufficient information to guide staff in how to support people in the way they preferred but this was inconsistent in all the care files we looked at. Some people's documents missed important information. For example, one person had a medical condition which impacted on their daily needs and care support. The professional visitor's record had an entry that the person's GP had been contacted about a reoccurrence of the condition and the registered manager told us they rang the district nurse who visited to provide treatment when required. However, there was no mention of the condition in the person's assessment or care plan and there was no guidance about what staff had to look out for and how they made the person comfortable should the condition reoccur.

We saw one person had an assessment and care plan which was highlighted in bold that they wished to be resuscitated, should they have a medical emergency. However, the person had returned from hospital with a 'do not attempt resuscitation' form in place and the care plan had not been updated to reflect a change in circumstances. We have asked the regional manager to check this out.

Some people had behaviours that were distressing and challenging to themselves and others, but staff did not have full information to guide them in how to support them. The risk and behaviour management plans only contained brief information about the types of behaviour and gave generic statements about how staff were to respond, for example, by distracting and reassuring. However, there were limited explanations about what distraction and reassurance techniques worked for each individual person. Despite limited information in the risk assessments and care plans for people with behaviours that were distressing and challenging, when we spoke with staff they could describe how to support people and what worked to calm and reassure them. However, over reliance on verbal rather than written information meant there was a risk that important care could be overlooked or not applied consistently.

We saw information in care plans and risk assessments had not always been updated. For example, one person was receiving treatment from a district nurse for an ulcerated leg but their care plan for skin care had not been updated to reflect this. We saw staff wrote monthly evaluations on a separate sheet behind the actual care plan but did not include any updates in the plan itself. This meant staff would have to trawl through pages of evaluations to see how needs had changed and to look for the most updated information.

We saw some evaluations stated 'no changes' or 'care plan remains current' when in fact there had been changes.

We saw that one person had a large bruise on their head, which staff said had occurred following a fall, so we checked their assessment, risk assessments, moving and handling guidance and care plan. Records showed the person had sustained several falls recently although information about these were written in different sections of the care notes and the falls log did not include all of them. This meant staff would have to read several documents to find out how many falls the person had actually sustained. The falls risk assessment tool did not adequately enable risk to be analysed and did not include measures to help minimise risk. We heard the person ask staff to support them to walk to the toilet and staff said they had to get a wheelchair now as the person was unsafe mobilising with the aid of a walking frame. However, the person's mobility care plan and safe system of work for moving and handling both stated the person used a walking frame to assist mobilisation. The inspector had to intervene several times and call for staff when the person tried to walk unassisted. There was no call bell within reach of the person where they sat in the quiet area of the sitting room.

We saw there were loose documents for one person who had been admitted for respite care in July 2017, although the pre admission assessment stated their admission date was 17 September 2016. This meant they had also had a previous admission. There were some daily records that showed the person also attended for day care. Some of the daily records for the respite stay were missing from the documents so it was difficult to check what care had been carried out. The assessment recorded a range of potential issues such as the person was living with dementia, had restless nights, often slept in a chair rather than a bed and had painful joints. The person did not have a care plan to guide staff in how to meet their needs in the way they preferred.

We saw staff had not responded and provided individualised care for one person who was at high risk of poor nutritional and fluid intake, although they had been referred to a dietician. Records showed they had minimal food and fluid intake on some days. We found more robust efforts were required in offering food and fluids of a high calorific content throughout the day and at night. There was no record of hourly interventions and no record of any offers of refreshments during the night.

Not ensuring people's needs were fully assessed and care was planned and delivered in a consistent and person-centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

We saw there were some activities carried out in the service and checked the monthly planner for June and July 2017. These included skittles, bingo, hand and nail care, baking, movement to music, reminiscing, games, sing-a-longs and playing musical instruments. The plan also identified a monthly outing, fund-raising events and in July there was a visiting entertainer. The activities were completed by care staff in the afternoons when they had time, as there was no designated activity co-ordinator. Staff told us they enjoyed doing the activities, but at times they could be called away from an activity to assist people with personal care tasks. We observed some people received more stimulation than others as they were more able to participate in activities.

We recommend the provider obtains information from a reputable source regarding providing meaningful activities especially designed for people living with dementia. We also recommend they consider the employment of staff specifically designated for the provision of activities.

The provider had a complaints policy and procedure which was displayed in the service; this provided guidance for staff in how to manage complaints. There was a leaflet about how to complain for people who used the service and their relatives. This included an assurance that the provider was committed to addressing complaints and putting things right. The leaflet explained who to talk to initially about concerns or complaints and timescales for acknowledging receipt of it. It also provided information on how to contact senior management and the provider directly if required.

Inadequate

Is the service well-led?

Our findings

During the inspection, we had concerns about the lack of management oversight to ensure people received the care they required and staff received sufficient support and monitoring.

General oversight of risk had not been managed appropriately. There were some systems to identify environmental risk, but these were not effective and risk remained. For example, maintenance work had not been risk assessed and planned to ensure people who used the service had limited access to parts of the service under decoration. There was no system of checking equipment used to prevent skin damage was in working order. There was no system for checking wheelchairs were ready and fit for use. There was no system for ensuring people had the correct walking frame. Bed rail risk assessments were not completed properly taking into account their suitability for people. These issues meant people who used the service were at risk of potential or actual harm.

Audits had been completed for areas such as the environment, infection prevention and control, care plans and medication. However, the audits had not been effective and had failed to indicate shortfalls. For example, weekly environmental audits which were completed between 5 June and 28 August 2017 all stated there was soap available in the four toilets. None commented that the soap was held in dispensers on a ledge approximately a foot off the floor and therefore not safely accessible to people who used the toilet unassisted. None of them commented that the lock had been removed from one of the toilet doors and exposed a hole; this meant anyone using the toilet would not be afforded privacy. All of them commented that the quiet lounge was free from clutter yet during the inspection, we saw multiple walking frames were stored in this small area, making the room look cramped and was a trip hazard.

Similarly, the most recent infection control audit completed on 5 September 2017, six days before the inspection scored 100% compliance. This had not highlighted any of the cleanliness issues we found during a tour of the environment. The bathrooms and toilets were ticked as free from communal products and not used as storage area but we found communal products in a bathroom and a toilet used as a store room, which was unlocked.

Medicines audits had not highlighted a longstanding pain relief patch administration error, a lack of protocols to give staff clear guidance when administering medicines when required, and also had not identified stock management issues. We saw in one audit in May 2017, a medicines error had been found and was discussed with the member of staff to ensure correct procedures were followed.

Care plan audits had found some shortfalls but had not captured issues regarding a lack of thorough risk and behaviour management plans for two people. They had also not highlighted the need for bed rail risk assessments to indicate whether they were suitable for the person to use. The registered manager confirmed that the care file audits checked for the presence of specific documents rather than the quality of what was written.

There had been no checking that the person completing the audits knew what they were looking for and

knew how to complete them accurately and thoroughly.

The registered manager recorded information about complaints each month. However, we saw these were brief and did not ensure lessons were learned. For example, in April 2017, there had been a complaint about noise levels outside the entrance to the service. There was no analysis of who was making the noise, at what time this occurred and whether it related to staff, people who used the service or visitors. There was no action plan to address the complaint in the 'monthly complaints analysis' form other than the previous regional manager 'texted' the complainant. There was no record of whether this resolved the complaint to their satisfaction. There were two further complaints the following month in May 2017 about the same issue. The action required stated there was to be a meeting with staff and the complainant to try and resolve the issue. However, there was no record on the 'monthly complaints analysis' form of whether the meeting took place, what involvement the registered manager had in the complaint resolution or indeed whether the complaint was actually resolved. A health professional told us they had raised a moving and handling concern and this was addressed. However, we could not see any record of this in the complaints log or monthly analysis.

Accident and incident analysis had only been partially completed. They were all logged and had been split into witnessed and un-witnessed, but the analysis lacked depth to ensure that lessons could be learned and to prevent a reoccurrence. There was a reduction in accidents and incidents following a large amount in April 2017, but this could not be sustained and had risen again in July and August 2017.

We found there had been communication issues within the service and at management and provider level. For example, the registered manager had been aware of domestic staff shortages at the weekend and had started to recruit more staff. The provider told us they had not been made aware of this or they would have given direction to use additional staff hours to back fill the role. We found there was no dependency level tool to determine people's needs so that care staffing levels could be adjusted to meet them. This had led to a shortage of care staff during the day and placed people at risk of not receiving the care they required.

There had been requests from the local safeguarding team for the provider and registered manager to look into incidents which had occurred between people who used the service. The local authority told us that the reports they had received did not provide sufficient analysis of the incidents and did not detail the plans to be put in place to protect people and prevent a reoccurrence.

Medication competency checks and supervision sessions regarding the management of medicines had not been carried out thoroughly in line with an action plan sent to CQC in August 2017. There were some recording issues with the competency checks, and supervision sessions had been signed but not carried out.

We asked to see supervision records for the registered manager completed by the previous regional manager. Although it was confirmed these had taken place and copies of the records should have been held at head office, the records could not be located.

We spoke with staff and they felt management support could improve. They stated the registered manager had been providing support at another service and this had impacted on their time and availability for staff support at The Elms. The regional manager confirmed this situation had now ceased and the registered manager was to spend all their time at the service.

Not ensuring appropriate management of the service was a breach of Regulation 7 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. 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.

Failing to ensure good governance and quality monitoring was a breach of regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provide to take at the back of the report.

The registered manager told us the provider visited the service and they could contact them when required. They said the provider was interested in the service, knew staff by name and cared about the people who used the service and the staff who worked there. They also said the culture of the organisation was 'open' and they felt able to raise concerns and make suggestions. Meetings had been arranged for registered managers so they could exchange ideas and learn from incidents. The registered manager told us they had received supervision from the previous regional manager and new dates were to be arranged with the new regional manager. The registered manager described the culture of the service as 'home from home'.

There had been meetings for staff and also with relatives to enable them to raise issues and exchange information. There had also been a questionnaire for residents, relatives and professionals in July 2017. An action plan had been produced but this did not have timescales rather it stated, 'on-going'. This meant it was difficult to audit if the shortfalls identified had been completed. There were positive comments in the questionnaires from people who used the service and their relatives about the care delivered to people. Some negative comments were highlighted in the action plan.

The registered manager told us they knew where to obtain guidance such as that produced by the National Institute for Health and Care Excellence. They had printed off several pieces of guidance but stated they had not had time to read them yet. However, the guidance was available if needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people's needs were fully assessed and planned for so that staff had guidance in how to provide care in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not consistently ensured people's privacy and dignity was maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure there were sufficient numbers of suitably competent, skilled and experienced persons deployed to meet service user's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured care and treatment was provided in a safe way for service users by: - 12 (2) (a) (b) assessing and doing all that is reasonably practicable to mitigate risk. (g) the proper and safe management of medicines. (h) assessing the risk of and preventing, detecting and controlling the spread of infections.

The enforcement action we took:

We have issued a warning notice and the registered provider must be compliant by 20 October 2017

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure adequate systems were in place to assess, monitor and improve practice.

The enforcement action we took:

We have issued a warning notice and the registered provider must be compliant by 31 October 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager failed to evidence they had the necessary competence and skills to manage carrying on of the regulated activities so that people received safe, effective, caring and responsive care and to ensure the service was well-led.

The enforcement action we took:

We have decided to cancel the manager's registration.