Mr & Mrs J Surae

The Elms Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Elms is a residential care home providing personal care to up to 13 people aged 65 and over. At the time of the inspection nine people were using the service.

People's experience of using this service and what we found
People's needs were not always assessed and care planned to enable staff to meet them and mitigate potential risks. This placed people at risk of not consistently receiving safe care and treatment.

People were not effectively safeguarded from potential neglect or abuse as potential safeguarding concerns were not always escalated to the management team or investigated to reduce future risk.

Infection control guidance was not always followed to ensure people were supported to reduce their risk of exposure and transmission of COVID-19.

People were not always supported in a clutter free environment to enable effective cleaning.

People's medicines were not consistently stored or monitored in a safe way.

Quality assurance procedures had not been regularly completed at the service to identify areas of improvement and drive change. This meant improvements required to people's care and treatment had not been identified in a timely way prior to our inspection.

People's feedback was not always acted upon to ensure they received care in line with their preferences.

People were supported by enough safely recruited staff that understood how to keep them safe, and had access to healthcare when required.

Rating at last inspection
The last rating for this service was requires improvement (published 10 April 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and we found further concerns. This meant the provider was still in breach of regulations.

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

Why we inspected
The inspection was prompted in part due to concerns received about the oversight at the service. A decision was made for us to inspect and examine those risks.

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

Enforcement
We have found evidence that the provider needs to make improvements. Please refer to the safe and well-led sections of this report. We identified breaches in relation to people not consistently receiving safe care and treatment and audit systems had not been completed to identify and drive improvements at the service.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always well-led.

Details are in our well-Led findings below.

The Elms Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was completed by one inspector.

Service and service type
The Elms is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and we wanted to be sure the management team were available to speak with us.

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

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and three relatives about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, senior care workers and care workers. We reviewed a range of records. This included three people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who visit the service.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● People did not consistently have care plans and risk assessments in place which contained accurate and up to date guidance for staff to follow. For example, one person had experienced fainting episodes however did not have a care plan or risk assessment which identified this or provided guidance for staff on how they should support them with these.

● Staff did not have clear guidance around how to support people with their mobility needs. For example, one person's care plan did not contain sufficient guidance around how staff should support them to transfer and staff had used their own judgement to make these decisions. However, staff training was out of date and the registered manager had not completed competency checks since March 2020. This placed people at risk of not receiving safe care in line with their mobility needs.

● Where people experienced periods of agitation and anxiety, staff did not have clear guidance around how to support them during these periods and to mitigate any associated risks. For example, one person had experienced multiple episodes of increased anxiety however did not have a care plan in place to reflect this and guide staff to reduce their distress.

● Staff did not have clear guidance to follow around how to support people to evacuate the building in the event of an emergency. This placed people at risk of harm through delayed care or receiving care that did not meet their needs in an emergency.

Preventing and controlling infection

● Whilst staff had some knowledge of government guidance in relation to COVID-19 they were not following this to reduce people's risk of exposure to COVID-19. For example, we observed staff did not wear appropriate PPE and did not always wash their hands between supporting people who were self-isolating.

● People were not supported to isolate in line with government guidance when newly admitted to the service. For example, the registered manager told us one person only had to isolate for 10 days following admission to the service as opposed to the 14 days advised by COVID-19 government guidance. This placed people at increased risk of exposure to COVID-19.

● People and staff did not all have personalised COVID-19 risk assessments which identified their increased risk of exposure to COVID-19 and gave clear guidance around how to reduce this.

● Areas of the home were cluttered and disorganised. For example, the bathroom had multiple boxes of incontinence aids and mobility equipment in it, this meant it could not be effectively cleaned. This increased the risk of transmission of COVID-19.

Using medicines safely

● Medicines were not always stored safely. For example, staff were not recording when they had opened

liquid medicines and creams. We also saw staff had not monitored where medicines had expired and one person's medicine should have been discarded over three months prior.
● Staff did not consistently have clear guidance to follow where people were prescribed medicines 'as required'. For example, people had multiple medicines recorded within one record which made guidance unclear. This placed people at risk of not receiving their 'as required' medicines as prescribed.
● One person had not had access to their 'as required' pain relief as staff were not aware they were prescribed this, despite this being on their records. The person told us this meant their pain had been left unmanaged for one evening.

Systems were either not in place or robust enough to demonstrate people's safety and risk were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, we saw other people's medicines had been administered as prescribed and had been reviewed by medical professionals, such as their GP, where required.

Systems and processes to safeguard people from the risk of abuse
● Whilst staff could recognise the signs of potential abuse, staff had not reported all potential safeguarding concerns to the management team for investigation and review. For example, staff had completed body charts for one person detailing injuries and markings on their skin dated from June to September however these had not been escalated to the management team.
● The registered manager had failed to ensure they were aware of all potential safeguarding concerns and take appropriate action in response to concerns. For example, during the inspection the registered manager was not able to locate the safeguarding folder and advised they had not completed a review of safeguarding concerns since March 2020. Following the inspection the registered manager begun reviewing all people's care files to ensure all potential safeguarding concerns were investigated and reported to the local safeguarding team where required.
● Staff did not all have safeguarding training and where they had, this required updating in line with the provider's policies. For example, we saw three staff members safeguarding training required renewing over two years ago.

Systems were not in place to ensure all safeguarding concerns were identified, investigated and referred to the local authority safeguarding team where required. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● We could not be assured lessons were learned when things went wrong as not all incidents, accidents and potential safeguarding concerns had been investigated and reviewed by the management team to enable improvements to be implemented where required.

Staffing and recruitment
● We received mixed feedback about staffing. One staff member told us, "We do struggle at times. No ones left at risk but there are definitely not enough staff." Despite this, during the inspection we saw people's needs were met in a timely way by staff. The management team have advised they will continue to review staffing levels.
● Staff had been recruited safely in line with the provider's policies.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
At our last inspection the provider had failed to ensure quality assurance tools had identified where improvements were required at the service and change was implemented effectively. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been sufficient improvements and the service remained in breach of regulation.

● The provider and registered manager had not completed any supervisions with staff since March 2020. One staff member told us, "We haven't had a manager for eight months. It's not been fair on staff we have had no one to turn to, especially how it's been with COVID-19."
● The provider and registered manager had not ensured people's feedback was acted upon in a timely way. For example, despite a feedback questionnaire being completed in September 2020 and two people indicating they no longer enjoyed the food no action had been taken to make improvements. This placed service users at risk of not receiving care in line with their preferences.
● Despite this, relatives gave positive feedback about the approachability of the manager. One relative told us, "[The registered manager] is always telling me call anytime."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had failed to ensure systems were in place to effectively monitor and assess the quality of the service in the absence of the registered manager. The registered manager told us no audits had been completed at the service since March 2020. This meant improvements required to people's care had not been identified or implemented during this time placing people at risk of harm.
● We saw senior carers had completed reviews on people's care files in July 2020. However, these reviews had failed to identify where care plans and risk assessments no longer reflected people's needs. This placed people at risk of receiving inconsistent care from staff which did not meet their changing needs.
● The provider and registered manager had failed to ensure there was an effective system in place for identifying, reporting and reviewing safeguarding concerns. This placed service users at risk of neglect and abuse as registered manager was not able to review potential concerns to identify action required to mitigate risks.
● The provider and registered manager had failed to monitor staff training to ensure this was kept up to

date. For example, on review of the training matrix we saw multiple staff training was out of date including dementia awareness, fire safety, emergency first aid, safeguarding and moving and handling; some of which was over three years past their renewal dates. This placed people at risk of not receiving safe care in line with best practice guidance.

● The provider and registered manager had failed to ensure staff had sufficient knowledge and understanding of COVID-19 government guidance and were following this. The registered manager was not able to locate attendance lists or training certificates for staff who had attended infection control training to ensure all staff had access these. As well as this, during our inspection we observed staff not adhering to guidance around PPE and engaging in appropriate hand hygiene between supporting people. This placed people at risk of harm from exposure and transmission of COVID-19.

● The management team had failed to drive and sustain improvements and to ensure compliance with the regulations. At this inspection we identified multiple breaches in regulations and this was the home's second consecutive requires improvement rating.

Systems were either not in place or robust enough to identify where improvements are required, and implement and sustain these. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had displayed their previous rating clearly on entrance to the service and on their website.

● The management team were open and honest about areas requiring improvement within the home and responded during and following the inspection to begin implementing these.

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

● Whilst the registered manager understood their responsibilities in relation to duty of candour, as they had not ensured they were aware of all accidents, incidents and safeguarding concerns; they had not met these.

Working in partnership with others

● Whilst we received concerns from professionals who visit the service around staff consistently following their advice in relation to wound care, we saw staff had followed guidance where this had been recorded. One staff member told us, "[The nurses] tell us what we do and don't need to do. We just find out off each other really."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had not been safeguarded from potential abuse or neglect as staff were not always reporting concerns. The registered manager was not able to locate the safeguarding folder and had not reviewed people's care files to ensure all concerns had been investigated and reported as required.

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 management team had failed to ensure people's care plans and risk assessments reflected their needs and gave clear guidance to staff about how to mitigate any associated risks. People's medicines were not always stored and monitored in a safe way. The management team had failed to ensure they had identified and investigated any concerns in relation to people's care. Infection control guidance in relation to COVID-19 was not followed effectively to reduce people's risk of exposure and transmission of COVID-19.

The enforcement action we took:

We issued a warning notice detailing our concerns to the provider. This set a requirement for the service to be complaint with the concerns we had raised by the 01 March 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance No audits had been completed at the service since March 2020, this meant no potential areas requiring improvement or concerns had been identified or acted upon during this time. Multiple concerns we noted during the inspection in relation to medicines, safeguarding, infection control and risk management had not been identified prior to our visit. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice detailing our concerns to the provider. This set a requirement for the service to be complaint with the concerns we had raised by the 01 March 2021.