Bupa Care Homes (GL) Limited

Elmwood Care Home

Inspection report

3 Wetherby Road
Oakwood
Leeds
West Yorkshire
LS8 2JU

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06 July 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 27 June and 6 July 2017. At the last inspection in May 2016 we rated the home as requires improvement. At the last inspection the service was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9, Person-centred care. At this inspection we found the provider was no longer in breach of the previously identified regulation and they had made significant improvements to the service and the care people received.

Elmwood Care Home is situated in the Oakwood area of Leeds. The home has 36 beds, providing accommodation and nursing care for older people and people living with dementia. There were 25 people living at the service at the time of inspection.

There was a registered manager in post. 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 told us they felt safe in their home. There were enough staff to deliver care safely, and staff received appropriate training and support. Staff had a good understanding of the signs of abuse and how to safeguard vulnerable adults and report concerns.

Overall medicines were managed safely; however we have made a recommendation about the management of some medicines.

Maintenance and premises safety checks had been falsely completed. This meant we could not be sure equipment was safe. The manager completed the checks robustly and confirmed safety. The manager told us they were investigating how this had happened to prevent a future reoccurrence.

There were appropriate recruitment processes in place to ensure staff were recruited safely and that they were suitable to work with vulnerable adults.

There were policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005. Staff were trained in the principles of the MCA and could describe how people were supported to make decisions; and where people did not have the capacity; decisions were made in their best interests.

We saw that people received support from kind and compassionate staff who understood their individual needs. Care plans were person centred and there was evidence of involvement from people and their relatives. People had plans in place to manage risks which were understood by staff.

People were supported to eat and drink safely and they told us they were able to choose what they wanted.

If people did not like the options, kitchen staff were able to prepare alternatives from a well-stocked pantry containing fresh produce and ingredients. People's weight was monitored and nutritional risk assessed appropriately.

People had regular and appropriate access to health professionals, and staff worked in partnership with health professionals to help people maintain their clinical wellbeing and manage their care needs.

There were systems in place for people to complain, and we saw evidence that complaints were responded to in line with the provider policy in a timely and appropriate way.

There was a clear leadership structure with the manager holding oversight of governance arrangements. Staff understood their roles and what was expected of them.

We saw that there was an effective quality assurance process, with a range of audits and monitoring systems in place to ensure quality of care was maintained and the environment of the home was safe.

We saw that the provider asked people what they thought of the service and that their views had generated actions to be taken by staff to make improvements.

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.

People were supported to take their medicines in a safe way. However some of the records viewed required improvement.

Safety check records were not always completed accurately. The manager reviewed the system to confirm all equipment was safe and to prevent this happening in the future.

People told us they felt safe living at the service, and staff knew how to raise safeguarding concerns appropriately.

There were adequate levels of staff to provide safe care, and staff were recruited appropriately.

Is the service effective?

Good

The service was effective.

People were cared for by competent and knowledgeable staff who were supported with their training needs and with regular supervisions and appraisals.

People were supported well to maintain sufficient levels of nutrition and hydration by staff who understood how to meet people's individual dietary needs.

People's health was maintained well and they had access to appropriate healthcare support.

Is the service caring?

Good

The service was caring.

Staff had a good rapport with people, and had good knowledge of the people they were looking after which meant that they received a more personalised service.

We saw that staff treated people with dignity and respect.

People were involved in making decisions about their care and

gave positive feedback about the care they received.

Is the service responsive?

Good

The service was responsive.

Care records were person centred, with regular reviews to ensure they were fit for purpose.

There was a programme of activities provided by a dedicated activities staff member with people's preferences and hobbies taken into account.

People knew how to make complaints and complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

The manager provided effective leadership and was supported well by the provider.

Staff felt well supported by the management team.

The provider had effective quality assurances systems and processes to monitor the quality and safety of the service.

Elmwood Care 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 inspection took place on 27 June and 6 July and was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection, providers are asked to complete a Provider Information Return (PIR). This form asks providers to give some key information about the service, what the service does well and what improvements they plan to make. The provider returned this to us in a timely way. We reviewed all other information we held about the service before the inspection. We asked partner organisations such as Healthwatch, an independent consumer champion that gathers and represents the views of the public and health and social care services in England, and the service commissioners for any information they held about the service prior to our inspection. We used all of this information to plan the inspection.

At the time of the inspection there were 25 people living in the home. During the inspection we spoke to seven staff, including the registered manager, senior carers, carers and kitchen staff, six people who used the service, two relatives of people who used the service and one visiting health professional. We reviewed four people's care records, and spent time looking at other documents and records relating to people's care and management of the service. We toured the premises, and observed a midday mealtime.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home. One person told us, "I feel safe here", and another person we spoke with told us "It's easy to get on with everyone, I like it here".

We looked at safeguarding incidents and found that the registered manager was in regular contact with the local authority when incidents occurred and had appropriately notified the CQC of all safeguarding incidents. Staff knew when and how to raise safeguarding alerts appropriately. Staff were able to describe what they would consider a safeguarding alert and what they would do to address the situation. One member of staff said, "It can be financial, or not getting proper care, or finding bruises on people. I raised an alert when I found someone crying. We found it was their visitor who shouted at them, I raised it with the manager who dealt with it." We saw records to confirm staff had been trained in safeguarding vulnerable adults.
We looked at how medicines were managed within the service. Medication Administration Records (MARs) contained essential information, for example the person's picture, allergy status, name and date of birth. We noted MAR's were signed by staff when they had administered medicines. We found an instance where missing signatures were found on one person's Topical Medication Administration Record (TMAR). When we raised this with the manager they contacted the person's GP who confirmed that no harm was caused, and the medicine was discontinued.

One person was supported to take their medicines via a percutaneous endoscopic gastrostomy (PEG) which is a tube passed through the stomach wall to enable food, hydration and medicines to be provided for people who cannot swallow. We found that there were some gaps in the recording of flow rates. When we raised this with the manager they told us that this document would be taken out of use to prevent confusion.

We recommend that the service consider current guidance on recording medicines administration and update their practice accordingly.

Medicine audits took place on a weekly and monthly basis. We saw the audits had previously picked up errors made in medicine management such as gaps in recording medicine administration. All issues identified were documented and followed up with action plans to prevent a reoccurrence.

Staff supported people to take their medicines safely. For example, the nurse lifted a remote controlled bed to ensure that the person was not laid down when taking their medicine to avoid choking. Once the person was sat up the nurse administered the medicine and, provided water to make it easier for the person to swallow. The member of staff observed that the person took their medicine and after asked the person if they were comfortable. Medicines were ordered, stored and disposed of safely. For example; bottles of liquids had been dated when opened and where necessary items were stored in a medicines fridge.

The home carried out a regular programme of monthly general maintenance checks. These included laundry cleaning, window restrictor, carbon monoxide monitor and bedrail checks. We reviewed the records

from January to June 2017 and found they had been completed as planned, however we also found these checks were recorded as having been completed in July 2017. This meant records had been falsified. We raised this with the manager and requested they oversee that all of these checks were completed appropriately. On day two we saw confirmation this had happened and that checks had been carried out. The manager also told us they were investigating how this had occurred to prevent a reoccurrence.

We found that all other health and safety checks and certificates were in place and in date appropriately. These included regular water temperature checks, gas and electricity certificates and a thorough fire risk assessment with weekly and monthly checks of fire equipment, emergency lighting and a record of fire drills. We found that where a concern had been identified, action was taken promptly and records of work done by external contractors were kept to ensure there was a complete audit trail.

Individual risk assessments for people living at the home were appropriately managed, and where people required specialised equipment for example crash mats (devices intended to prevent harm if a person were to fall), risk assessments were reviewed monthly to ensure equipment and control measures were safe and effective for that person. People had personal emergency evacuation plans which identified individual moving and handling needs in the event of an emergency evacuation.

We saw there were enough staff to deliver care safely. The registered manager used a dependency tool to calculate the hours of care needed to deliver safe support to each person and allocated staff accordingly. People's dependency levels were calculated from their support needs identified in their care plans. We reviewed rotas and saw there were always enough staff to deliver care planned for each shift as per the dependency tool.

Staff were visible during the inspection, and people were comfortable in the presence of staff. The registered manager told us they had brought in a second nurse to work during the day shift because they identified this would improve people's care and allow staff more time to perform more efficiently, which meant there was a registered nurse on each floor. Staff told us this had a positive impact on the service. One staff member told us, "We have enough staff. Two nurses and five carers in the mornings. It depends on resident's dependency and we can always ask for more." Another staff member told us, "The extra nurse helped." We spoke to another member of staff who said, "There are enough staff, but there could always be more! We have a good team and all pull together."

People we spoke with did not raise any concerns about the staffing levels. One person told us, "I can't fault any of the staff, they do very well. When I ring the bell they come." We saw that the registered manager had oversight of call bell response times, and when we reviewed the printout for call bell response times we found they were responded to promptly.

Staff were recruited safely and appropriately. We reviewed four staff personnel files and saw that there was a thorough screening and interview process and that photo identification, professional references and Disclosure and Barring Service (DBS) checks were present. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use care and support services. Nurses were appropriately recruited with all qualifications and registrations with the nursing and midwifery council kept on file. Their fitness to practice was checked as part of the recruitment process.

Good

Is the service effective?

Our findings

People told us they were supported by staff who were competent and knew how to carry out their job. We looked at how the service inducted new staff, and how they ensured staff were adequately trained to deliver good quality care. One staff member who was new to the service told us, "It prepared me, and got me to know the residents." We saw the service had an effective induction programme for new staff which included health and safety, safeguarding and fire safety.

The service also had a programme of training the provider deemed mandatory which was designed to ensure staff were competent and trained to deliver care effectively. We looked at the training matrix which showed that 92% of staff were up to date with all mandatory training. The matrix was able to show training records for individual members of staff and identify where refresher training was needed. Staff told us they were happy with the training, and they could request extra training from external providers. One staff member told us, "Training is good and always updated. BUPA are very good. I have done syringe driver training by liaising with the community nurses, because I asked for it."

We looked at how the provider conducted supervisions and appraisals for staff. We saw that staff received regular supervisions and appraisals, and were able to give their own opinion and request extra training if they wanted to. The service also had regular themed discussions with staff in response to performance, for example we saw a talk delivered to all staff around dignity and respect at mealtimes. This meant that staff were given meaningful supervisions and appraisals that were also relevant to people who used the service.

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.

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were knowledgeable about the MCA and their responsibilities. One member of staff described capacity to us as "unless it is proven, everyone has capacity and we have to respect their decisions. If they refused care and do not have capacity, we have to make a best interests decision." We saw that decision-specific capacity assessments were completed in people's care plans, and these were regularly reviewed to ensure they were still necessary and effective. For example, we viewed one person where they had a 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) document in their care plan, which also had an accompanying mental capacity assessment with input from the general practitioner and their relative as the person had been assessed as not having the capacity to make this decision.

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). We saw that people's capacity had been assessed and that the provider had made appropriate DoLS applications where required.

We found the registered manager kept a tracker which recorded dates when DoLS applications were made, when applications were granted and whether conditions were attached to these by the local authority. We saw where a DoLS expired the registered manager had reapplied to have these conditions reinstated, and all correspondence was held so that the service could evidence they had done everything required of them.

We observed a midday mealtime at the service. The tables in the dining area were laid out in cafe style with tablecloths set, menus and flowers on tables. Staff used personal protective equipment and washed their hands before serving food. People were offered clothing protectors. The meal had three courses, with a soup starter, a choice of two mains (one hot and one cold) and a choice of two desserts. People were offered refreshments continually throughout mealtime. We saw people being supported to eat on a one to one basis, and that people were reassured throughout. For example, we heard a staff member asking someone they were supporting say, "Is it okay [name of person]. How does it taste. Tell me when to stop okay." Food looked of good quality and portions were of an appropriate size. A relative told us, "I've seen the food, it's of good quality. We had concerns over my family member's low weight when they came here, now they have a bit of a tummy on them!"

There were snacks and refreshments available at all times during the day. Kitchen staff were knowledgeable about different dietary requirements and preferences. The kitchen staff made dishes from a seasonal menu sent by the provider. The menus were assessed by dieticians to ensure they were nutritionally balanced. We were told by the head chef they were able to accommodate religious and cultural needs for example if people required halal and kosher meals. Kitchen staff received feedback by asking people what they thought of the food and through residents meetings and annual surveys where food was a topic of discussion. The head chef conducted a weekly spot check by observing food service and recording how staff behaved to ensure high standards were maintained.

People's feedback on food was largely positive, with some minor criticisms. For example, one person told us, "The food is not bad, sometimes not good but sometimes very good. More often good than bad. I'm always offered choice. The tuna sandwiches are delicious." Another person told us, "I eat for nutrition. I'm not a fair judge. It's alright; I've survived so it can't be that bad! They offer us biscuits and cakes throughout the day." We saw staff regularly offered people snacks and hot drinks in communal and residential areas. Snacks included fruit, biscuits and freshly made cakes.

People who used the service were weighed monthly, and if somebody lost 2kg or more or there was a trend of weight loss over time, a malnutrition universal screening tool was completed and their weight was monitored weekly. We saw an example in someone's care plan where higher calorie foods and thickeners had been recommended as a result of someone's weight loss. This meant that people's weight and nutrition was monitored and managed appropriately.

People were supported to access health professionals and they maintained good health. All interactions with health professionals were logged in people's care plans. We spoke with one visiting health professional. They said, "They [the staff] are absolutely fine. One of the relatives told me they almost care too much!" and that staff "seem to know the patients." They said "we know things are getting done. I have input into multi-disciplinary team meetings, and I have no qualms about the home".

Good

Is the service caring?

Our findings

We asked people whether staff were kind and caring towards them. One relative of a person living at the home told us, "Staff are generally brilliant. I've not found one that is not absolutely caring. They go over and beyond. They always pop in to [name of person] room and chat to her." Someone living at the home told us, "There are the staff who are good, and the staff who are even better." Another person told us, "Two of the staff were taking me out and they did a dance for me and I was hysterical with laughter. Those two make me happy! They are all lovely. I couldn't be happier."

Throughout the inspection we saw people moving around the home independently and doing things for themselves. One person we spoke with told us they regularly did laps of the corridors, "To keep fit." We saw where people wanted to go outside this was facilitated in a safe way, with one person telling us, "I usually like to go in the garden at around half three or four". This meant that people could make decisions for themselves regarding what they wanted to do throughout the day, also promoting their independence. People told us they had regular visitors, and we saw relatives taking people outside to the park or having cups of tea with them in the lounge.

People told us they were supported to be as independent as possible. One person told us "I wash my face, neck and body; I am independent and want to do it for as long as I can." Another person told us "They fill the bowl at the right temperature and I do my private parts myself." When we looked at this person's care plan, we found that staff were directed to help the person wash themselves in the way the person described to us.

When we looked at staff noticeboards, we saw copies of discussions held around privacy and dignity available. We observed staff knocking on people's doors before entering their rooms. When we asked people living at the service if this happened all the time, they confirmed it did. One person told us, "Staff always knock. One domestic staff member didn't knock, but I told them and now they always knock."

Staff knew the people they were caring for well. They told us about their life histories, likes and preferences for care, and what activities they participated in. When we checked the care plan of a person who was described, we found what was written reflected the conversation we had. One person said, "They (staff) all know me here and I know all of them."

We saw no evidence to suggest that the service was not meeting its obligations under the Equality Act (2010) to protect people's diverse needs such as gender, race, disability, sexuality and religion. Peoples wishes were respected and their needs recorded sensitively, for example where people preferred female care givers for assistance with washing and dressing, this was noted in their care plans. People's religious and cultural wishes were also noted in their care plans, for example in one person's care plan where they identified as Catholic, the care plan recorded, '[name of person] wants a priest to give them their last rites, with their sister to arrange."

We saw end of life care was discussed and recorded sensitively in people's care plans. Their religious beliefs and funeral wishes were detailed, however where people did not want to discuss end of life care this was

also noted. We saw evidence that people's relatives were included in discussions around end of life.

Good

Is the service responsive?

Our findings

At our last inspection in May 2016 we rated the service as 'requires improvement' because people's care plans did not sufficiently guide staff on how to care for people in line with their individual needs and preferences. We concluded that the service was in breach of Regulation 9, Person Centred Care, Health and Social Care Act 2008 (Regulations 2014).

At this inspection we found that the service had made the required improvements and was no longer in breach of regulation.

We reviewed four people's care plans and saw detailed, personalised plans that identified how people liked to receive their care. We saw care plans had been created in partnership with people who used the service and their relatives. One relative we spoke to said, "I'm involved in all of the care planning; they discuss it with me and my wife". Another relative said, "There was an incident where we were asked our opinion. It had to go in the book. I gave my opinion. They are on the ball."

Care plans were easy to read and organised well, with a photo of the person at the beginning. Care plans were reviewed monthly by staff with detailed comments on their effectiveness to deliver care for that individual person.

There was an effective admissions process in place to assess people's needs and suitability to move into the service. As part of the admissions process, people were asked about their personal details, life story, religious and cultural background, health questions, and questions around their current care needs for example personal care and mobility. The document gave a score which assigned a dependency level, to ensure the person received care that best suited their needs. This ensured that people were admitted safely.

The service had an up to date complaints policy, as well as literature available on how to complain distributed throughout the home. For example, there was a complaints leaflet on the wall of the communal lift. We reviewed the complaints file and found that there were no trends or themes; however the responses were timely and appropriate in tone. Where complaints were serious, we saw the manager had identified them as safeguarding referrals and included the safeguarding referral documentation, which indicated that the service acted appropriately in response to people's complaints. One person told us, "I know how to complain." Another person told us, "If I had a formal complaint, I'd go to the manager. I made a complaint once, and the response was satisfactory and cooperative."

There was a weekly activities programme in addition to external entertainers and trips into the local community. On the day of our inspection we witnessed people supported to sit outside in the garden. We saw picture boards in communal areas showing people engaging in past activities such as a trip to a stately home and playing with a pat dog. People were mostly positive about the activities programme, one relative of a person at the home told us, "[Name of activities coordinator] does a fantastic job, there was a play your cards right night. I got a friend to make a proper board for it."

We saw there were regular monthly residents meetings held on each floor which included topics of discussions such as food and activities. The service had a 'you said, we did' board, where residents suggestions from each floor were paired with actions taken by the service. For example, where people said they wanted to go on more outings, a programme of external visits was created including visits to garden centres and stately homes. This demonstrated the service listened to what people wanted and had acted on their wishes.

There was a compliments book containing cards and letters sent by people and their relatives. One compliment read 'Just a note to thank you so much for taking good care of my auntie, the family so much appreciate your kindness'. Another compliment read 'You treated my mother with total respect and love'.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by deputies and team leaders. The manager had access to support from the provider. Staff spoke very positively about the manager. One member of staff told us, "She is supportive; I can call her any time, even at her home. She also helps out with care, for example helping people to eat." Another staff member said, "She's approachable, I can go talk to her, she's better than the last one and more visible".

We asked staff about the culture at the service. Staff told us they enjoyed working at the service. All staff we spoke with said that they would be happy for their loved ones or relatives to live at the service. Staff told us they felt there was an open culture, and that the manager was approachable and receptive to staff ideas. We reviewed staff meeting minutes which demonstrated this, we saw recorded evidence of staff challenging managers and raising ideas. One member of staff told us, "I like to work here, I think I will retire here!" and another member of staff said "I just love it".

The registered manager had oversight of all complaints, accidents and incidents within the home. We found that the registered manager appropriately notified CQC of all incidents and safeguarding alerts that they were obliged to.

There was a regular programme of audits and quality assurance processes to ensure governance and oversight was effective, and where trends and themes were identified support was accessed. For example, the manager submitted a monthly report to the provider which included information such as number of pressure ulcers, people who had lost more than 2kg of weight, DOLs applications, medications errors, complaints and incidents. This was analysed by the provider, who had the ability to make comments and trigger action plans where a trend or theme was found.

People who used the service were asked for their views in order to improve the service. We reviewed a residents and relatives meeting held in June 2017. There were 17 attendees. Topics of discussions included latest news, issues with the property, and plans for the future and an introduction to new staff. We spoke to a relative of a person living at the home who told us, "We sat in the last meeting, people were asked their opinion, it was an open meeting, there were no issues whatsoever." A person living at the service told us they attended a meeting and raised concerns about a proposed conservatory, and that they were able to express their concerns openly. When we spoke to other people at the home and their relatives, we found that they were all aware of proposals to build a conservatory for the home.

The service also conducted an annual resident's survey. We reviewed the 2016 survey and found that it covered a range of topics including happiness, safety, dignity, food and activities. We found the service scored highly in all areas and that satisfaction with the service was generally high. This demonstrated a commitment to listening to people's views to improve the service.