Care Quality Commission

Mr & Mrs J Surae

The Elms Care Home

Inspection report

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Date of inspection visit:
13 September 2022

Date of publication:
29 June 2023

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service
The Elms is a residential care home providing personal care for up to 13 people. The service provides support to older people, some of whom were living with dementia in one adapted building. At the time of our inspection there were ten people living in the home.

People's experience of using this service and what we found
People did not always have risks to their safety assessed and planned for. We found where risks were known these had not been reviewed and where health needs had changed these were not reflected in people's care records.

People did not have their medicines administered safely. People's medicines administration records were not accurately completed and there was insufficient guidance for staff on how to administer some medicines safely.
People were not supported by enough staff to meet their needs at the times they required. People had to wait for their support and told us they had limited choice about when their care needs were met.

People did not have their individual needs and preferences considered and were not consistently supported to meet their nutrition and hydration needs in line with health professional advice.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The building was not well maintained and clean. There were fire safety concerns which had not been addressed.

Staff were not consistently trained, and their competency was not checked on a regular basis. The provider did not have systems in place to ensure staff were recruited safely.

Governance arrangements in the home did not identify areas for improvement and where concerns had been raised about safety and quality actions had not consistently been taken to make changes to the service and drive improvements.

Rating at last inspection and update
The last rating for this service was requires improvement (published 27/01/2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had not completed the actions and remained in breach of regulations.

This service has been in Special Measures since 16 December 2020. During this inspection the provider did not demonstrate improvements have been made and the overall rating for this inspection is inadequate and the provider remains in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection and was prompted in part due to concerns received about medicines, governance and staffing. A decision was made for us to follow up on past concerns and examine those risks.

We carried out an unannounced comprehensive inspection of this service on 19 November 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care, staffing levels, recruitment practices, person centred care, mental capacity act application and governance

Please see the action we have told the provider to take at the end of this report. For 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

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 Health and Social Care Act 2008.

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 site visit was carried out by two inspectors. Calls were made to relatives following the inspection by an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Elms is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Elms is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed the information we held about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 1 September 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection

During our inspection we spoke with two people and three relatives. We also spoke with the deputy manager and the provider. We spoke with three staff including, care staff, kitchen staff, senior care staff. We looked at the care records for four people and multiple medicine administration records. We looked at records relating to the management of the service, including audits carried out within the home.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate.

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

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

At our last inspection the provider had failed to assess risks relating to the health safety of people and operate safe medicines practices. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medicine was not always administered in a safe way. When Transdermal pain relief patches had been applied, the location of the site administered had not been recorded. This is not in line with the manufacturer's instructions. This placed the person at risk of side effects from the medicine.
- Medicines administration records (MAR) had been incorrectly completed, for example, staff had recorded the wrong dosage of medicines administered and some had been handwritten without being signed. This meant people were at risk of not having their medicine as prescribed.
- People were prescribed medicines on an 'as required' basis. Guidance was either not in place or not clear for staff on how to administer these medicines. This placed people at risk of not receiving their medicines as required.
- Risk assessments and care plans were not always personalised or regularly reviewed to manage risks to their safety. One person had diabetes and there was no guidance for staff on how to support the person, what to look for if their diabetes became unstable, or when to escalate concerns to a health professional.
- People's risk assessments were not reviewed to take account of changes in their needs or the advice from health professionals. One person had been assessed by the speech and language therapist team (SALT). The persons care plan required updating to reflect this and this was not completed. Staff were unclear in their descriptions of what support this person needed. This meant the person was at risk of receiving support which was not in line with SALT recommendations.
- Risk assessments relating to the environment were not robust enough to mitigate risks for people. Personal evacuation plans were not in place for everyone living at the home. This meant emergency services may not know how to safely support people to leave the building in the event of an emergency leaving people at risk of harm.
- Action had not been taken to manage risks to fire safety. A fire safety risk assessment had identified actions which were required to maintain fire safety and we found these had not been taken for a period of

18 months.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The provider did not have adequate cleaning schedules in place, and we found the cleanliness of the home was poor.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. This was because the home was in a poor state of repair impacting on the ability of staff to prevent the spread of infection through cleaning schedules.
● We could not be assured that the provider's infection prevention and control policy was up to date as this was not provided to us at the time of the inspection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely, systems ensured people had enough stock of medicines.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.

Visiting in care homes
The provider had a system in place to ensure people could receive visitors to the home.

Staffing and recruitment
● People were not supported by enough staff to meet their needs. One relative told us, "They do ask my relative to go to bed very early in the evening, but they do say it's the personal choice not a demand." Another relative told us, "Minimal staff at night when someone else is being cared for my relative might need to wait."
● Staff told us people had to wait for their support as there were times when there was not enough staff to support people when they needed it.
● We observed three people needed support to eat their lunch during the inspection but there was only one staff member available. The staff member was moving between people giving them some of their meal and then they had to wait whilst others were supported. This meant people did not have their meal in a timely way.
● There was no system in place to check people's dependency levels and use this to determine the levels of staff. This meant the staffing levels available were insufficient to meet people's needs.

Systems had not been established to ensure there were enough staff available to meet people's needs safely. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not been recruited safely. We found the provider had not followed safe recruitment practice as some staff had been recruited without appropriate references and disclosure and barring service (DBS) checks being in place. This meant people were potentially left at risk of harm. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Failure to ensure the employment of fit and proper persons was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to safeguarded people from potential abuse. Incidents had not been identified, investigated and reported as required. This was a breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13 (1,2,3)
● The provider had put systems in place to ensure where incidents had been reported these had been referred to the appropriate body and investigations completed.
● Systems to ensure all incidents had been appropriately recorded, investigated or reported needed to be improved.
● Although staff we spoke with could describe how to recognise abuse and report any concerns, not all staff had received training in this area placing people at an increased risk of harm.

Learning lessons when things go wrong
● Where accidents had happened, we could see there had been a review and this had promoted learning which had been implemented.
● Improvements were needed on how actions taken to review care plans and refer people to other health professionals were documented.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had failed to make applications to the authorising body when people were subject to restrictions. We found people were subject to restrictions from bed rails and locked doors and there was no evidence of consideration of the least restrictive approach.

People were deprived of their liberty without lawful authority. This was a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a failure to implement the principles of the MCA. Staff lacked understanding about the MCA and whilst they asked for verbal consent there were no processes in place to support MCA assessments and best interest decisions where people were unable to give consent.
● The provider did not demonstrate an understanding of the MCA. For example, consent forms had been signed by people who appeared to lack capacity, relatives had been asked to consent to care without the legal authority to do so.
● Where people appeared to lack capacity there had been no assessment undertaken and we saw no evidence of how decisions were taken in people's best interests.

The provider had failed to follow the principles of the MCA and we could not be assured people had given lawful consent to their care. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

● Care plans did not take account of people's assessed needs and reflect their preferences. Care plans lacked details of people's preferences about how they would like their care delivered. For example, there was limited information about people's oral health care needs and peoples likes and dislikes, past histories.
●There was no evidence people and their relatives were actively involved in reviews of their care. One relative told us, "They didn't ask for input from me or [person's name] on their family background, history, likes and dislikes."
● People did not always receive person centred care. One person told us, "It is a bit regimented here get up at the same time and go to bed at the same time." The person explained they would prefer to have a choice about when to do this.
People were not supported to receive care which was designed to meet their needs and reflect their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff had not consistently received adequate training to meet people's needs. We found some staff had not received training in safeguarding, person centred care, mental capacity act and diabetes awareness. Where staff had received training, they had not received refresher courses and we could not be assured they had up to date knowledge and skills.
● The registered manager had failed to ensure staff had regular competency and supervision for their roles. Staff could not tell us when they had received supervision and there were no records of planned supervisions or competency checks.

The provider had failed to ensure appropriate support, training and supervision was in place for staff. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment required maintenance, repair and cleaning throughout. We saw flooring was in a poor state of repair, paintwork was chipped, ceilings were cracked. This placed people at risk of harm from poor infection prevention control.
● The passenger lift flooring was in a poor state of repair. The risk assessment indicated the lift required replacing but there was no plan in place to do this placing people at continued risk of harm.
● There were no evidence water outlets had temperatures checked on a regular basis. We found one tap had very hot water in a room which could be accessed by people as the door had been left open. This meant people were at risk of scalds and burns.
● There was no evidence the provider had undertaken legionnaires testing in the home. Testing can reduce the risk of exposure to the legionella bacteria which can place people vulnerable to infection at risk of harm.

The provider had failed to ensure the premises and equipment was cleaned and maintained. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Peoples care plans and risk assessments did not always take account of their needs and preferences for nutrition and hydration. For example, where people had specific needs such as diabetes and modified diets this had not been risk assessed and there was no reference to this in the nutrition plan.

● People did not consistently have the support they needed to maintain a healthy diet. For example, where people required monitoring for malnutrition this was not consistently in place.

● People and relatives told us they enjoyed their meals and were given a choice. One person said, "I enjoyed the meal today, sausage and mash with cake and custard." A relative told us, " [Person's name] does have a choice of different meals, which is good as they are very particular about what they like. The kitchen offer something else if nothing on the menu suits them."

Supporting people to live healthier lives, access healthcare services and support

● People were able to seek support from health professionals when needed. One person told us they had recently seen their doctor about a new health condition and received treatment.

● Records showed people had been referred to health professionals for advice, however peoples care plans were not consistently updated to reflect this. For example, one person needs had changed following assessment by the SALT team, and this was not updated in their risk assessment and care plan.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- The providers oversight systems had failed to ensure improvements to the service were identified and made. For example, the lift required a repair to make it safe and this had been identified but not completed. This placed people at risk of harm.
- The provider had failed to ensure known fire safety risks were mitigated. For example, essential repairs had been identified by a fire safety specialist and the provider had not taken action to address these. Personal evacuation plans were not in place for everyone living at the home. This left people at risk of harm. We reported our concerns to the local fire service to ensure people were safe.
- Audits had failed to identify where medicines administration was not done safely. For example, audits had not identified when there was no guidance for staff on how to administer 'as required' medicines and transdermal patch recording had not been completed effectively. This meant people were left at risk of not having medicines as prescribed.
- Care plans and risk assessments were not audited effectively. For example, health needs had not been risk assessed or planned for, risk assessments had not been reviewed following changes to advice from health professionals.
- The providers systems had not ensured the principles of the MCA were followed. For example, people were being unlawfully restricted without a DoLS in place and where people may lack capacity to consent this had not been assessed and there were no records of decisions taken in people's best interest.
- The provider had no system in place to ensure there were enough staff to meet people's needs. This meant people were left waiting for their support at lunchtime as there was not enough staff to support.
- The providers systems had not ensured staff were suitably trained and supported. For example, some staff had not received training, some staff required updates to training and there was no evidence of supervision and competency checks.
- The providers systems had failed to ensure safe recruitment practices were followed. Staff had not been recruited safely.
- The provider had not ensured people were receiving person centred care. For example, assessments and care plans did not take account of people's needs and preferences for nutrition and people told us they were living in a regimented environment.

The provider had failed to ensure the governance of the home was effective in identifying areas for improvement and taking required actions to keep people safe. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider told us they had engaged people and relatives in meetings to discuss the service and had issued questionnaires to seek feedback, these had not yet been analysed.
- The provider was engaging staff in meetings to discuss the home and make improvements.
- The provider shared an example of how they had made changes following an incident and feedback from people and their families to staffing levels in the home, however there was still insufficient staff available and this required further improvement.
- The registered manager had not ensured professional advice was followed and used in people's care plans when working with other agencies to inform peoples care plans. This placed people at risk of harm.

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

- The provider had not notified relevant people when incidents occurred.

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 People did not receive care which was designed to meet their needs, and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have consent sought in line with the principles of the MCA. MCA assessments and best interest decisions were not in place where people lacked capacity to consent to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe recruitment practices were in place and followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by enough staff to meet their needs and preferences.

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 Risks to people were not assessed, reviewed and mitigated. Medicines were not managed safely and where risks to safety of the environment had been identified these had not been mitigated.

The enforcement action we took:

Notice of proposal to cancel provider and registered manager registration.

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 were subject to unlawful restrictions as the provider had not followed the principles of the MCA.

The enforcement action we took:

Notice of proposal to cancel provider and registered manager registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises and equipment were safe as actions to address maintenance and repairs had not been taken which left people at risk of harm.

The enforcement action we took:

Notice of proposal to cancel provider and registered manager registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were systems in place to mitigate risks to peoples safety and identify areas for improvement. Where

concerns were identified the provider had failed to make any improvements.

The enforcement action we took:

Notice of proposal to cancel provider and registered manager registration.