Morleigh Limited

Elmsleigh Care Home

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

Elmsleigh is a care home that provides nursing care for up to 48 older people, some of whom had a diagnosis of dementia or other mental health conditions. On the day of the inspection there were 45 people living at Elmsleigh. Thirty-three people lived in the main house and 12 people lived in the adjoining annex (called the bungalow).

The service is required to have a registered manager and at the time of our inspection a registered manager was not in post. The manager who was in charge of the day-to-day running of the service had applied to become the registered manager. At the time of this inspection their application was being processed. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

We carried out this unannounced inspection of Elmsleigh Care Home on 25 October 2016. At this comprehensive inspection we checked to see if the service had made the required improvements identified at the inspection of 14 June 2016.

In June 2016 we found the premises and equipment were not properly maintained. There were two shower rooms, where the showers had been removed, and the floors were stained and dirty. There were three bathrooms that were not in full working order, including water that was too hot to be safely used by people living at the service. An unlocked boiler room, accessed through a bathroom, put people at risk of harm because the room had hot pipes and electrical equipment. There was broken equipment stored around the premises, including in areas identified at a previous inspection in September 2015.

At this inspection while we found some improvements had been made to the premises and the environment there were still areas of concern. There were communal bathrooms and en-suite bathrooms that either did not have hot water or had water that was too hot with the risk of scalding people. One shower room had a wall mounted electric bar heater approximately three feet immediately opposite the shower which meant water could come in contact with the heater. There was no hot water available in the kitchen on the day of the inspection. While the door to the boiler room, accessed through a communal bathroom, was locked the door leading into the boiler room in a corridor was not locked. Three bedroom self closing fire doors were seen wedged open by furniture and a suitcase in one case. These issues put people at risk of harm.

Most of the broken equipment that had previously been stored around the building had been removed. However, we did find an unused pressure mattress, unnamed continence pads and a ladder stored in the entrance area to a toilet used by people. The premises were warm throughout the inspection, except for one corridor which was cooler than the rest of the building. The communal areas were clean and odour free. However, some people's bedrooms were not clean and had strong incontinence odours. Several toilets and bathrooms did not have paper towels, soap or waste bins to enable effective hand washing and infection control. All of the above created an environment that was not homely or pleasing for people to live in.

In June 2016 we had concerns about the safety of two people living at the service who had been assessed as being at high risk of falls and 'unsafe if left unobserved'. At this inspection we found action had been taken to help reduce the risk of harm for these two people. One person's health had deteriorated and they were less mobile than they had been. They had also been provided with head protection, to protect their head if they did fall. The other person had been given funding to have individual care. While this had helped to reduce their falls this person could still suddenly get up and attempt to walk. However, there was no risk assessment to provide instructions for staff about assisting them to mobilise safely as they were very unsteady on their feet.

At this inspection we found some people did not receive consistent or good care because systems to provide for, and monitor, people's needs were inadequate. This included systems for food and fluid charts, hourly observation charts, monitoring people's weight and checking the settings on pressure relieving mattresses. These inadequate systems had led to poor outcomes for some people. For example, some people had been assessed as needing hourly observations by staff because they were cared for in bed. These checks were had been introduced to try to ensure they were safe, their personal care needs were met and they had everything they needed. Despite these checks being in place for two people their needs had not been met. Staff had not provided personal care, made the environment safe or respected these individuals' dignity.

The provider had not taken adequate action to address how staff could provide appropriate care for people identified as refusing care and who were at risk of self-neglect. The service had not monitored these people's repeated refusal of care or sought any advice or guidance from external professionals in meeting their needs. Staff had not been given sufficient direction and guidance about how to meet these people's complex needs. We observed that staff lacked knowledge and confidence in how to provide care for these people. Following our inspection visit we 'alerted' these two people to Cornwall Safeguarding to ensure they were protected from further harm.

Some people had been assessed as being at risk from developing skin damage due to pressure. Pressure mattresses were in place for these people. However, the mattresses were not monitored to ensure that they were correctly set for the person using them. If pressure mattresses are not set to the weight of the person using them there is a risk that pressure damage to their skin will not be prevented. Where people had been assessed as needing to be re positioned regularly, to help reduce the risks of pressure damage, this was being completed for most people. However, one person was not routinely re-positioned or checked by staff.

We found that slings used when people needed to use a hoist, of different sizes appropriate to peoples' different sizes and weights, were shared between people. Net pants, used to wear over continence pads were shared. Continence pads were supplied to meet each individual person's assessed continence needs to ensure people used the right size and type. However, it was clear from supplies left in communal bathrooms and other areas that these pads were also being used between people. These practices did not respect people's dignity and human rights and represented institutional ways of working.

The care we saw provided to people during the inspection was often task orientated rather being than in response to each person's individual needs. Some people living in the service had complex behavioural needs and limited communication. Care plans did not always give staff guidance about how to communicate with people, especially where people refused care and were at risk of self-neglect. We observed some staff had little interaction with people with complex communication needs. Bedrooms for some people did not have any identification on the doors such as a number, their name or a picture to support people in recognising their own bedrooms. This meant it could be difficult for people living with dementia to orientate around the building and find their room.

Some people were at risk of losing weight due to having a poor diet. Food and drink monitoring was in place for these people, but records were not being checked so no action had been taken to address any concerns. Where records stated that people needed to be weighed weekly this was not being carried out. Some people had sustained substantial weight loss and it was not clear what action had been taken to help the person maintain a healthy weight. This meant some people were at risk of their needs not being met in relation to their weight, and food and fluid intake because this was not being sufficiently monitored.

Where people needed assistance or prompting from staff to eat their meals this was not actioned in a timely manner. Some people did not show any interest in eating nor had any insight into it being mealtime. These people were left, sat in the same seat in which they had spent their day, with their meals in front of them uneaten, even though most needed encouragement to eat. Hot drinks were provided throughout the day. However, some people didn't drink them and staff took them away when they got cold. People who needed assistance from staff to eat did not always have hot food. Staff helped more than one person during the lunch period. However, meals came from the kitchen together so some meals were cold by the time a member of staff was available to help some people to eat.

When we observed the lunchtime period we found there was little interaction between people and staff. Staff who assisted people to eat their meals did so without any real conversation. There were three bank staff on duty on the day of the inspection. We noticed that they needed guidance from permanent staff. While they were willing and completed the tasks assigned to them competently they were reluctant to initiate interactions with people, due to being unfamiliar with people's needs.

The management of medicines was not robust. We identified some concerns with the recording processes used by staff when administering and managing medicines. There were gaps in records which meant it was not always clear that people received their medicines as prescribed. Two peoples' medicines were found in their rooms, having not taken them. One person had them on their bedside table and in another room medicines were strewn on the floor. However, when we checked the Medication Administration Records we found the nurse had signed to state that both people had taken their medicines. Some people's medicines records did not contain a photograph. This meant there was a risk that if a nurse was administrating medicines, who was not familiar with service, they might not know the identity of each person. Some people had been prescribed creams and these had not been dated upon opening and not always recorded when applied.

There were not always enough staff on duty to adequately meet people's needs. Staffing levels were frequently lower that the level assessed by the service as being the number needed to meet people's needs. Staff confirmed that they regularly worked with a numbers of staff lower than the assessed level and always 'managed' as staff worked together as a team. One member of staff did say, "The staffing levels are a problem. There is always sickness, annual leave and maternity leave." The manager confirmed that there were staff vacancies and they were in the process of recruiting to fill these vacancies.

There was a lack of meaningful activities for people living in the service. In the afternoon, on the day of the inspection, music was playing in the bungalow, which people seemed to enjoy until a person turned it off. We did not notice any activities in the main house. A care worker said when asked what activities would take place that day, "They have tea and cake at 3pm and between 4pm and 5pm soup, sandwiches, beans or potatoes". This meant that staff were not clear on what were relevant and meaningful activities for people living at the service.

We found the management and staff were not working within the principles of the Mental Capacity Act. The service asked people, or their advocates, to sign consent forms to agree to the care provided. However,

some people had signed consent forms without any evidence of whether that person had a Power of Attorney in place, to give them the authority to sign on behalf of the person living at the service.

Records showed that manual handling equipment, such as hoists and bath seats, had been serviced. There was a system of health and safety risk assessment. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. However we saw fire doors were inappropriately held open making the fire protection ineffective.

The staff files we looked at had evidence that the relevant recruitment checks to show staff were suitable and safe to work in a care environment had been carried out. Staff knew how to recognise and report abuse. Staff told us they felt supported by the manager and senior care workers. They told us they had received an annual appraisal to discuss their work and training needs and had regular supervision. Nurses received regular one-to-one supervision with the clinical lead.

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People's care plans recorded their choices and preferred routines. For example, what time they liked to get up in the morning and go to bed at night. People were able to choose where to spend their time, either in one of the lounges or in their own rooms. During the inspection people moved around the building and went outside into the garden when they chose to. Staff asked people where they wanted to spend their time and what they wanted to eat and drink.

People, who could tell their view of the service, told us they felt safe. Comments included, "It feels safe. They keep an eye on me", "I press the bell when I need something" and " Staff look after me." People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. Comments received from relatives were positive about the service and they told us they were encouraged to make their views of the service provided known.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Elmsleigh Nursing Home and has been rated as Requires Improvement since the first rated inspection carried out in November 2014. The Care Quality Commission has carried out five inspections (including this one) of the service since November 2014. At each inspection there have been breaches of the regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

We are taking further action in relation to this provider and will report on this when it is completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The premises and equipment were not properly maintained.

People were not always protected the from risk of harm because risks were not always identified and managed. Pressure mattresses were not correctly set putting people at risk of skin damage. Medicines were not safely managed.

The numbers of staff on duty was often lower than the level assessed as needed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not effective. Some people did not receive care and treatment that met their needs. The service had not sufficiently identified the risks to people with complex needs in relation to eating and drinking.

Some people's individual rooms were not clean and had strong incontinence odours.

Permanent staff had the knowledge and skills to meet people's needs. Bank staff didn't always have enough knowledge about people to meet their needs.

Management did not have a clear understanding of the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not entirely caring. Staff were kind and compassionate when they spoke with people. However, some staff completed tasks for people with little conversation.

Staff had not been given sufficient guidance or support in how to communicate with people with complex needs.

People's privacy and dignity was not respected because slings, net pants and continence pads were shared between people.

Care plans detailed people's choices and preferences about their care and support.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive care and treatment that was responsive to their individual needs. The care provided to people was often task orientated rather than in response to each person's individual needs

Care plans were not personalised to reflect people's care and treatment needs. Care plans were not updated as people's needs changed.

There was a lack of meaningful activities to meet people's social and emotional needs.

Is the service well-led?

Inadequate

The service was not well-led. The provider had not adequately assessed, monitored and mitigated the risks to people living in the service.

Some people did not receive consistent or good care because systems to provide and monitor people's needs were inadequate.

Audit processes were not effective as these had failed to identify shortfalls in relation to the premises, medicines, care plans and the monitoring of people's health and care needs.
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Elmsleigh 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 25 October 2016. The inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience. The specialist advisor had a background in providing nursing care for older people and in the management of nursing care services. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service. The expert's area of expertise was dementia care and care for older people.

We reviewed information we held about the home before the inspection including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with one person who was able to express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs. We looked around the premises and observed care practices.

We also spoke with eight care staff, a nurse, the deputy manager, the organisation's head of operations and the provider. We also spoke with eight visiting relatives. We looked at nine records relating to the care of individuals, four staff recruitment files, staff training records and records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

At our inspection of 14 June 2016 we found the premises and equipment were not properly maintained. The two shower rooms, identified at the inspection in September 2015 as being dirty, had been partially re-decorated by June 2016 although the floors where the showers had been were stained and dirty. There were three bathrooms that were not in full working order at that time, including water that was too hot to be safely used by people living at the service. There was also an unlocked door into a boiler room and there was broken equipment stored around the premises, including in communal areas as identified at the previous inspection in September 2015.

At this inspection while we found some improvements had been made to the premises and equipment there were still areas of concern. Many of the people that used the service had dementia and had significant confusion. We found people were still able to access the two shower rooms, identified at two previous inspections as not being suitable for people to use. The manager advised us that they were not being used and there was no toilet paper or washing items in these rooms. However, there was evidence that one of the bathrooms had been used on the day of our visit.

The door to a boiler room, accessed through a bathroom, which was unlocked at the last inspection was now locked. However, this boiler room could also be accessed from the corridor and this door was not locked despite being marked "keep locked". This meant people were still at risk of harm because the room had hot pipes and electrical equipment which were accessible. In a toilet there was a pipe running from floor to ceiling which was extremely hot to touch and posed a risk to people using the toilet should they touch it or fall against it.

One bathroom had no hot water and another had water that was too hot. Some bedrooms also had sinks which had very hot water coming from the hot taps. This meant people were at risk of being scalded. One shower room had a wall mounted electric bar heater approximately three feet away and immediately opposite the shower. When we turned on the shower it was clear that it was possible for water to come in contact with this electric heater. This meant there was a risk of people coming to harm and being injured.

There was no hot water available in the kitchen on the day of the inspection. The cook told us that there had been no hot water for a few days. This meant the kitchen staff had to carry containers of hot water from elsewhere in the service into the kitchen to be used to wash their hands and other items. The manager and provider were unaware of this. They told us there had been a problem with one of the boilers and they were waiting for a part. In the meantime the other boiler was attempting to supply hot water to the whole building.

Three bedroom fire doors were seen wedged open by furniture and a suitcase in one case. This meant the fire doors would not close in the event of a fire alarm. An emergency exit door was not secured and opened easily out in to the car park. This meant people could leave the service without the knowledge of the staff.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities)

2014.

At the inspection in June 2016 we had concerns about the safety of two people living at the service who had been assessed as being at high risk of falls and 'unsafe if left unobserved'. At this inspection we found action had been taken to help reduce the risk of harm to these two people. One person's health had deteriorated and they were less mobile than they had been. They had previously been assessed as being at high risk of hitting their head when they fell. Since the last inspection they had been provided with head protection, to protect their head if they did fall.

The other person who had been assessed as being at high risk of falls had been given funding to have individual care. This had helped to reduce the number of falls they suffered. However, they did not have an up to date risk assessment to provide instructions for staff about how staff should assist them to mobilise. Their care records stated that they would need two staff to assist them to mobilise safely. The manager advised us that only one member of staff was needed since the person had started to use a walking frame. However, on the day of inspection we saw that they frequently got up from a chair and started to walk without using the walking frame. When this happened the member of staff, who was allocated to work individually with the person, held them under their arm and tried to keep them upright as they were very unstable on their feet. On several occasions other staff came to help and although the person did not fall while we were watching they were very unstable. There were no instructions for staff about how to manage this situation and what manual handling methods to use. The manual handling techniques used by staff were not safe.

Some people had been assessed as being at risk from developing skin damage due to pressure. Pressure mattresses were in place for these people. However, the mattresses were not monitored to ensure that they were correctly set for the person using them. We checked the mattresses in three people's rooms and found them all to be incorrectly set. One pressure mattress was set at '3'. We asked the nurse what this represented and they told us, "It is sort of in the middle, I think you would need to check the user manual, but I am not sure where that is." This meant the nurse was not able to ensure the person using this mattress was protected from the risk associated with pressure damage. Another mattress was set for use by a person weighing over 90 kgs, and a red warning light was showing. This person's weight was recorded in their care plan as 66 kgs. Another person who weighed 56 kgs had a mattress set for a person weighing 28 kgs. If pressure mattresses are not set to the weight of the person using them there is a risk that pressure damage to their skin will not be prevented.

We found one person, who had also been assessed as being at risk of pressure sores, was not routinely re-positioned or checked by staff. This person was incontinent and regularly refused to be assisted with any personal care from staff. Records showed that often for several days the person had received no personal care. This meant that the risk to this person of sustaining urine burns to their skin was not being managed.

Other risks in relation to people's care were not being adequately managed. One person's care plan stated that they were not able to recognise environmental risks to themselves because of their dementia. As a result of this any equipment and furniture in their room had to be safe for them to use to protect the person from harm. This person preferred to remain in their bedroom most of the time. We found their bedroom window opened wide enough for a person to climb out on to the first floor balcony. There were low railings around the edge of this balcony which posed a risk to the person should they climb over and fall from the first floor to the ground below. In addition the pedestal sink in this person's bedroom was not fixed to the wall and was loose.

In the morning of the inspection visit we found call bell cords, were missing from four rooms. Later in the day

these call bells were returned to these people's rooms. While these call bells were removed people had not had adequate means to call for assistance when they needed it. This put these people at risk of not receiving adequate care because they could not alert staff if they needed assistance.

At this inspection we identified some concerns with the recording processes used by staff when administering and managing medicines. We checked the medicine administration records (MAR) and it was not always clear that people received their medicines as prescribed. There were gaps in nine people's MAR where staff had not signed to show they had given people their medicines at the prescribed times. Staff had transcribed medicines for people on to the MAR following advice from medical staff. Two handwritten entries were signed but had not been witnessed by a second member of staff. This meant that there was a risk of errors and did not ensure people always received their medicines safely.

Two people were receiving their prescribed medicines disguised in food or drink (covert) in order to support them to take these medicines. There were covert medicine assessments for both people which had been signed by family. However, there was no evidence that agreement had been sought from a medical professional to ensure the medicines were suitable to be given in food or drink and that they agreed with this action.

Some people had medicines that were prescribed to be taken when required (PRN). Staff used the code 'N' which indicated the item was not required. This meant it was not clear if the person had been offered and refused the medicine or did not require the item.

The MAR files contained photographs of some people living at Elmsleigh which were to help staff to identify the correct person when administering medicines. However, thirteen peoples' MAR did not contain any photographic evidence. This meant there was a risk that if a nurse who was not familiar with the service, was administrating medicines, that they might not identity each person correctly.

Two people were found to still have their prescribed medicines in their rooms, having not taken them. One person had them loose on their bedside table and another had medicines strewn on the bedroom floor. However, when we checked the MAR for each person we found the nurse had signed to state that both people had taken these medicines.

Some people had been prescribed creams and these had not been dated upon opening. This meant staff were not aware of the expiration of the item when the cream would no longer be safe to use. Staff did not always record when these prescribed creams were applied. One person had prescribed items such as creams and wound dressings in their room, named for themselves but also for two other named people. This meant prescribed medicines were being shared between people.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were not always enough staff on duty to adequately meet people's needs especially in relation to meals. Some people had to wait some time to be assisted by staff to eat, resulting in some people having their food cold. On the day of the inspection there were eight care staff and one nurse on duty from 8.00am until 8.00pm to meet the needs of 45 people. In addition to these staff were the manager, kitchen and domestic staff. Staff were allocated to work either in the main house or the bungalow. Five care staff were allocated to the main house and three to the bungalow. The manager told us there were usually nine care staff on duty in the morning and eight in the afternoon, as this was the level determined by the dependency tool used. A dependency tool is used to identify the numbers of staff required by assessing the level of

people's needs.

However, when we looked at rota records for the current week and the previous three weeks these rotas showed that there had been 10 staff on duty for one day, nine for six days, eight for 16 days and seven for five days. Staff confirmed that they regularly worked at a staffing level lower than the assessed required level. One member of staff did say, "The staffing levels are a problem. There is always sickness, annual leave and maternity leave." The manager confirmed that there were staff vacancies.

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

Some people, who could tell us their view of the service, told us they felt safe. Comments included, "It feels safe. They keep an eye on me" and "I press the bell when I need something."

The staff files we looked at showed that two appropriate references had been obtained and there were Disclosure and Barring Service (DBS) checks. Records showed that manual handling equipment, such as hoists and bath seats, had been serviced. There was a system of health and safety risk assessment. Fire alarms and evacuation procedures were checked by staff and external contractors. However, we had found some self closing fire doors were wedged open making the fire safety system ineffective.

Requires Improvement

Is the service effective?

Our findings

At our inspection of 14 June 2016 we found there was broken equipment stored around the building, in areas regularly used by people. For example, we saw broken equipment in bathrooms used by people, in corridors, and in one of the lounges. A visitor at that inspection reported a broken chair in one of the lounges, which was then removed by staff. The heating in one corridor of the main house was not working and people, who were in rooms in that corridor, told us they felt cold. However, the heating in that area of the building came on once the temperature on the thermostat was turned up.

At this inspection while we found some improvements had been made to the environment there were still areas of concern. There was no longer broken equipment stored around the building and the corridors and communal areas were mostly warm and odour free. However, we did find an unused pressure mattress, unnamed continence pads and a ladder stored in the entrance area to a toilet used by people. Also in this room was an open bucket of grit and salt mixture which was being used as a waste bin, with paper cake wrappers and tissues in it.

Some people's bedrooms were not clean and had strong incontinence odours. One person's bedroom had a very soiled but empty commode. There were brown deposits on their wall of their room by the bed. There was no soap in the soap dispenser in their room, no paper towels and no waste bin. The floor was soiled with pieces of uneaten food and an empty cola bottle.

The premises were warm throughout the inspection, expect for one corridor which was cooler than the rest of the building. Several toilets and bathrooms did not have paper towels, soap or waste bins. This meant people, visitors and staff were unable to wash their hands after using the toilet.

All of the above created an environment that was not homely or pleasing for people to live in.

This contributed to the continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people were at risk of losing weight due to receiving poor nutrition. Food and drink monitoring was in place for some people living at the service. We found records in bedrooms where staff had recorded what people ate and drank each day. However, these records had not been totalled or monitored to ensure the person had received sufficient nutrition. One care plan stated that a person had lost weight, the records stated this person had a, "Small loss of 5.6 kgs" when this is a considerable loss of weight. There was no evidence of any action taken to address this concern.

The wipe board in the nurses' office stated that three people needed to be weighed weekly. None of these people had been weighed weekly when we checked their records. One of these people had been recorded as having lost 3 kgs since June 2016, when the last weight was recorded in September 2016. This person was having their food and drink intake monitored but these records were not being checked. Supplements had been prescribed but there were no records of these having been given to the person. The care plan review

stated, "Remains current" but we found this person's weight loss was not being managed.

One person's care plan stated they were to have 1500 mls of fluid every 24 hours. Staff were recording their fluid intake but these records were not totalled or monitored so it was not clear if this person received their 1500 mls each day.

Other people were to be weighed monthly according to their care plans. There were gaps in all the files we checked where monthly weights had not been checked. One person was recorded as having lost 4 kgs between March 2016 and June 2016. Despite this weight loss their weight had not been checked again since June 2016. The records stated, "Encourage food and fluids." There was no further guidance for staff on how to do this effectively. This meant some people were at risk of their needs not being met in relation to their weight and food and fluid intake because this was not being sufficiently monitored.

In the morning we saw a care worker take three plates of porridge upstairs and supported each person to eat one at a time. The last person had a long wait and the porridge was cold by the time the worker supported them to eat. We observed the lunchtime meal on the day of the inspection. Meals were not made a pleasant occasion and were quite chaotic. Some people did not show any interest in eating nor had any insight into it being mealtime. These people were left with their meals in front of them, even though most needed support and encouragement to eat. Three people did not eat the food put before them. Staff periodically walked by and reminded them to eat. However, after two hours the uneaten food was taken away from these people. Hot drinks were provided throughout the day. However, some people didn't drink them and staff took them away when they got cold. Therefore these people did not receive a drink.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. Management carried out assessments to see if there were any restrictions in place for people that might mean an application under DoLs would need to be made. The manager advised us that DoLS applications had been made for fifteen people and these were being processed by the local authority.

We found management and staff were not working within the principles of the MCA. The service asked people, or their advocates, to sign consent forms to agree to the care provided. At the last inspection we found that consent forms were not consistently signed or an inappropriate explanation recorded if it was not possible to obtain written consent. At this inspection we found people had been asked to sign to give their consent. Some consent forms had been signed by both people without capacity and their families. One person, whose care plan stated they did not have capacity to make decisions about their care, had signed a consent form. This meant that the service was not clear on this person's ability to understand such a decision and sign appropriately. Other care files showed people's friends had been asked to sign consent forms on behalf of people living at the service who were unable to do this for themselves. There was no

evidence of any Power of Attorney being in place to show that these friends could legally act on the person's behalf. This meant that staff were not clear on who was authorised to consent on behalf of people.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Most permanent staff were knowledgeable about the people living at the service and had the skills to meet people's needs. There were concerns raised by staff that sometimes bank workers didn't always have enough knowledge about people living in the service. We observed on the day of the inspection that some bank staff needed guidance about how to care for people and waited to be told what to do by other staff. Staff told us they had received relevant training for their role and training was regularly updated. The training matrix we looked at confirmed that staff received regular training.

New staff completed an induction when they commenced employment which included training identified as necessary for the service and familiarisation with the service's policies and procedures. There was also stated to be a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. The service's induction incorporated the Care Certificate. This is designed to help ensure care staff, who are new to care, have a wide theoretical knowledge of good working practice within the care sector.

Staff told us they felt supported by the manager and senior care workers. They told us they had received an annual appraisal to discuss their work and training needs and had regular supervision. Nurses received regular one-to-one supervision with the clinical lead. The supervision matrix confirmed that supervisions for care staff and nurses were taking place.

Requires Improvement

Is the service caring?

Our findings

While we saw some good examples of kind and caring interaction between people and staff, we also saw other practices that did not respect people's dignity and enhance people's well-being.

We found that slings, used when people needed to use a hoist were shared between people. Net pants, used to wear over continence pads were shared. Continence pads were supplied to meet each individual person's assessed continence needs to ensure people used the right size and type. However, it was clear from supplies left in communal bathrooms and other areas that these pads were used between people as well. This meant people were not always wearing the size appropriate for their needs which could lead to unnecessary discomfort for people. These practices did not respect people's dignity and human rights and represented institutional ways of working.

Some bedrooms did not have any identification on the doors such as a number, the person's name or a picture to support people in recognising their own bedrooms. This meant it could be difficult for people living with dementia to orientate around the building and find their room.

Some people living in the service had complex behavioural needs and limited communication. Care plans did not always give staff guidance about how to communicate with people, especially where people refused care and were at risk of self-neglect. Staff had little interaction with people with complex communication needs.

One person's room had a sign on their wall stating that a named person, not their name, was to have their socks removed at night. We concluded this notice had remained from the room's previous occupant.

When we observed the lunchtime period we found there was little interaction between people and staff. Staff who assisted people to eat their meal did so without any real conversation. There were three bank staff on duty on the day of the inspection. We noted that they needed guidance from permanent staff to know how to support people. While they were willing and completed the tasks assigned to them competently they were reluctant to initiate interactions with people, as they were not familiar with their needs. Bank workers were provided centrally by the Morleigh group and the service was not able to ask for specific bank staff who had knowledge of the needs of the people living in the service.

On the day of the inspection an agency worker was assigned to work on an individual basis with one person. It was clear that the person did not respond well to this worker and may even have become more agitated by their presence. This worker had been booked by the commissioners of the person's service and the manager was not able to choose the worker. However, there was no attempt to suggest that the worker be replaced by a regular member of staff, even for short periods, to help to relieve the person's anxiety and distress.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's care plans recorded their choices and preferred routines. For example, what time they liked to get up in the morning and go to bed at night. People were able to choose where to spend their time, either in one of the lounges or in their own rooms. During the inspection people moved around the building and went outside into the garden when they chose to. Staff asked people where they wanted to spend their time and what they wanted to eat and drink.

Inadequate

Is the service responsive?

Our findings

Care plans contained information which was held in an organised format. There was information in the care files about each person's background, preferences and dislikes, although not all information was personalised to the individual. Care plans were regularly reviewed, however, changes in people's needs were not always recorded in a timely manner. This meant that sometimes staff were not provided with accurate and current information on people's care and support needs. For example, one person's care plan stated that the person was, "Unable to walk" then later stated, "If they decide to walk a short distance staff are to follow with a wheelchair." This meant that it was not clear if this person could walk or not.

Another care plan stated the person had a pressure sore and an, "air mattress" was to be used to reduce the risk of further pressure damage to their skin. An air mattress was not in place for this person. The dressing to this person's pressure sore was directed to be changed, "Every other day." We found no record of any dressings having been done for this person since 16 October 2016. We were then told by staff that this pressure sore was now healed. This meant the care plan was not accurate and had not been reviewed in a timely manner to provide accurate information for staff.

The care we saw provided to people during the inspection was often task orientated rather than being in response to each person's individual needs. For example, staff carried out routine monitoring checks of people, but often failed to recognise or report when someone needed more assistance so that their needs were met. For example, some people were at risk of becoming distressed or confused which could lead to behaviour which might challenge staff and cause anxiety to other residents. Care records contained information for staff on how to avoid this occurring and what to do when incidents took place. On the day of our inspection visit we identified two people who were refusing care and were verbally aggressive to staff and their care plans suggested that staff should withdraw for a few minutes then return later to try again to seek their acceptance of care. However, in neither case had the service recognised that the plan of care was failing and that neither of these people were having their needs met.

One of these people was found lying in a wet bed, with no sheet or duvet cover at 10.30am. Their room smelt very strongly of incontinence odour. The floor was strewn with three medicine pots and their contents of pills, a bottle of cola lying in the door way, and dirty tissues and food debris. This person's care plan stated they were unable to wash themselves and, "Has very little insight to any dangers to himself…..short term memory loss and unable to make some choices." We identified that this person was very confused and was challenging to the staff. We returned to this person's room four times throughout the day. Staff had entered the room at least four times to deliver hot drinks, a hot meal and a desert and then returned to collect the dishes. During this period from 10.30 up until 4pm staff did not provide any care for the person or clean the floor or the room in general. This person's care plan stated that their room should be kept clean and free from any obstructions on the floor as they transferred independently to a wheelchair and used this to move around their room. The care records also stated that this person was, "Prone to sore areas, "and was therefore in need of regular and effective personal care. However, care records stated this person had refused all personal care since the 20 October 2016, and had only been provided with personal care once in the 10 days since the 15 October 2016. The nurses' records for each day over the past week stated, "No new

concerns." The service had failed to recognise that the person's needs were not being met.

Another person was found at 11.00am lying in a very wet bed. We checked again at 12.30 and it was still wet. We checked again at 12.50 and they were sitting up in bed eating their lunch and the bed was still wet. At 12.55 we told the nurse in charge who checked with staff. They said that they were going to change the bed when two staff were available. Hourly observations were carried out by staff for this person. Records of these observations showed that between 10.00 - 11.00am and 11.00- 12.00am there was no record of the bed being wet when staff checked the person. At some time after 12.30 records stated, ".refused personal care. Wet in bed. Will request another carer to go back in 15 minutes and try again. Lunch given." This meant the person was in a wet bed for at least two hours despite hourly checks being completed by staff, and then was given their meal to eat while still in a wet bed .

The rota stated that there were four days a week where there were activities provided between 2.00 and 4.00pm.The activities planned stated that there would be individual time spent with people in the afternoon. In the afternoon, on the day of the inspection, music was playing in the bungalow, which people seemed to enjoy until a person turned it off. A relative of a person living in the bungalow told us their relative regularly enjoyed listening to the music. Another relative said, "The activities are not bad. The carers do their best with the time they have." We did not see any activities in the main house. A care worker said when asked what activities would take place today, "They have tea and cake at 3pm and between 4pm and 5pm soup, sandwiches, beans or potatoes". This meant that staff were not aware of what meaningful and relevant activities were or how to provide them for people living at the service.

This contributed to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Other people had been assessed as needing to be re positioned regularly to help reduce the risks of pressure damage. Staff were regularly recording when this was being done. People were being moved regularly. 'Skin bundle' nursing kits were in use and no deterioration of people's skin condition was seen on these records.

People and their families were given information about how to complain and details of the complaints procedure was displayed in the service. The service had not recorded any formal complaint since the last inspection. Comments received from some relatives were positive about the service and they said they were encouraged to make their views of the service provided known.

Inadequate

Is the service well-led?

Our findings

The service is required to have a registered manager and there had not been a registered manager in post since March 2015. The manager who had been in charge of the day-to-day running of the service since February 2016 had applied to become the registered manager. At the time of this inspection their application was being processed.

Since March 2015 we have regularly asked the provider to tell us what action they intended to take to ensure there was a registered manager at the service. In May 2015 a new manager was appointed and started the process to become the registered manager but left the organisation in August 2015 before the process was completed. In August 2015 a new deputy manager was appointed to cover the service until a new manager could be recruited. In October 2015 another new manager started and left in a few weeks, before any application to become the registered manager could be submitted. At the same time the deputy was moved by the provider to work at another of the provider's care homes, leaving the service without any management. In February 2016 the current manager was appointed.

These frequent changes in the management of the service have meant that the leadership of the service has been inconsistent. This also shows that the provider had repeatedly failed to retain managers long enough for them to become a registered manager. The provider has failed to recognise the risk to the quality of the service provided to people of not having consistent management. This lack of understanding was demonstrated when the provider moved the deputy manager to work at another service at the same time as the second manager had left.

There were quality assurance systems in place. Regular audits were completed for maintenance, care plans, pressure mattresses, bed rails, medicines, pressure sore management, falls and assessing staffing levels. Monthly visits to the service by the head of operations were in place to check that quality assurance systems in the service were being completed. However, these systems had not been effective in identifying the areas of concern we had found at this inspection.

We have had concerns about the suitably of the environment and the maintenance of the premises since September 2015. We asked the provider to take action to improve areas of concern at inspections in September 2015 and June 2016. At this inspection and the inspection in June 2016, while we found some improvements had been made to the premises and equipment, there were still areas of concern. At each inspection new concerns were found demonstrating that while the provider mostly improved the areas we asked them to, other parts of the premises had fallen into disrepair. This meant the provider did not have effective systems to maintain the premises or have adequate oversight to ensure there was a suitable and safe environment for people to live in.

Some people did not receive consistent or good care because systems to provide and monitor people's needs were inadequate. This included systems for food and fluid charts, hourly observation charts, monitoring people's weight and checking the setting on pressure relieving mattresses. These inadequate systems had led to poor outcomes for some people. For example, some people had been assessed as

needing hourly observations by staff because they were cared for in bed. These checks were in place to help ensure they were safe, their personal care needs were met and that they had everything they needed. Despite these checks being in place for two people, as detailed in other parts of the report, their needs had not been met. Staff had not provided personal care, made the environment safe or respected these individuals' dignity. Following our inspection visit we 'alerted' these two people to Cornwall Safeguarding to ensure they were protected from further harm.

People were at risk of receiving inconsistent care because the service had staff vacancies and most days there were between two and three bank workers on duty to cover for those vacancies. The manager was able to request bank staff when necessary although it was the registered provider who arranged this. The manager had no control over which bank worker was booked as they were not able to request a specific worker or workers. This meant the manager could not ensure that people received care from staff who had the right skills and knowledge to meet the needs of people living at Elmsleigh.

The provider had not taken appropriate action to address how staff could provide appropriate care for the two people identified as often refusing care and who were at risk of self-neglect. The service had not monitored these two people's repeated refusal of care or sought any advice or guidance from external professionals about how to meet their needs. Staff had not been given sufficient direction and guidance by the service about how to meet these people's complex needs. We observed that staff lacked knowledge and confidence in how to provide care for these people. The provider had also not ensured that there were always enough staff on duty to adequately meet people's needs.

The service's website and service user guide states that the service specialises in caring for people who have a range of complex mental health conditions. For example, conditions such as dementia, schizophrenia, alcohol and drug dependency, bipolar conditions and challenging behaviour. While some staff had received training in dementia and challenging behaviour other specialist areas had not been covered. We were not assured that the training staff had received in dementia and challenging behaviour had been effective in giving staff the knowledge and skills to care for people living at Elmsleigh.

All of the above issues demonstrate that the provider had not adequately assessed, monitored and mitigated the risks to people living in the service.

The Morleigh group carried out annual surveys to gather the views of people living in each service and their families. When surveys were returned these were collected and collated centrally at the provider's head office. The manager told us surveys were given to people and their families to complete in April 2016. However, they were not aware of any results of these as this information had not been passed to the service. This meant that improvements to the quality of the service provided had not been as a result of feedback.

Confidential personal information relating to the care of named people at the service and staff records were found in a cupboard in a main corridor, and were easily accessible to anyone using this corridor. This confidential information was not being held securely.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Elmsleigh Nursing Home and the service has been rated as Requires Improvement since the first rated inspection was carried out in November 2014. The Care Quality Commission has carried out five inspections, (including this one), of the service since November 2014. At each inspection there have been breaches of the Health and Social Care Act 2008 regulations including two warning notices that were served because the service was failing to meet legal requirements in relation to regulation 12 (safe care and treatment).

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The manager had been in post since February 2016. The manager was supported by a deputy manager and two senior care staff. Staff told us they felt supported by the manager and felt more settled as previously there had been several changes of managers. Staff told us they had confidence in the manager. Staff told us they did not have much contact with the owner and if they had any concerns they would go to the manager of the service. One member of staff told us, "The owners don't know staff; there is a new manager in the home. They are alright."