Elmwood Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 24 and 25 September 2018. The inspection was to follow up whether improvements had been made from the previous inspection in September 2017.

Elmwood residential home is registered to provide accommodation with personal care for up to 38 people with physical disabilities, long term medical conditions or memory loss. 37 people lived there when we visited.

At the previous inspection on the 13 and 14 September 2017, the service was rated as requires improvement overall, with the safe, effective, responsive and well led domains rated requires improvement and the caring domain rated as good. Four breaches of regulations were found in safe care and treatment, safeguarding, quality monitoring and in relation to a failure to notify the commission about an allegation of abuse. Following the inspection, CQC took further enforcement action by imposing a condition on the provider's registration. This was because the service had been rated requires improvement with breaches of regulations for the fourth successive inspection. The condition required the provider to provide CQC with a monthly report to demonstrate they were making the required improvements at the service.

CQC met with the provider on 10 January 2018. The purpose of the meeting was to ensure the provider was clear that CQC's expected improvement at the next inspection, with no breaches of regulations. We also emphasised the need to ensure these improvements were sustained. Since December 2017, the service has sent monthly reports, which have included examples of continuous improvements.

Since then, the service has worked closely with the local authority, their quality assurance improvement team and the Care Quality Commission to make the required improvements. The local authority quality assurance and improvement team has visited the service regularly to support the provider to continuously improve their quality monitoring systems. Joint meetings were held with the provider, local authority and care manager to monitor progress and ensure continuous improvements were made. At this inspection, significant improvements had been made in the provider's quality monitoring systems. People's care records had improved, care plans, risk assessments and daily records were more detailed, and personalised. However, further improvements were still needed to make sure staff had the training and sufficient equipment to use electronic care records effectively.

The provider, registered manager and deputy manager, worked well together. People, relatives, staff and professionals gave us positive feedback about the quality of people's care. They spoke about improvements in communication, professional development and improved quality monitoring systems.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from abuse because the leadership team had completed additional safeguarding training with the local authority. They demonstrated a good understanding of their responsibilities to report safeguarding concerns, and worked in partnership with other agencies, where concerns about abuse were identified. The service informed the local authority safeguarding team about suspected abuse and notified the Care Quality Commission (CQC). Where concerns about staff practice were identified, they were robustly dealt with through additional training, supervision, and if needed, by following the provider's disciplinary procedures.

Staff demonstrated a good awareness of each person's safety and how to minimise risks for them. Improvements had been made in the garden to improve people's access and reduce their risks of slips trips and falls. All hazardous chemicals were safely stored when not in use in accordance with health and safety regulations. People's risk assessments were comprehensive with actions taken to reduce the risks as much as possible. Regular health and safety checks were carried out with improvements made in response.

People received their medicines safely and on time. Robust recruitment processes were in place to ensure staff employed were suitable to work with people. People were protected from cross infection by regular cleaning, handwashing and good infection control systems.

People were supported by staff that were caring, compassionate and treated them with dignity and respect. Where concerns or complaints were raised, they were listened and responded to and used as opportunities to improve.

People were supported by staff who had the skills and knowledge to meet their needs. Staff had a better understanding of their responsibilities and felt more confident to carry out their roles. People's health was improved by staff who worked with a range of professionals to access healthcare services. People praised the quality of food, and staff promoted people to improve their health through good nutrition and hydration.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

The service was well led, with no breaches of regulations at this inspection. CQC is satisfied the provider has made the required improvements in quality monitoring and has decided to remove the monthly reporting condition from the provider's registration.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse, because safeguarding systems had improved. Staff knew about their responsibilities to safeguard people and how to report suspected abuse. Any concerns were appropriately responded to.

People were protected from avoidable harm because internal and external improvements made had minimised risks. Risks for people were assessed and actions taken to reduce them.

People reported feeling safe living at the service, which had enough staff to meet their needs.

People received their medicines in a safe way.

People were protected from cross infection by good hygiene and infection control measures.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Good

The service was effective.

Improvements had been made in meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked capacity, best interest decisions had been made, which minimised restrictions on people's freedom.

People were well cared for by staff who had regular training to gain the knowledge and skills to support people's care and treatment needs.

People were supported to access healthcare services. Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were positive about the choices and quality of food. Staff

supported people to improve their health through good practice in nutrition and hydration.

Is the service caring?

Good

The service was caring.

Most people and relatives said staff were caring and compassionate and treated them with dignity and respect. Where any concerns were identified, they were robustly dealt with by the provider.

Staff knew people well and developed positive relationships with them.

People were able to express their views and were involved in decision making.

Is the service responsive?

Requires Improvement

Some aspects of responsive needed further improvement.

People's care records had improved. They were more personalised, detailed, up to date and securely stored. Further improvements were needed to ensure care staff had the equipment and training to use electronic care records effectively.

People received care which met their individual needs. Improvements had been made to make activities more personalised.

People knew how to raise concerns and complaints which were positively and robustly responded to.

People who received end of life care at the service were kept comfortable and pain free.

Is the service well-led?

Good

The service was well led.

The quality of people's care had improved because the service had made significant improvements in quality monitoring systems.

The leadership team were proactively monitoring and reducing risks, and continuously improving care and the environment through audits, and in response to feedback.

People, staff and visiting professionals expressed confidence in the registered manager and deputy manager. The culture was more open, with improved partnership working with external agencies.

The provider set clear expectations for staff about their performance. Senior care staff were being developed to take on more responsibilities, with further development planned.

People, relatives' and staff views were sought and taken into account in how the service was run.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on 24 and 25 September 2018. The inspection team comprised of an inspector and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses care service for older people.

The provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the monthly provider monthly reports over the past nine months. We also reviewed other information we held about the home, such as the provider's improvement plan, and feedback we received from families, and health and social care professionals.

We met with 21 people using the service, and spoke with six relatives. We looked at three people's care records and at medicine records. We spent time meeting with people in their rooms and in communal areas of the home. We observed interactions between people and staff. This helped us make a judgment about the atmosphere and values of the home.

We spoke with the leadership team, (which consisted of the nominated individual, registered manager and deputy manager) and with 10 staff. These included care staff, housekeeping, maintenance and kitchen staff. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and at five staff files, which included recruitment records for new staff. We also looked at quality monitoring systems the provider used such as audits, daily, weekly and monthly checks and provider visit reports. We

sought feedback from commissioners, and health and social care professionals who regularly visited the home and received a response from five of them.

Good

Is the service safe?

Our findings

At our previous inspection in September 2017 we identified breaches of regulations in safe care and treatment and safeguarding. This was because some environmental risks were not adequately managed in the external grounds. Also, people were at risk because of inadequate supervision of contractors working on site and lack of secure storage of hazardous chemicals. Some safeguarding concerns had not been reported to external agencies because the leadership team did not fully understand their responsibilities to protect people from abuse. At this inspection, improvement had been made in all of these areas and there were no breaches of regulation.

People said they felt safe living at the home. Everyone looked comfortable with staff, and the atmosphere was calm and relaxed. People's comments included; "I feel safe, they always want to know if you are alright," "They handle me well, I trust them," and "'Safe as houses. The place is secure."

People's safety had improved. In the garden, uneven paths had been made level, and slip, trip fall hazards were minimised. Additional handrails had been added to help people access the garden safely and independently. Safety systems had been improved so contractors working on site were monitored to make sure people were protected from tools and equipment risks. Indoors, people were protected from harmful chemicals such as bleach. When not in use, these were securely stored in a designated cupboard for chemicals, in accordance with health and safety regulations.

People were protected from abuse because the leadership team demonstrated they understood their safeguarding responsibilities. They had done additional safeguarding training with the local authority safeguarding team. Where concerns about suspected abuse were identified, they contacted the local authority safeguarding team and sought advice about suspected abuse, and notified the Care Quality Commission (CQC), in accordance with the regulations. Where concerns about staff practice were identified, these were robustly dealt with through additional training, supervision, and where necessary, by following the provider's disciplinary procedures. For example, in response to a recent complaint about verbal abuse relating to a staff member.

Safeguarding policies and procedures had been updated and included relevant local contact details for reporting concerns. Staff knew the signs of abuse, and how to report concerns outside the home, and were confident concerns raised were dealt with. They had completed safeguarding update training, and signs of abuse and how to report concerns had been discussed at individual supervision and staff meetings to raise awareness.

People's safety and wellbeing was promoted, because there were enough staff to meet people's needs at a time convenient for them. People said staff responded to call bells swiftly. People's comments included; "They come, I don't wait long, at night, two or three minutes at the most" and "Sometimes we have to wait a short time."

The registered manager used a dependency assessment tool, which identified each person's support needs

and planned the staffing rota accordingly. Staff rotas were reviewed monthly and as people's needs changed. Staffing levels were used flexibly, to ensure there were more staff to support people at busy times of the day, such as early in the morning and early evening, when people needed more assistance. There was one vacancy for a senior member of staff, which the service hoped to recruit to soon. Where there was any sickness, or leave, other staff worked additional hours, which minimised use of agency staff.

Effective staff recruitment and selection processes were in place. All pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Personalised risk assessments provided comprehensive guidance for staff, which included a detailed assessment of their needs and steps being taken to manage and reduce risks as much as possible. For example, a falls risk assessment showed a person with a history of falls. Staff made a referral to the community falls team for advice. Their risk assessment identified a number of steps taken to reduce the person's risk of falling. Staff visited the person regularly throughout the day and night to check if they wanted anything, such as a drink or to go to the bathroom. The person also had agreed to use of pressure mats, which rang when person got out of bed, or stood up from their chair, so staff knew to offer the person assistance. They had also ensured the person was wearing good fitting footwear. These steps had reduced the person's risk of falling.

All accidents and incidents were reported, with steps taken to try and reduce the risk of recurrence. For example, following a person falling in the dining room, staff moved the tables further apart, to allow people with mobility aids more room to get to their seat at the table.

Environmental risk assessments highlighted potential hazards and measures to minimise risks. For example, by regularly checking hot water temperatures were within safe limits. There was an ongoing programme of servicing, repairs, maintenance and redecoration. Two new smoke alarms had been fitted and work on fire doors to meet new fire regulations had been completed. Monthly health and safety checks were undertaken in all areas of the home, with actions taken in response to findings. For example, to repair a wheelchair, and address trailing leads to minimise slip trip falls risks.

People were prevented from cross infection because all areas of the home were clean and odour free. A relative said, "Cleanliness is excellent." Staff completed infection control training, they had hand washing facilities and used gloves and aprons appropriately. Housekeeping staff had suitable cleaning materials and followed a cleaning rota. Regular infection control audits were undertaken, with areas for improvement fed back to staff and discussed at staff team meetings. For example, to attend to spillages promptly. New flooring had recently been fitted in the kitchen, which made it much easier to keep clean and hygienic. An environmental health inspection awarded the kitchen a top rating of five out of five.

People received their medicines safely and on time. Senior care staff who administered medicines were trained and had yearly assessments to check they did so safely. Staff explained to each person what their medicines were for and checked if they wanted pain relief. Medicines administered were well documented in people's Medicine Administration Records (MAR). Tablets were checked daily, to ensure all doses were accounted for, although this was done by hand, which was a cross infection risk. We made the registered manager aware of tablet counters they could use to avoid touching tablets, which were ordered straightaway.

There were suitable arrangements for ordering, receiving and disposal of medicines, including those

requiring extra security and recording. Detailed policies were in place to guide staff on medicines management, and staff had information about people's individual medicines. Medicines were audited regularly and action taken to follow up any areas for improvement. For example, to sign and date newly opened creams, and where any signature gaps in MAR sheets were identified.

Good

Is the service effective?

Our findings

At our previous inspection in September 2017, improvements were needed. People's legal rights were not fully protected because staff had a poor understanding of what constituted restrictive practices. They placed undue restrictions on a person who lacked capacity. At this inspection improvements had been made in this area.

People's consent to care and treatment was sought in line with requirements of the legislation and guidance. The Mental Capacity Act (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People were offered day to day choices. People commented; "I'm an early riser so they take that into account" and "They definitely know me, I choose what I want to wear."

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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 and found they were.

Where people lacked capacity, staff demonstrated a good knowledge and understanding of their responsibilities. Mental capacity assessments were completed with best interest decisions made. The registered manager had made several DoLS applications to the local authority DoLS assessment team for people living at the home, who lacked capacity, because of dementia and was awaiting assessment. This was where staff recognised those people had some restrictions to their liberty for their safety and in their best interest.

We followed up what steps were taken to minimise restrictions for a person we identified at the last inspection. This was because the person was distracted, whenever they indicated they wanted to go outside, rather than assisted to do so. Staff involved the person's relative and their legal representative in a best interest decision to ensure the person could go outside more regularly, accompanied by staff, for their safety. For a while, the person enjoyed going out more often, but had recently become more frail. The person's care plan showed they now relied on others to anticipate their needs. This was because their mental deterioration meant they could no longer contribute to decisions about their care. Staff now visited the person's room regularly, to chat and spend time with them. The provider arranged for an external professional to do weekly one to one visits with the person, and family visited regularly. These steps all reduced any feelings of restriction or isolation.

People received effective care and treatment to meet their health needs. A relative praised the improvement in a person's health when they came to live at the home. They wrote, "He arrived in a poor state, over subsequent weeks we saw an amazing transformation in his wellbeing, level of contentment and enjoyment

of life." Another relative said, "She has the physio on Fridays, it's all included." The service had a private physiotherapist who visited people twice a week, to support them with exercise and mobility needs.

Before people came to live at the service a senior member of staff visited them and carried out a detailed pre-admission assessment. The service used evidence based tools to identify people at risk of fall, pressure ulcers (known as bedsores) and those at risk of becoming malnourished. People's individual care plans include clear instructions for care staff about how to meet their needs. For example, about the need for moisturising cream, pressure relieving equipment, and regular repositioning to keep a person's skin healthy.

People were supported to live healthier lives, through partnership working with local professionals to ensure they had effective care and treatment. Health professionals said staff contacted them appropriately to seek advice about people's health care needs. People also had regular eye tests, dental checks and visits from a chiropodist and were supported to attend hospital appointments.

Community nurses praised people's skin care, and said people at risk of pressure ulcers were repositioned regularly, with pressure relieving equipment used appropriately and creams applied regularly to keep their skin healthy. They identified getting staff to ensure people with leg ulcers wore compression stockings, recommended to improve blood flow, as an area for improvement. The deputy manager explained some people were reluctant to do follow this advice, as they found them uncomfortable.

Staff had the skills, knowledge and understanding they needed to care for people. Most staff had qualifications in care. Staff training and updates included first aid, fire safety, moving and handling, food hygiene, safeguarding vulnerable adults, dementia and the Mental Capacity Act. Improvements had been made in making sure staff attended regular training and updates. This included completion of self-assessment booklets, to check staff had understood the training given. This meant staff had a better understanding of people's health needs and felt more confident to carry out their roles.

The registered manager and deputy manager worked alongside staff day to day around the home. They used observations of staff practice and regular one to one supervision meetings to promote good practice, monitor staff skills and attitudes and identify further professional development needs. This meant they were proactive in identifying and tackling any areas needing further improvement.

A new staff member confirmed they undertook a period of induction, and worked alongside more experienced staff to get to know people. Staff new to care completed the Care Certificate, a nationally recognised set of standards that health and social care workers were expected to adhere to in their daily working life.

People praised the quality of food and choices available. Their comments included; "Food is excellent," "The cook is very, very good," and "The quality of food, is very good indeed." A relative said, "If Mum doesn't want something on the menu she can ask for something else." People selected their food choices for the week from a wide variety of options, including for people on special diets. Each person kept a copy of their menu, as a reminder, but could change their choice on the day. Where a person did not have had much appetite, the chef offered lighter alternatives, such as an omelette, or a jacket potato.

Kitchen staff had up to date information about people's food preferences, their nutritional support needs and any special dietary requirements. Where people need pureed or soft food, this was presented in an attractive and appetising way. The service used a red/green serviette system to indicate staff needed to

provide extra support for people with their nutrition/hydration needs. Red serviettes on people's trays showed the person needed staff assistance to eat and drink. Green serviettes alerted staff that the person had special dietary needs. Detailed records of food and drink were kept for anyone at risk of malnutrition or dehydration. People at risk were weighed regularly, so further action could be taken if any concerns were identified. For example, by a referral to a GP or dietician.

People's individual needs were met because improvements had been made to improve access indoors and outdoors, to meet people's needs and promote their independence. A relative said the best thing about Elmwood was knowing their mother was "safe, with space and accessibility to mobilise, and the staff support." Since we last visited, a new hi/lo bath had been installed, so people with limited mobility could access bathing more easily. There was a disabled access toilet downstairs, although several people with mobility needs preferred to use a small toilet nearer the lounge. This toilet was not large enough to accommodate people's mobility equipment, which meant they had to leave the door open, which was not dignified. We made the provider aware of this, and they undertook to try and improve this toilet area. Some areas had good signage, but improvements could be made in other areas. For example, to make signage larger, and easier to read, and by using more picture/symbol and personalised signage on bedrooms.

Throughout both days we visited, people and relatives enjoyed using the garden. One person said, "In the summer the garden is fabulous here." Handrails had been fitted to sloping areas to help people go outside independently. The garden was beautifully kept with trees, shrubs and borders with lots of areas of interest to explore. A new paved area had been laid, which provided wheelchair access to the garden pond, so everyone can enjoy this area. Seating areas were provided throughout the garden, so people could sit and rest.

Good

Is the service caring?

Our findings

Most people said they were supported by staff who provided kind and compassionate care, although three people said their experiences of caring varied, depending on the member of staff. People's comments included; "Everybody's nice here," "Staff are very approachable," "If you want anything you've only got to tell the staff and they'll get it for you." Relatives' comments included; "Staff wave through the window, if they are walking by, and will come in and have a little chat." Written compliments included; "We were really impressed with Elmwood," "Thank you for your loving care whilst our mother was with you," and "Their dedicated help and cheerful assistance."

One person said, "Some can be a bit more caring than others," another said, "Sometimes if you ask them to do something they can be a bit off, it only happens the odd time, it's not a regular thing." On one occasion, a staff member staff came into the lounge during an activity, said "Hello" to a person and proceeded to undertake a care task with them without further explanation or communication. We were aware from our discussions with the leadership team, monthly reports to CQC and individual supervision records, of proactive steps being taken with individual staff to improve interpersonal skills and provide more personalised care and support. For example, through staff training and one to one supervision support.

Staff interacted well with people around the home. There was lots of laughter and banter. One staff member took time to help a person finish their crossword puzzle, another sat patiently with a person holding their hand. When a person first came to the home, and lost their way, a staff member described how they helped the person find their room, which the person can now do unaided. A local chaplain said, "The management and staff are extremely welcoming and hospitable, people speak with great warmth about the care, kindness and support they receive, and the dignity that they are afforded."

People and relatives described a happy welcoming atmosphere. There was a sense of community, people had made new friendships and rekindled contacts with people they knew previously. The environment was homely, people's rooms had photographs of family members and furniture and personal mementoes they brought with them when they came to live at the home. People's comments included; "I've made friends here, in the lounge and my neighbours," "It's nice everyone comes out, and chats in the afternoon." One person said they appreciated having a phone in their room, so they could keep in touch with their sister. Families were welcomed anytime, and people were still talking about the summer fete, which was organised for family and friends. People were in the process of organising an afternoon tea session, and planned to invite people living in sheltered accommodation nearby.

Staff treated people with dignity and respect. People's comments included; "Privacy, on the whole its quite good, they knock, then they come in," "They throw a towel over your shoulders, and shut the curtains." People could express a preference for male or female care staff, and their wishes were respected. Care plans showed what aspects of personal care people could manage independently and which they needed staff support with. For example, one person needed staff to help them wash their back, and put cream on their feet.

Staff protected people's dignity. For example, they spoke about a person who, because of their dementia, had a tendency to remove their clothing. Staff were aware of this, and checked regularly and made sure the person was appropriately dressed. This was in accordance to person's care plan and promoted their dignity. Care plans included details about people's continence care needs, and people were offered help to use the toilet regularly and receive regular personal care.

At lunchtime, meals were well presented and looked appetising. Tables were attractively set with linen tablecloths, linen napkins, cutlery, glasses, a water jug, condiments and table decorations. After dessert, a platter of chopped/sliced fresh fruit and a fruit bowl was offered to people.

People were supported to eat and drink independently. One person had a pottery mug with two handles, they said, "I can get three fingers in to make it stable." Another person had a beaker with two handles and a straw, which was light and easy for them to manage. A person with poor eyesight had a plate guard to help prevent spillage. A member of care staff cut up the person's food, and described for them what was on their plate. Staff said to another person; "It's a bit hot, watch the plate, enjoy your meal." Where needed, people were offered clothes protectors to keep their clothes clean.

People's cultural and religious needs were met. For example, several people attended local church services, and people were looking forward to a monthly communion service on the first day we visited. People were also supported to attend local church services and regular church coffee mornings. In turn, Elmwood invited people from church to attend social events at the home.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support. Each person had a telephone in their room, which they used regularly to call the office where the registered manager and deputy manager were based. Discussions included making plans for hospital appointments, requests to see a GP or other professionals. The registered manager and deputy manager regularly responded to requests from people to visit them in their room for a chat. Where there were any concerns, or the service needed advice, for people who lacked capacity, they consulted people's legal representatives and sought advice from the local authority safeguarding or deprivation of liberty team on care decisions.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in September 2017, the service had just introduced an electronic computerised care records system. These were being used alongside existing paper records, with some confusion and duplication. Further improvements were needed to improve secure storage of records and make them more personalised, detailed, and up to date.

At this inspection, people's care records had improved. Care plans and risk assessments were more detailed, and daily records showed people made day to day choices about what time they got up, and what to wear. However, some new issues related to the implementation of electronic records were identified, which needed to be addressed. For example, the service only had two computers, both of which were both located in the office and shared by registered manager and deputy manager. These were in daily use, and were not accessible to care staff during the day or out of hours.

Care staff used hand held portable devices to complete daily records. Three staff we asked to demonstrate use of hand held devices did not know how to access care plans or risk assessments via these devices. When the provider demonstrated to us how to do this, the writing in care plans was too small to easily read. When we asked staff how they read people's care plans, they showed us a filing cabinet in a storage room, full of spare furniture and equipment. They needed to obtain a key to access this, from the registered managers office.

Staff said practically, they mostly relied on daily handover meetings or alerts via their hand held devices to keep up to date about changes in people's care needs. The lack of access to computer equipment also meant care staff were not being developed or taught how to create or update people's care plans and risk assessments. This resulted in an over reliance on the deputy manager and registered manager to create and update people's care records. This left people vulnerable of having out of date care records, if managers were not available, and was not sustainable in the longer term.

We asked the provider to take further immediate steps to improve staff access to electronic care records. The following day the provider contacted the Care Quality Commission to outline immediate steps being taken. These included installing a computer in the staff room the next day, and giving staff further training on how to access people's electronic care records. Printed copies of paper care plans, stored in a lockable filing cabinet, were moved to the staff room, to make them more accessible to staff. A laptop was ordered, so staff also had portable equipment they could use to update care records. Purchase of a further computer was planned, for people and staff to share.

We recommend further steps to provide staff training on the use of electronic care records.

We also identified other care record issues, which needed to be improved. For example, written documents could be uploaded for storage into the electronic care record. However, when we tried to view several of these, they could not be opened because of document naming issues. The system included a section on recording best interest decisions but did not include mental capacity assessments. Paper copies were

available, but ones we requested could not be located. Separate records for people were being kept for people by two visiting professionals, a private physiotherapist and a person doing weekly one to one visits. Currently, these were kept in a way that meant people's individual care records couldn't be separated to store with their main care record. This meant those records were not securely stored.

We recommend record keeping policies and procedures are reviewed and updated to include guidance for staff on naming scanned paper records in a consistent way, so they are accessible. Also, to include guidance for managing paper records made by visiting private practitioners about people's care and treatment.

On the first day we visited, support for people at lunchtime varied, depending on which dining room they had their lunch. In one dining room, there was a member of staff was present throughout the meal, but not in the other. In the second dining room, when staff served lunch, a person did not have the specialist cutlery they needed to eat lunch independently. When they asked for it, the staff member misunderstood and initially gave them a knife and fork, so they had to ask again. A second person wanted a drink, which another diner tried to help them with, which resulted in a spillage. A third person fell asleep at the table, and a staff member placed dessert in front of them and left without attempting to wake the person, so others at the table tried to do so. We fed this back to registered manager and deputy manager. In response, on the second day, they made sure people were appropriately supported in both dining rooms.

People received personalised care that responded to their needs. Daily records were more personalised and detailed about people's physical care and emotional wellbeing. For example, people's nutrition and hydration, their mood, how they had spent their day and any activities they had undertaken. Staff knew people well, recognised changes in their health and care needs and took appropriate action in response. For example, one person's care plan showed they were unable to use a call bell and could become distressed and scream out if asked to leave their room. Staff did regular 'comfort round' to visit this person to see if they needed anything and to interact with them to minimise their risk of falling or becoming isolated.

People and relatives praised the variety of activities at Elmwood. Their comments included; "They provide a lot of activities, that goes well," "I join in the exercise class," "We have a trip out now and again in the minibus." A relative said, "They have a film night, ask if she wants to watch or choose a film." Another relative said their mother liked the company, had put on weight and was more stimulated and articulate, because they had people to talk to.

People were consulted about preferred activities at monthly meetings and received a copy of the monthly activities programme. This included a variety of external musical entertainment, singing, card games, crafts, quizzes, exercise classes and regular outings. Care plans included personalised details about people's interests and hobbies. For example, a person enjoyed looking at pictures of animals and birds, and listening to the radio.

Several people living at the home had organised activities of interest to them. One person had set up a weekly 'Knit and natter' group, with their relative's support, which was very popular. Another person was a keen artist and was planning to get other involved in a weekly painting group. A third person said, "I'm going to set up a group to satisfy my interest in discussing books and poetry." The relative of another person, who recently moved into the home, said their mother was hoping a regular flower arranging activity could be arranged, which we made the registered manager aware of.

People spoke about the recent garden fete they organised with staff support which everyone enjoyed. Some people displayed their knitting, others displayed their artwork and made cakes. The local Seaton Majorettes, put on a display, and two local people played the ukulele. Photographs showed people proudly displayed

their work and sold their creations at the summer fete.

We observed a seated exercise activity with six people, there with lots of joking with everyone participating. A staff member praised people's efforts and offered to help a person when they struggled with an exercise, which encouraged them to continue. However, some of the equipment needed updating and replacing. For example, one exercise included rolling a ball, but only one person had a ball with others having to use beanbags. People said it wasn't easy to roll a bean bag, so they decided to abandon that exercise. Another exercise used stretchy bands to encourage people to use their arm and leg muscles, but several of these were broken. People said; "These bands are broken, we need new equipment," which we made the registered manager aware of. Two staff helped with activities, as part of their daily duties, but sometimes had to stop to respond to people's call bells.

We recommend staff undertaking activities have some dedicated time, when they are not expected to carry out care, so they can plan and manage activities uninterrupted.

Significant improvements had been made to ensure people who were confined to their room or chose not to participated in group activities had someone to one interactions with staff to prevent isolation. Each person had a designated keyworker, whose role included spending time with those people. In addition, the service employed a professional who did weekly one to one sessions with several people. These sessions included reminisce and sensory activities using herbs and scents, as well as chatting to people and using a computer to research things of interest to them. These visits were popular with people, and an example of good practice. Care records confirmed each person had regular social interaction with staff and visitors.

We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Each person's care plans included a section about their individual communication needs. For example, for staff to remind people about wearing their glasses, and fitting their hearing aids. They also included details for staff about how to help people communicate effectively. For example, one person's care plan showed they often got their words mixed up, due to their dementia, that sometimes no meant yes, or the other way around. This meant staff needed to pay attention to their non-verbal signals to respect their wishes.

In the lounge, the television had a facility to display subtitles, for people with hearing difficulties. A whiteboard reminded people with memory problems of the date, season, weather. The staff board, showed photos and names of staff on duty, although these were tiny and difficult to see, so could be more accessible if they were enlarged.

People's concerns and complaints were listened and responded to with improvements made to improve the quality of care. The provider had a complaints policy and procedure. Written information about how to raise a complaint was in each person's room and was on display in the home. The registered manager and deputy manager were proactive in making sure day to day concerns and grumbles were dealt with, before they became more serious. A complaints log was kept of concerns raised, and showed actions taken in response. For example, to respond to concerns when people complained another person's TV was too loud, and was disturbing them.

Earlier in year, a relative contacted us with concerns about their relative's care, which they had raised with the provider and registered manager. The response sent showed the relative's concerns were taken seriously, and investigated thoroughly with improvement actions taken to address their concerns. For

example, staff sought professional advice about person's seating from an occupational therapist, which resulted in purchase of a specialist chair for them. At the time we visited, a complaint about a member of staff was being investigated. Minutes of staff meetings also showed any concerns raised by people and relatives were discussed. This showed complaints were dealt with more robustly and used as opportunities to identify further improvements.

People at the end of their life were supported to have a comfortable, dignified and pain free death. A church professional said, "I have been particularly struck by how wonderful staff are with the dying and those at the point of death. I remember one occasion when I was with a resident when she died and then sat with her. As I sat, members of staff came quietly in and out to say their goodbyes and express their grief. We were able to support one another just when that was most needed."

Where people had expressed any advanced decisions about resuscitation, the withdrawal of treatment or preferred funeral arrangements, these were recorded in their care plan. This gave people the opportunity to let other family members, friends and professionals know what was important for them in the future, should they no longer be able to express their views.

Good

Is the service well-led?

Our findings

At the last inspection in September 2017, although improvements had been made in some aspects of the quality monitoring, these were still not fully effective. This was because people were at increased risk because four breaches of regulations were found in relation related to safeguarding, notifications about abuse, safe care and treatment related to environmental risks, and good governance. None of which had been identified through the provider's quality monitoring systems. A breach of the good governance regulation was identified at the fourth successive inspection. In response the Care Quality Commission (CQC) took further enforcement action, and imposed a condition on the provider's registration. This required the service to submit a monthly report to demonstrate it was addressing the issues found and making the required improvements.

CQC met with the provider on 10 January 2018 and impressed on them CQC's expectations that at the next inspection, all required improvements should have been completed with no breaches of regulations. We also emphasised the need to ensure these improvements were sustained. At this inspection, significant improvements had been made in the provider's quality monitoring systems. The service was well led, with no breaches of regulations.

The culture of the service was more open with the leadership team working in partnership with the local authority, Care Quality Commission and local professionals to make the required improvements. The local authority quality assurance improvement team visited the service monthly between March and July 2018. This was to support the service to progress and embed improvements in quality assurance and further improve care planning. The provider said, "I feel the service has learnt how to learn, we are more open to seeking outside help and guidance."

The service developed a service improvement plan which showed progress with ongoing improvements. A new quality assurance policy was developed which set out roles and responsibilities for quality monitoring. A director in the company became the nominated individual, and took an active role in monitoring the quality of the service, and supporting the registered manager. Since December 2017, monthly reports demonstrated ongoing improvements in quality monitoring. governance systems and processes were improved with evidence of continuous improvements in response to audits, health and safety checks and in response to feedback from people, relatives and staff.

The service used a range of quality monitoring systems such as audits of care records, activities and medicines management. Audit action plans showed the service made continuous improvements in response to their findings. For example, regular health and safety checks of beds, bed rails, and of pressure relieving mattress were undertaken. This was to ensure equipment was working correctly and mattresses were correctly set for each person's weight. Regular equipment checks showed brakes were repaired on one wheelchair and another wheelchair was replaced. Audits of people's involvement in activities records showed staff were reminding people of planned activities and offering to help people to participate.

CQC has received safeguarding notifications about suspected abuse concerns. These showed the provider

was working closely with the local authority safeguarding team, families and staff to protect people from abuse.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was in day-to-day charge, supported by a deputy manager. Both cared for people living at the home and acted as role models for staff. People, relatives and staff praised how the provider, registered manager and deputy manager were visible around the home. People's comments included; "Relations with the management are very good, the two who run it, (registered manager and deputy manager) have done all sorts for me," and "They follow things up. Speaking about the deputy manager, a professional said, "She is beloved by all the residents and I am awed by the way she cares for them and relates to them." Other comments about quality of care at the home included; "Very good, I feel very confident" and "They're as good as gold," and "On the whole I think Elmwood is top of the list." A church professional said, "There is lots going on, residents always seem happy."

The registered manager and deputy manager were more aware of local health and social care professionals and agencies they could contact for support and advice. They worked more closely with the other home within the group. For example, each registered manager had visited the other service to carry out a quality monitoring audit. This meant good practice ideas were being shared across both homes. The registered manager received the CQC monthly newsletter and a professional care publication to keep them up to date about development in adult social care. The registered manager was more aware of other sources of information and support they could access such as Skills for Care and Social Care Institute for Excellence websites. This ensured the service were aware of ways they could continuously learn and promote continuous improvement.

There was an emphasis on providing more person-centred care, and moving away from a task approach, by developing staff, through individual supervision and at staff meetings. This incorporated the provider's values to promote people's privacy, their independence, rights, ensure they had choices, lived with dignity, and had fulfilling lives. For example, encouraging staff to spend time interacting with people and by capturing people's mood, emotional wellbeing and how they spent their day in daily records. Health professionals commented care staff were still overly reliant on the deputy manager. For example, how care staff often referred them to the deputy manager when they asked staff simple questions about people's skin and whether they had any redness.

Some progress had been made in developing senior care staff to take on more responsibilities, as part of their development, with further progress needed. A job description for a senior care worker had been developed to set out more clearly the role to oversee the staff team and support the registered manager and deputy manager. Two senior staff had been appointed, with a further appointment planned.

We met with a senior care worker who described their additional responsibilities to oversee the staff team on the shift, allocating staff to work in different areas of the home and promoting improved record keeping. They described resistance to the senior role from some staff, which the leadership team were aware of and were working on overcoming. The senior care worker was hoping to take on further responsibilities in the near future. For example, by learning how undertake and update care plans and risk assessments in electronic care records. The registered manager had plans to further develop the senior care staff by arranging leadership and management training for those staff.

Staff participated well in the inspection and team work seemed to have improved. Staff spoke about improved relationships within the staff team. Staff comments included; "Generally its coming along nicely, with improvements being made," "Team are getting on better than they used to," and "I think more regular staff meetings would be helpful in sorting things out." Minutes of September 2018 staff meeting showed staff airing their differences, and being involved in decision making. They also showed the leadership team were exerting their authority to make sure the focus was on people. Where concerns were raised about individual staff practice, these were positively dealt with through additional training, ongoing supervision. Where necessary, robust action has been taken to address repeat concerns in accordance with the service staff conduct and disciplinary procedures.

Daily staff handover meetings were held, which included more detailed reports. Staff also received updated information about changes for people via hand held electronic devices, communication books and whiteboards. For example, about people's appointments and prescription changes. A radio-controlled system was used for staff to communicate with one another in different areas of the home. For example, to seek additional staff for moving and handling people.

People were consulted and involved in day to day decisions about the running of the home and through monthly residents' meetings, a suggestion box, and regular surveys. A relative told us they suggested the service purchased more sun umbrellas in the summer and said, "They did what I asked." Monthly meeting minutes showed people discussed changes to the menu and ways to improve people's dining experience. A survey was underway, and responses so far, had identified the laundry service as an area for improvement. In response, keyworkers had been asked to check people's clothing and ensure all garments were clearly labelled, so clothing was returned to the correct person as soon as possible. A newsletter kept people up to date about local news and events. For example, the August newsletter included an article of local interest about a smuggler and features historic dates of importance in August.

All accidents/incidents reported were monitored to look for trends and identify further changes needed to prevent recurrent risks. For example, to check if anyone was having a lot of falls, or whether people had more accidents at times of the day, or in areas around the home, so steps could be taken to further reduce risks. Where these were identified, referrals had been made to the community falls team and their recommendations incorporated into the person's support plan. For example,
one person was using the call bell to ask staff to help them mobilise, and another person could walk around more safely and independently with their new walking frame.

The registered manager had notified the Care Quality Commission (CQC) about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider had displayed their previous inspection report in the home, and on their website in accordance with the regulations.