R&N Partners

Elmhurst Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 1 August 2016 and was unannounced. The service had previously been inspected in May 2014 when it met all the legal requirements at that time.

Elmhurst Residential Home provides accommodation and personal care for up to 20 people. At the time of our inspection, there were 19 people living at the service. The service had bedrooms on the top two floors and communal living space on the ground floor. The basement was for staff access only and contained the laundry, office and storage areas. The communal areas included two dining areas, a conservatory, TV lounge and a quiet lounge. Separate from the kitchen, there was also a kitchenette area where people could make their own drinks if they wished.

There was a registered manager at the home who had been in post for a number of years. 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.

We observed and people told us they felt safe living at the service. Staff were trained in safeguarding and understood how to keep people living at the service safe.

General risk assessments and service risk assessments were completed although some person specific risk assessments were not in place.

Medicines were not always managed in a safe manner. A clear 'as required' (PRN) policy was in place which was being followed by the service. However, there was no stock audit completed for boxed medicines and we saw some medicine counts did not correspond to the amounts that should have been in the packets. 'Time specific' medicines were not given when indicated on the medicines administration record (MAR). Handwritten MARs were not countersigned.

Accidents and incidents were clearly documented although resulting action plans such as new risk assessment forms or revised care plans needed to be more clearly evidenced on the form.

The premises was clean and generally well maintained. Staff used gloves and aprons where appropriate to help control the risk of infections.

Staffing levels were good and there was a robust recruitment procedure in place.

There was wide ranging evidence of consent requested, although the provider had not documented consent from people living at the service and staff about the use of close circuit TV (CCTV) in communal areas.

Staff had a good understanding of the Mental Capacity Act 2015 (MCA) and Deprivation of Liberties Safeguards (DoLS) and knew how to apply this in practice.

People were provided with a choice of nutritious, home cooked meals. People told us they enjoyed the food consumed at the home.

Staff training was up to date. A training matrix was in place which showed when training was due. Staff had access to key training and service specific courses and told us training was good and supported by management.

Good interactions were observed between staff and people living at the service. Staff knew people's care needs and their likes and dislikes. There was a relaxed and friendly atmosphere at the home and a positive culture among the staff.

There was good evidence of people and their involvement in the planning of their care. Care files were up to date, person centred and reflected people's care needs.

People's independence was promoted and we saw people's choices were respected, with people treated with dignity and respect.

The service had an effective complaints policy and people told us they knew how to complain.

An activities programme was in place, according to people's wishes.

People and staff told us the management team were approachable, professional and well respected. Staff told us they felt supported in their roles.

Staff and resident/relatives meeting were held regularly.

A range of quality audits were in place with analysis and improvements seen to take place where required as a result of these.

Statutory notifications were generally received by the Care Quality Commission in a timely manner.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service wasn't always safe.

Some person specific assessments had not been completed.

People told us they felt safe.

Medicines were not always safely managed.

The premises was clean and generally well maintained.

Is the service effective?

Good

The service was effective.

Staff understood the practical implications of the Mental Capacity Act 2015 (MCA) and Deprivation of Liberties Safeguards (DoLS).

The food was nutritious, home cooked and people enjoyed the meals. There was a choice provided.

Training was up to date and appropriate to the needs of the people living at the service.

Is the service caring?

Good

The service was caring.

The atmosphere at the service was relaxed and welcoming.

Staff had good knowledge about people living at the service and treated people with dignity and respect.

There was clear evidence of people being involved in their planning of care and people had signed their own care plans.

Is the service responsive?

Good

The service was responsive.

Care records reflected people's care needs and were person specific.

People's personal preferences were respected and taken into account when planning care.

A complaints policy was in place and clearly displayed in the home.

Is the service well-led?

Good

The service was well led.

People and staff we spoke with told us the management team were approachable.

Morale was good at the service and there was a low staff turnover.

Quality assurance systems were in place to monitor, analyse and improve the service provided.

Elmhurst Residential 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 inspection took place on 1 August 2016 and was unannounced. This meant no-one at the service knew we were planning to visit.

The inspection team comprised two Adult Social Care inspectors.

Prior to the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received from the home. The service had submitted a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The service had completed and returned this information in a timely manner. We also contacted commissioners from the local authority, health care professionals and the local authority adult protection team.

During our inspection, we spoke with five people living at the home, two relatives, two care staff, the cook, the assistant manager and two managers from a sister service who came to support staff during the inspection process. We observed staff providing care and support, reviewed three people's care records, three staff recruitment files, training information and other information in relation to the running of the home.

After the inspection a relative of a person living at the service sent us information using the Care Quality Commission on-line feedback form.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person living at the service told us, "I feel safe. I don't want to be anywhere else." Another person said, "We are all very safe here; the staff are very good at that." "A person's relative contacted us through the Care Quality Commission on-line questionnaire. They commented, "As a family, we visit on a regular basis and have never seen anything to cause us any concern."

Staff we spoke with told us they had received training in the safeguarding of vulnerable adults and records we looked at confirmed this. We noted staff had access to safeguarding policies to provide them with information about what should be considered as abuse and the action staff needed to take. All the staff we spoke with were able to tell us how they would respond to and report any concerns about a person who used the service. Staff told us they would also be confident to report any poor practice they observed. The service had placed information and literature about safeguarding on boards around the home. However, we saw one incident where a safeguarding concern had been raised with the local authority and the service had not notified the Care Quality Commission. We spoke with the assistant manager and were confident this was an isolated omission and safeguarding events would be reported appropriately in the future.

We reviewed records which showed us risk management policies and procedures were in place. These were designed to protect people who used the service and staff from risk including those associated with cross infection, the handling of medicines and the use of equipment. Records also confirmed all equipment used in the service was maintained and regularly serviced to help ensure the safety of people at Elmhurst Residential Home.

Standard risk assessment documentation was completed for people in relation to their identified area of risk. For example, we saw risk assessments for falls, pressure ulcer prevention and nutrition. However other non-standard personalised risks had not been identified or assessed against. For example, one person could be un-cooperative at times and had refused food and medicines in the past. Another person had no specific risk assessment completed in relation to their bed side rails.

We saw a fire risk assessment had been completed for the service and that this was reviewed on an annual basis. Risk assessments included basic information about the support individuals would need in the event of an emergency and a personal emergency evacuation plan (PEEP) had been completed for all people who used the service. We found that regular checks of fire safety equipment took place and staff had received annual fire safety training. We also noted an emergency event plan was in place to provide information for staff about the action they should take in the event of an emergency such as a failure of the gas or electricity supply to the premises.

Accidents and incidents clearly were documented. However, the accidents and injuries form did not include information about action plans as a result of these. This form was generated by the provider. We spoke with the two managers from another service within the company who were supporting the service on the day of the inspection and they agreed this was an area that could be addressed within the company as a whole. However, action plans following accidents and injuries had been documented in people's care records and

risk assessments.

We observed the person administering medicines during the morning medicines round. We saw medicines were given in a calm, professional and supportive manner and the staff member waited with the person to observe them taking their medicines. Consent was requested before entering people's rooms or administering medicines such as eye drops. Medicines were signed for after the medicines had been taken. We saw the staff member wore gloves and apron and used a liquid sanitizer in between administering each person's medicines.

The service had a medicines policy and staff we spoke with had been trained in the safe handling of medicines. However, we saw examples where medicines practice was not in accordance with this policy. For instance, medicines administration records (MARs) were mainly printed and the medicines file also contained clear information about people's medicines, side effects and interactions. However, we saw instances where MARs had been handwritten. In these instances, the National Institute for Health and Care Excellence (NICE) guidelines state the MAR should be checked and countersigned by a second member of staff. This had not taken place. We spoke with the assistant manager who said they were not aware this was a requirement. This showed us the service had not followed best practice in relation to the administration of medicines.

Some medicines are 'time specific', such as those needing to be given 30 to 60 minutes before food. We saw the MAR charts reflected this. However, we observed people received these tablets after food. We discussed this with the assistant manager who assured us this was a 'one off' mistake due to delaying of medicines because of the inspection process. However, this happened for all the 'time specific' medicines administered during the medicines round which meant we could not be certain all medicines were given at the correct time.

Medicines stock was checked and counted upon receipt from the pharmacy and this logged on the MAR. However, we saw one occasion where this had not been noted on the MAR chart which meant we were unable to audit stock amounts for that medicine. No stock balance checks were done of boxed or dossette medicines at the service. This meant any issues with stock balance were not highlighted so actions could be taken in a timely manner.

We carried out a random check of boxed medicines and found discrepancies in four people's medicines stock. For instance, we saw one person had been prescribed tablets for pain relief. Both the MAR chart and the information on the label on the medicine box stated to administer two tablets up to four times daily. However, we saw the number 'one' had been printed by the side of each time for administration of the tablets. We discussed this with the person responsible for administering medicines on the day of inspection. They told us the person had never received two tablets and this was also reflected in their care records. This meant we were unable to clarify if the person was receiving the correct dose of medicine as prescribed by the GP. We were also unable to reconcile the amount of tablets in the box with what should have been present, since there were 19 extra tablets present. Although there was a weekly medicines audit system in place this audit did not include stock control checks. An effective and robust medicines audit should have been in place to highlight any discrepancies and take appropriate actions as a result. This showed us an effective management of medicines stock control was not in place.

We spoke with the CQC medicines team who agreed an more effective audit process needed to be in place to include robust reviews of MARs and medicines stock control.

This was a breach of Regulation 12, (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The service had an 'as required' (PRN) medicines policy in place. We saw evidence this was being followed during our observation of the administration of the morning medicines.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs). We found these medicines were kept securely and recorded in line with best practice.

As part of the inspection, we looked around the premises and found it clean and well maintained. The service had a maintenance plan in place and we saw evidence replacements and decoration was an on-going process. Bathrooms had sufficient stocks of soap and hand towels and rooms had nurse call leads in accessible areas. However, we saw some toilets did not contain toilet roll holders, with the toilet roll placed on top of the toilet cistern. This would be difficult to reach for someone with poor upper body mobility. We raised our concerns with the assistant manager who agreed to take steps to remedy this. Some chairs in the lounge areas were new and others were in good condition. This showed us the service replaced items when they were no longer suitable for use.

Procedures were in place to prevent and control the spread of infection and infection control was part of the essential training programme for all staff.

We saw there were few storage areas in the home for larger equipment. One small bathroom contained two wheelchairs and two bathing chairs. The assistant manager told us these were removed when the bathroom was in use and the equipment was placed on the landing. However, we were concerned this would constitute a falls hazard for people with poor mobility and the service should explore alternative storage arrangements.

We reviewed staffing levels and saw there were enough staff deployed for safe care and support of people at the service. The assistant manager told us the service deployed extra staff over holiday periods to cover for staff absences. The service did not employ agency staff and the assistant manager explained why, saying, "There's no continuity with the clients." A relative of a person living at the service contacted us via the Care Quality Commission on-line feedback form and commented, "Whenever we visit, we see the same members of staff and have never seen any temporary agency workers, which suggests that the staff think that this is a good place to work."

Effective recruitment procedures were in place to ensure staff were suitable for the role and safe to work with vulnerable people. This included obtaining two positive written references before staff commenced work as well as a Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults by checking their criminal background for any cautions or convictions. We reviewed three staff files and saw correct procedures had been followed in all cases. Induction for new staff lasted six months and all new staff received a staff handbook when they joined the service. There was a stable staff team working at the service and turnover was low. A staff member told us, "I like how all the carers are vetted and proper protocol is followed with interviews."

Good

Is the service effective?

Our findings

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. There was one person who had a DoLS authorisation in place. However the documentation for this person had not been received at the time of the inspection. Authorisation had been sought from the local authority and the support plans clearly showed that the assessments and decisions had been made properly, and plans were in place to support people in the least restrictive way. Referral documentation was also not available at the time of our inspection. However we saw communication with the DoLS team via e-mail. People's care records contained a 'DoLS' section which indicated if a referral had been made and what stage it was at.

All staff had received MCA/DoLS training. They understood and had a good working knowledge of the key requirements of the MCA, putting these into practice effectively to ensure people's human and legal rights were respected.

Throughout our visit we saw staff checking with people if they were happy to receive support and interventions before these were carried out. Staff told us they supported people to make decisions by giving them time to understand the situation. One staff member told us some people they supported could be over whelmed by choice and so they would offer two or three options for people to choose from. Other documentation used to seek consent from people or their families was present. For example, we saw consent forms signed for the use of documentation and one person signed a form that they wanted their hospital treatments to be restricted in line with their faith.

During our tour of the service, we noted the ground floor contained five CCTV cameras in communal areas. The assistant manager told us staff and people living at the service had been consulted about the installation prior to the work being done and people had consented to the cameras being fitted. CCTV was not in use in private areas. This was confirmed by the provider who contacted us after the inspection and told us informal meetings had been held with staff, people living at the service and their relatives and consent was sought. Information on the use of CCTV was displayed in the entrance to the home. We could find no documented evidence of these meetings in people's care files on the day of inspection. However, the provider sent us a copy of the CCTV policy developed to cover the use and management of the images that would be recorded as well as the service data protection policy. They agreed to disable the CCTV until

written permission had been granted by staff and people living at the service. Given the high level of consent sought in other areas, we concluded we were satisfied appropriate steps were being taken to gain people's formal consent.

We saw people had access to a range of health and social care professionals including district nurses, GPs, chiropodists and social workers and their health care needs were being met.

People who lived at the service told us they enjoyed the food provided and consumed a good and varied diet. One person told us, "The food's very good. I've no complaints about it." Some people received nutritional supplements and dietician referrals had been made where appropriate.

We saw a choice of food was offered with home cooked meals, using fresh produce where possible. The service had a rolling four week menu and we observed the cook checking with people about their enjoyment of the food and asking what they wanted to eat. We heard one person telling them, "The porridge is lovely." Another person responded when asked about the food, "It's lovely."

We spoke with the cook who told us they would cook alternative meals for people if they didn't want to eat what was on the menu. They were aware of people's special diets and what different people liked and disliked. We saw they baked sweet tarts, flans or cakes daily and used full fat products to fortify foods.

The menu was displayed on a notice board in the dining room and updated daily. Tables were laid with cloths, napkins and 'butterfly' table decorations which indicated where people would normally sit. Drinks were offered to people regularly throughout the day.

The notice board in the dining room also displayed the names of the people on duty each day.

The service had a training matrix in place which highlighted when up-date training was completed, required or overdue. This enabled the service to book staff on courses appropriately. We saw evidence in staff files of up to date training in key subjects such as moving and handling, fire safety, infection control, first aid, dementia awareness and the Care Certificate. The Care Certificate is a nationally recognised standard of induction training for new care staff. Staff we spoke with told us they were happy with the amount of training received and were encouraged to book further training of interest to them. Training was provided either face to face or via training booklets from an outside company, which were then sent away to be independently marked. The area manager had been certified as a moving and handling 'train the trainer' which meant this training was available 'in-house'.

Good

Is the service caring?

Our findings

We observed staff treated people with kindness and compassion and witnessed many caring interactions between staff and people. For instance, we heard a staff member gently reassuring a person when they were supporting them using the chair lift, saying, "You're all right, darling. I'm going to put the seat belt on. Is that ok?"

People we spoke with told us they were happy living at the home and were treated with dignity and respect. People's comments included, "They're (staff) lovely. I like it here. I don't want to be anywhere else," "I haven't got a bad thing to say about them," "Can't fault them, we have a great relationship together," "They're always very nice to everyone and they will take their time. They always have a smile on their face," and, "They always knock on my door before they come in."

Staff were able to give us examples of how they treated people with respect and dignity including knocking on people's doors, respecting their decisions and quietly asking people if they required the toilet. We observed the person administering medicines on the day of the inspection discretely asking people if they required laxatives and taking someone to their room to administer prescribed ointments.

We read in the minutes of a recent resident's meeting how a person living at the service had commented about it being a nice gesture everyone receiving a rose on Valentine's Day and dinner was made special. A staff member told us about how they felt rewarded in their role and said, "Just a smile is enough."

A relative of a person living at the service contacted us via the Care Quality Commission on-line feedback form and commented, "The care and compassion [relative's name] has received has been fantastic," and, "The staff are always friendly and show genuine interest in the people and their care."

We saw framed photos of people living at the service throughout the communal areas, including photographic poster displays of events, such as someone's recent special birthday celebrations. We saw the service had a pictorial display of the 'Elmhust Family Tree', which included photographs of people living at the service and the staff who supported them. This confirmed what people and staff told us about the service being a 'family home'.

A number of staff had relatives living at the home which showed us they recommended the service as a good and caring place to live.

We saw staff went 'the extra mile' to support people living at the home, such as assisting someone to attend a relative's christening at a local church.

Staff had good knowledge of people living at the service. For instance, we observed a member of staff chatting with a person living at the service and asking them about their relative who had been in hospital. Staff were able to tell us about people and their likes, dislikes and care needs.

We saw people who lived at the service had signed their care plans. This showed us evidence people had been involved in planning their care.

We saw independence was promoted by encouraging people to do as much as possible for themselves. Care documentation reminded staff to encourage people to do things for themselves where possible. For example, during personal care, it was noted to ask people to wash as much of themselves as they could. Staff told us it was important to remain patient sometimes because people could do things for themselves but they may take slightly longer to do it. On the day of inspection we saw staff encouraged one person to eat a little more themselves.

We saw there were no restrictions on visiting at the service. Visitors were made to feel welcome and greeted warmly when they arrived. A staff member commented this was something they felt the home did well, "Knowing visitors are happy with the welcome."

Good

Is the service responsive?

Our findings

We saw pre-admission assessments were completed to assess people's care needs and ensure the service was appropriate to fulfil these needs.

We found care records included complete information about people's needs, wishes and preferences and the level of support they required from staff. Care records contained specific information important to each individual and staff were able to tell us how people liked their support which was in line with their care records. All the care records we looked at had been reviewed and, where necessary, updated on a monthly basis. Where people had a change in needs, this had been changed in their care records. Staff told us changes in people's needs would be recorded in their care records but they would also know through handover meetings between shifts. This ensured staff had access to accurate information about people's needs.

All the people we spoke with who used the service told us they always received the support they needed, but that staff would allow them to do things for themselves should they wish to do so. Comments people made to us included, "I prefer showers and they (staff) help me with that," "Staff have to do more and more for me but they are very good," and one relative told us, "We helped create [person's name] care plan and as we have great communication, if anything changes we always speak with staff."

We observed people's personal preferences were taken into account when providing care and support. For instance, we saw the person administering medicines on the day of inspection asking a person, "Do you want your tablets first or your inhaler?"

We saw the service had a complaints policy in place and this was displayed prominently in the home. We saw there was a complaints/suggestions book kept in a container at in the entrance hall, although this had no entries. One person told us, "I've nothing to complain about. I'd speak to staff if I wasn't happy."

The service did not employ an activities organiser and staff were responsible for organising activities within the service. However, we saw people living at the service were involved with choosing and planning activities and were consulted about events at the resident's meetings. For instance, we saw someone had suggested holding an afternoon tea to mark 'Armed Forces Day' and this was discussed and plans made. We saw an activities board was displayed in the hallway of the service and included hairdressers, foot spa/massage, pampering afternoon, board games, baking, sing-a-long, chair aerobics, quizzes and bingo. Staff told us it was people's choice if they took part in activities and they often altered planned activities to suit people's choices. However, one person had recently commented in a survey, "I'd like to go to the pub." The assistant manager told us they tried to organise outings such as this and people often decided they didn't want to go.

On the day of the inspection, we saw the hairdresser visited in the morning and some people and staff taking part in board games during the afternoon. However, one person we spoke with told us there wasn't much going on. A relative of a person living at the service contacted us via the Care Quality Commission on-line feedback form and commented, "I regularly take [person's name] out for lunch, this is not discouraged at

all."

Good

Is the service well-led?

Our findings

Staff and people we spoke with praised the way the service was managed and felt they could approach the management team with any concerns. One staff member told us, "I feel they (the management team) go the extra mile. They're trying to improve the home and increase independence. It's not institutionalised."

Staff told us they felt supported in their roles and teamwork was good at the service. One staff member told us, "[Registered manager's] been there for me. [Registered manager] has supported me. I am very happy here. We work as a team."

On the day of our inspection, the registered manager was not on duty due to annual leave and we found the assistant manager to be calm and professional in the way they carried out their duties. We spoke with them about their role and they told us they were passionate about holistic care, communication and dignity. This was apparent through our observations. We observed staff respected the assistant manager and there was good communication between them and the rest of the staff team.

We saw there was a positive culture in the home and staff morale was good. This was evidenced by low staff turnover and a stable staff team.

There were a number of quality assurance systems in place at Elmhurst Residential Home. These included regular audits completed by the registered manager in relation to the environment, health and safety, medication and care records. We saw that where necessary, action plans were in place to ensure any identified shortfalls were rectified. The registered manager demonstrated a commitment to on-going service improvement and evidenced this through action being taken.

We saw the service had recently received a quality assurance visit from the local authority and the registered manager was taking actions to address any concerns highlighted.

We saw evidence of residents/relatives meetings which were an opportunity for people to discuss any concerns or issues about the service, discuss and organise social events, and inform people about any updates. People were actively involved in these meetings, although we saw some had not taken place due to people and their relatives not turning up. This had been investigated and relatives had commented they didn't feel the need for a meeting since the management team were available when they were visiting. This showed us the management team had high visibility within the home.

We saw regular satisfaction surveys were sent to people living at the service and their relatives. Responses to these were positive and included comments such as, "My [relative] is the happiest [relative's name] has been for years. [Relative's name] loves it in the house," "Feel happy at Elmhurst," "There is nothing I don't like about this house," and, "I feel I am being looked after." However, one person commented, "I would like to go to the pub."

Records we looked at showed regular staff meetings had taken place. We noted staff were able to raise any

issues of concern, request additional training and put forward suggestions as to how the service could be improved. We saw the registered manager also used these meetings as a forum to reiterate their expectation that all staff would provide the highest quality of care.

Generally, appropriate statutory notifications had been received by the Care Quality Commission in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always recorded, administered or managed in a safe manner Regulation 12 (1) (2) (g) The proper and safe management of medicines. Health and Social Care Act 2008 (Regulated Activities) Regulations 2004