Mrs Bernadette Tisdall

Elmhurst Residential 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

This inspection took place on the 24 October 2016 and was unannounced.

The service is a residential home that offers care without nursing to a maximum of 30 older people living with dementia. At the time of our inspection there were 26 people living in the service.

There was 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.

Prior to this inspection the service was last inspected on 14 December 2015 and was found to require improvement with four breaches of the regulations. At the previous inspection we found the Safe domain was inadequate with an unsafe environment, a lack of reviews of people's risk assessments and unsafe recruitment processes. There was a limited variety of activities for people and care plans did not contain all the necessary information. The governance of the service required improvement as records were not kept up to date and the concerns had not been identified by the management team during auditing.

During this inspection we found there had been an improvement and most areas of concern had been addressed by the service who had worked in partnership with the local authority to improve the quality of care.

The service had adequate staffing to meet the support needs of people living at the service and staff had received training and supervision sessions to support them in their role. The service had systems in place for the safe recruitment of staff but had not renewed some disclosure and barring service checks for many years in line with good practice.

People told us they felt safe at the service. Staff had received training in safeguarding adults and knew how to report abuse. However the senior staff were unaware of their responsibility to report grade three and four pressure ulcers as a safeguarding adult concern to the appropriate authorities. Senior staff explained they had believed this to be the responsibility of the district nurses only. Following our visit the senior staff reported pressure ulcers appropriately.

The environment was much improved, the garden area was well maintained and had been fenced to stop access to the stream. Previously stored items that were a fire hazard had been removed or stored in a safe manner. The interior of the service was now well maintained and repairs had been completed.

There were now risk assessments to keep people safe from harm and these had been reviewed to reflect any changes in circumstances.

There were robust systems in place for the safe administration and storage of medicines and staff were knowledgeable about people's health support needs and knew what the medicines prescribed for people were for.

The staff supported people's rights under the Mental Capacity Act 2005 by asking their permission before supporting them. Mental capacity assessments and best interest decisions were recorded and when appropriate the service had made Deprivation of Liberty Safeguards applications to the statutory body.

People were supported to eat well and remain hydrated and were supported with their dietary requirements.

Staff were caring and respectful to people and there was now a variety of activities to entertain and engage people throughout the day.

People's care plans were person centred and contained relevant information to tell staff how people wished to be supported. Care plans and associated documents were updated on a regular basis. Records including daily notes were complete and did not contain gaps.

The service had systems of auditing in place to check the quality of the support provided and relatives were asked to feedback their views at care plan review meetings and in yearly surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.Staff were not aware that pressure ulcers should be reported as a safeguarding adults concern. Staff could tell us signs and symptoms of other types of abuse.

There were enough staff to offer appropriate care and support to people living in the service. There were recruitment process to ensure staff suitability to work with vulnerable people but disclosure and barring checks had not been renewed in line with good practice.

The service had risk assessed the environment and put in place measures when necessary to keep people safe from harm.

The service had systems in place for the safe administration of medicines and supported people to take their medicines in an appropriate manner.

There were systems in place to ensure good infection control.

Is the service effective?

Good

The service was effective. Staff received training and supervision to support them in their role and were knowledgeable about people's needs.

The registered manager and senior staff understood their responsibilities under the Mental Capacity Act 2005 and made Deprivation of Liberty Safeguards appropriately.

Staff supported people were supported to access appropriate health care services.

Staff supported people to eat well and remain hydrated throughout the day.

Is the service caring?

Good

The service was caring. Staff were kind and respectful towards people.

People were treated with dignity and respect.

People and their relatives were involved in their care planning.

People had their end of life wishes recorded.

Is the service responsive?

Good

The service was responsive.

There was a choice of activities for people to enjoy.

People had person centred care plans that were reviewed on a regular basis.

People and relatives knew how to complain and concerns were addressed in a timely manner.

Is the service well-led?

Good

The service was well-led. There was an experienced registered manager who was well supported by the senior staff team.

Staff were encouraged to speak up and were supported by the senior staff.

The service had systems to audit and ensure the quality of the service given.

The service worked in partnership with health and social care professionals and commissioning bodies.

Elmhurst Residential 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 the 24 October 2016 and was unannounced.

The membership of the inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We spoke with the commissioning body prior to our visit for feedback on their visits to the service.

During our visit we spoke with four people using the service and spoke with spoke with four people's relatives. We interviewed two care staff, spoke with the senior staff throughout the visit, and met the registered manager. We spoke with a visiting health and social care professional. We also observed staff interaction with people throughout the day.

We looked at four people's care records this included reviewing risk assessments, daily records and turning charts. We observed eight people's medicine's administration and reviewed their medicine administration records. We checked storage of medicines and controlled drugs. We reviewed seven staff personnel records.

Following the visit we spoke with two relatives and the commissioning body again.

Requires Improvement

Is the service safe?

Our findings

One person told us "It's the best home I've ever been in." Another person said "I'm comfortable here, I am safe."

We checked staff recruitment procedure and found some improvements could still be made to ensure that staff were safe to work with vulnerable people. All staff had Disclosure and Barring Service (DBS) checks although two were undertaken in 2006 and 2008. Good practice would be to renew DBS checks every three years to ensure no criminal convictions or concerns had taken place in the intervening years. In addition two staff had no references in their personnel file. This meant the service could not confirm the staff's previous work conduct with their former employers. We brought this to the attention of the team leader and registered manager who did not know why the references were not available in the staff's files but sent us copies immediately after our visit. We discussed with the registered manager the need for a recruitment check list to avoid documents being misplaced in future and to ensure every check had taken place. The registered manager agreed that this would be done and DBS checks would be renewed. This reassured us that the correct practices had taken place.

All staff we spoke with said there was always enough staff and they did not feel rushed, describing they had time to do activities with people and take their breaks. There was adequate staffing on the day of inspection. There were seven care staff on duty and two senior staff acting as team leaders. This was in line with the rota and the usual level of staffing. There were three waking night staff each night. The deputy manager who was on annual leave during our visit took responsibility with the senior staff for the day to day running of the service.

We met with the registered manager who had an oversight of the service and demonstrated they were knowledgeable about people and staff. The senior staff told us the service was very occasionally short staffed explaining rather than use agency staff they used existing staff to work additional hours and cover when someone was absent. They did not use agency staff as they felt it was better for the people using the service to have the continuity of staff they were familiar with. In addition to the care staff there was a cleaning staff member who also supported people at lunch times to eat and supported staff with activities. There was also a laundry staff member and a maintenance manager on duty to support the service provided to people.

There was a safeguarding adult policy and procedure available to staff. Staff had received safeguarding adult training and were able to tell us the signs and symptoms of abuse. "You can tell if something is wrong by people's mood, gestures and eye contact," adding "we must always report abuse." Staff knew to tell senior staff or the deputy manager of any concerns they had. However we found that senior staff did not know it was their responsibility to report grade three and grade four pressure ulcers to the appropriate authorities. This meant they left the responsibility solely to the district nurses. We brought this to the registered manager's attention and following the inspection the service reported pressure ulcers appropriately to the local authority and the CQC.

During our last inspection there were concerns about the storage of equipment as a possible fire hazard and there was a lack of risk assessment and measures to ensure the safety of people living in the service. We found that the service had taken appropriate measures to ensure equipment was now stored in a safe manner and entrances were clear of items. Measures had been taken to make the environment safer for people. For example a fence had been erected to prevent access to a stream at the end of the garden.

The service had appropriate risk assessments for people living at the service. There was for example a fire risk assessment and each person had a personal evacuation plan that indicated the level of risk and the staff support they required in the event of a fire. To ensure the plans were realistic there were fire drills to check measures were effective. We noted there had been continuous weekly fire alarm testing from our last inspection until three weeks prior to our inspection when there was a gap. We found it was because the person who usually oversaw this was absent. We brought this to the attention of the team leader who undertook to ensure fire alarm testing always took place when the regular staff member was absent. Other safety checks had taken place including gas in March 2016, a five year electric installation test in 2014, portable electric appliances in July 2016 and fire alarms in April 2016.

In people's care records we saw there were risk assessments to maintain people's safety. These included for example people's use of bed rails, mobility and falling. The risk assessments flagged high risks and detailed measures to be taken to minimise risks to the person. One person's care records lacked their risk assessments although we could see the plastic envelopes in the person's file where they would have been placed. We raised this with the team leader and registered manager who thought it was probable they had been removed in error by recent visiting health and social care professionals when they photo copied the person's records for their assessments. The service sent us copies following our visit and we accepted them as evidence risk assessments were in place and had been removed in error.

We saw that the service now had a risk assessment matrix to ensure risk assessments were reviewed on a regular basis and staff understood risk assessments and importance of reviewing them. We saw an example of a person who could no longer weight bear whose risk assessment was updated to reflect this.

The service had robust systems to ensure the safe administration of medicines. We observed medicine administration was undertaken appropriately. All medicine administration records were completed without errors or gaps and stated relevant information such as allergies to certain medicines. All medicines including controlled drugs were kept securely at an appropriate temperature. The controlled drugs book was signed by two staff when drugs were administered as the procedure stated and all drugs counted tallied with the amounts recorded in the controlled drugs log.

All staff had received infection control training to ensure they understood the importance of infection control. Washrooms and toilets contained soap and paper towels and there were posters to remind people and staff to wash their hands correctly to avoid cross infection. Staff wore protective equipment such as gloves and aprons when supporting people. The cleaning staff member could describe how they maintained a good level of hygiene, mops were now stored appropriately, and colour coded to avoid cross infection.

After lunch time the floor was cleaned of any crumbs that might have been spilt. The service had procedures in place in to ensure all equipment such as the hoists were cleaned every week to maintain a good level of hygiene. The kitchen had received a food hygiene rating of five stars in May 2016 indicating a high standard of practice by the kitchen staff.

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. We found that Elmhurst Residential Home as the managing authority had applied for DoLS from the statutory body appropriately, having taken into account the mental capacity of people at the service to consent to their care and treatment. DoLS applications had been followed up when there had been a slow response and staff had reapplied for DoLS applications when a review was due.

Staff had received MCA and DoLS training. There was evidence that mental capacity assessments and best interest meetings had enabled decisions to be taken on behalf of people who lacked capacity. Staff told us why it was important to work to the MCA and were
aware of restrictions made through DoLS to people's liberty. Staff explained they gave people choice and asked their permission before acting. Staff said for example "All adults are considered to have capacity, even if they have dementia." and "You must always give people options and ask them what they want" and "We must ask people's permission [before providing care]." As such we found the service was working under the principles of the MCA.

During our last inspection visit we found supervision sessions were not taking place on a regular basis however we found this had been addressed. Staff were being supported to undertake their role with regular supervision sessions and appropriate training. Both records and staff confirmed regular supervision sessions and on site observations in areas such as the use of hoists and pressure ulcer management. Staff confirmed they found the supervision sessions and observation supportive and helpful to carry out their work.

Records showed that new members of staff completed a week's class room training and two weeks shadowing experienced staff. Staff confirmed this had taken place. Induction covered relevant topics such as first aid, safeguarding, moving and handling, MCA, infection control, medicines and record keeping. There was additional training offered to staff this included management of falls, end of life care, continence and strokes. Staff told us that all the training was classroom based and said "The training is really good here."

Staff were knowledgeable about the people's medical needs and told us what support was required to keep people well. People's care records contained a description of relevant medical history highlighting current conditions such as dementia and diabetes. We saw that people had been supported to access appropriate health and social care services such as the GP, district nurses, chiropodists and dentists. District nurses

provided people's wound care and staff had received training in pressure ulcer management. There were wound assessment charts available for staff reference. People had Waterlow assessments to maintain their skin integrity. Measures taken to minimise the risk of pressure ulcers included pressure relief equipment and repositioning at specified intervals such as two hourly. The staff kept repositioning records to record how people were last positioned and at what time. People were monitored for pain and care records contained a pain chart that people could use to show how great their pain was. We saw examples recorded of people who may not be able to clearly express they are in pain being given pain relief when they were showing agitation or restlessness as this might be an indication of some discomfort..

Staff had received training in dementia and supported people who had mental health conditions. People were supported to access the community mental health team and psychiatric consultants. Behavioural chart records were kept when people were unsettled to give accurate information to the psychiatrist about frequency and duration of unsettled behaviour.

The people all told us that they enjoyed the food and there was always plenty of choice. One person said "I eat everything; I have to try and cut down on breakfast as I was getting fat, but I definitely will never go hungry." There was a daily menu displayed in writing and in pictures to support people with a cognitive impairment to understand what was for breakfast, lunch and supper. People were weighed on a regular basis and weight monitored for gradual or sudden change. People's care records contained a Malnutrition Universal Screening Tool assessment (MUST). The MUST assessment showed if people were at risk of malnutrition or obesity and the service took appropriate action if a person's MUST assessment showed they required a referral from the GP for a dietitian. We saw that people who required them had dietitian reviews and were supported for example to eat a fortified diet by staff. We observed staff supporting people to eat a pureed diet and have thickened drinks as highlighted in red on their care record.

There was a lift so people had access to all areas. Staff told us they "always supported people when they wished to use the stairs." There was a large lounge and an adjacent smaller dining area. There was an attractive and well-kept garden that people were supported to access in the warmer months.

Good

Is the service caring?

Our findings

One relative told us "I am very happy, the staff are delightful and doing a fabulous job with Dad. They are like angels in this home. This is a home! A big family that welcomes you no matter when with a big pot of tea. We can visit anytime we want really. Even the children can come and see grandad."

We observed staff were friendly and attentive to people, for example, one staff member spoke with a person who was becoming upset. The staff member spoke in a kind friendly manner and reassured the person. When we checked ten minutes later we found the staff member was playing a board game with the person who was smiling and enjoyed the activity and company of the staff member.

Staff told us "I treat people like my own family" we saw staff were respectful of people who were living with dementia when one person asked "how much is lunch" the staff member replied "It is free for everyone" treating the question as a valid enquiry and was not dismissive to an often repeated question. We observed staff had conversations with people throughout the day and asked about people's family members and showed a genuine interest in people's replies.

The service was described as "homely" by people and people had been encouraged to bring their furniture from their home. This gave a pleasant relaxed atmosphere to the environment with objects in a style that would have been familiar to older people. The registered manager explained "we have older people and we want them to feel they are in the right era".

A number of people shared a bedroom and the team leader explained people are asked if they are willing to share a room. If they and their relatives are in agreement with this it goes ahead if not the person is offered a single room if one is available. Some people with high support needs shared ground floor bedrooms so they were close to the lounge area for all staff to monitor. People and relatives we spoke with said they were happy with the sharing arrangements. Staff told us how they maintained people's privacy and dignity by knocking on doors before going into people's rooms and described how they used screens to maintain people's privacy in the shared rooms. There were screens available for use in the rooms.

People were supported with their diverse needs. For example one person was Portuguese speaking and as the service did not have staff who spoke this language well, had arranged a Portuguese speaking person to visit twice a week to talk with the person in Portuguese. This meant the person had a befriender who spoke their language and also was able to raise any concerns clearly to the management team. We saw also that some people had returned to the language of their country of origin. Many of the staff spoke several languages, so for example, one person was encouraged to take their medicines in Arabic as they responded well to this. Also the chef came into the lounge on occasions to talk to a person in their shared language.

People's religious diverse needs were met; care plans identified people's religious and cultural needs. Some people were supported to attend a local church service. Other people were supported by a Church of England vicar who visited and a Catholic priest who gave communion. People's family members were welcome to attend also. Staff were aware of people's cultural requirements providing halal meat for one

person and for another the care plan stated "normal diet prefers Indian foods" . The chef was able to tell us how this was provided. Staff supported people's life style preferences for example one person was vegetarian and we saw the chef had prepared a vegetarian meal specifically for them at lunch time .

All families told us they were involved in care planning and were invited to meetings. Although one family member felt that it had been a while since the last meeting and they could be more frequent as the needs of their relative had changed since entering the service. We saw that relatives had signed care plans and that the service had in some instances contacted families to keep them updated and ask their views.

People were supported with their end of life wishes. We saw some care plans that contained Do Not Attempt Resuscitation Forms for a life threatening emergency. These were clearly displayed in the care records. DNAR contained people's and family wishes such as "to remain in the home." Some people did not have DNAR but had instructions to contact specific family members in the event of an emergency.

Good

Is the service responsive?

Our findings

Care plans reviewed were person centred and gave a clear picture of the person and their support needs, detailing for example how they were to be supported with personal care and the number of staff required to assist. Care plans contained specific instructions centred on the person's choice for example one care plan stated "[X] likes to choose clothes with the support from one staff. [X] likes to dress smartly …. loves pink clothes …it makes me look beautiful." We saw people being supported to remain as independent as possible. For example one person was supported to walk independently using a walking frame as their care plan stated, but two staff remained very attentive and got a chair for them rest for a while before they continued to walk again. All care plans seen were reviewed and updated regularly.

When we last visited the service there was a limited variety of activities to engage and stimulate people living at the service. Relatives told us there was a "big change" since our last inspection and now activities were taking place. We saw people undertaking individual activities including board games, listening to music chosen for the occasion, and group activities such as drawing throughout our visit. There was a programme of varied activities including reminiscence. Staff supported people to sit with a view of the television if they liked watching programmes and supported some people to move to other areas of the lounge for games and conversation. We were told by one person that they felt uncomfortable sitting in the larger group in the lounge and so they sat in a quieter area and this was suggested to them by the staff. They explained they are much happier now. Activities were recorded on a matrix to show when people had participated.

Records showed people who remained in their bedrooms and could not always use their bell due to their cognitive impairment, were monitored and checked by staff on a regular basis. Staff also visited to reposition people, support them to eat and remain hydrated and to offer personal care. Staff described they did get people out of bed to sit in a chair if this was appropriate but sometimes medical needs prevented this. Staff said they chatted to people and kept them company. We saw from records people who stayed in bed had twice weekly 1:1 planned activities such as hand massages. However one relative told us they felt their relative in bed did not have enough activities. "There is no button to press if they need help and the door is closed." We discussed this with the deputy manager who told us staff do check frequently and we have the radio on for people to listen to. However agreed to explore further with people and their family members what other measures and activities could be implemented.

One relative told us "The staff are all the same, never strange faces; everything is dealt with in house. Any member of staff can be approached. Everything is dealt with immediately and they don't take it as a criticism. Open door in every aspect." Although most people and relatives felt staff were approachable one relative told us that they found not all the management team were approachable and did not feel listened to. We brought this to the attention of the deputy manager. The service had systems in place to manage concerns and complaints there was a complaints policy and procedure displayed in the main entrance to tell people how to complain. There were no recent complaints recorded. The registered manager explained they aimed to address any concerns immediately before they became complaints. We discussed the need to

log all complaints written and verbal so service trends could be analysed by the registered manager. The registered manager confirmed they would do this when complaints were made.

Good

Is the service well-led?

Our findings

One relative told us "He is still our Dad; they haven't taken over his life. They are outstanding here, that really is all there is to it." There was a registered manager at the service who was supported by a deputy manager and two team leaders. All people and relatives we spoke with knew the registered manager and the senior staff.

All staff spoke highly of the management team and told us "I have stayed here because I am happy, we are a great team." and "It is very well managed" and "They are not just the bosses, they are our leaders." Staff described they felt able to approach the managers and speak up when they wanted to. Information was shared in daily handover meetings to the oncoming staff shift and staff referred to the daily notes, diary and communication book. The team leader confirmed that they met with the registered manager frequently in the deputy managers absence for support and to relay information.

Staff told us that the deputy manager and the team leaders were "hands on" and often worked alongside them. Staff and records confirmed there were regular observations in areas like use of hoists and pressure ulcer management. In addition the team leaders worked from the lounge to observe staff practice throughout the day. Staff confirmed team leaders would correct them if they were approaching a task incorrectly.

We found that documents were better organised than during our previous visit and there were for example training and risk assessment matrix in place to provide an oversight when before there was none. As such there was an effective quality assurance system in place. We saw there was regular auditing of medicines, care plans and associated documents and the service had put in systems to ensure reviews of documents including risk assessments were not overlooked. There were now systems to track supervision and training requirements.

People were asked their view of the service in their reviews and relatives were asked for feedback when they were visiting and in review meetings. We were shown an annual survey where people, relatives and professionals were asked their views of the service provided. The service produced a report in July 2016 that showed clearly how many responded and what their views were. The report detailed what would be implemented to assure a high quality service. For example most relatives were aware of the complaints procedures two relatives said they were not. The service documented actions of information given to the relatives "via family meeting and bulletin board memos." We saw the bulletin board contained the complaints procedure and relatives spoken with knew how to complain.

We met a health and social care professional who confirmed the service worked well with them and kept them informed and made referrals when appropriate, they described the service "as very good". The service attended provider forums and worked in partnership with the commissioning body to improve the service offered to people and had for example participated in shared training events.