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Elderholme Nursing Home

Inspection report

Clatterbridge Road
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Date of inspection visit: 17 June 2015
Date of publication: 22/07/2015

Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 and 13 February 2015. At this inspection a breach of legal requirements was found. This was because the provider had failed to protect people from the risks of inappropriate or unsafe care; had failed to ensure people's consent was legally obtained in relation to the care they received and had failed to ensure that adequate quality monitoring systems were in place to ensure the service was well led.

We issued the provider with a warning notice in relation to their breach of people's legal right to consent to their care and treatment. A warning notice is an enforcement action used by the Care Quality Commission to direct a provider to improve their service to meet requirements of a specific regulation within a set time period. We gave the provider until the 11 May 2015 to meet their legal requirements in relation to consent.

We requested an action plan from the provider in respect of the other breaches found during our inspection. After the comprehensive inspection, the provider submitted an action plan outlining the improvements they intended to make to meet the legal requirements in relation to safe care and treatment and quality monitoring.

We undertook a focused inspection on the 17 June 2015 to check that they had met the requirements of the warning notice and their action plan in order to meet, the legal requirements in relation to the breaches described above. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for ' Elderholme Nursing Home' on our website at www.cqc.org.uk'

Elderholme Nursing Home provides accommodation with both personal and nursing care for up to 61 people. The

Summary of findings

home is single storey and set within the grounds of Clatterbridge Hospital. All 61 bedrooms are single occupancy. There are three communal lounges/dining rooms and a pleasant garden with seating area for people to access.

The home also offers an intermediary care service. This means that the home offers support to people discharged from hospital who require a period of rehabilitation before they are ready to return home independently. There are 14 beds reserved for this purpose.

The home had a registered manager in place who, was in attendance during our inspection. 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 and associated Regulations about how the service is run.

Summary of findings

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 generally safe but required improvement in relation to risk management planning.

Care plans and risk assessment identified people's risks but some risk management plans were generic and did not relate to people's individual needs or care.

Adequate emergency evacuation plans were in place and an accessible emergency call bell system was in use by people who lived at the home.

Is the service effective?

Requires improvement

The service was generally effective but the way in which the provider assessed people' capacity to make certain decisions required further development.

The care files looked at were informative, well maintained and contained more person centred information about the people who lived in the home.

Is the service well-led?

The service was generally well led

Improvements were required in staff attitudes and the culture of the home and the way in which the service identified, assessed and managed risks to people's health, welfare and safety.

Quality monitoring systems were in place to enable the provider to come to an informed view of the standard and quality of care.

Elderholme Nursing 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.'

We undertook a focused inspection of Elderholme Nursing Home on 17 June 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 11 and 13 February 2015 had been made. We inspected the service against three of the five questions we ask about services: is the service safe; is the service effective and is the service well led. This is because the service was not meeting legal requirements in relation to these questions at our last inspection in February 2015.

The inspection was undertaken by an Adult Social Care (ASC) Inspection Manager and an ASC Inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

During our visit to the home we spoke with seven people who lived there, the manager and the lead nurse. We looked at eight people's care records, emergency evacuation plans and records relating to the quality monitoring systems implemented by the provider.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Elderholme Nursing Home on 11 and 13 February 2015 we found that the home was not protecting people sufficiently from the risk of receiving inappropriate or unsafe care and had not ensured that adequate emergency evacuation provisions were in place to protect people from risk during an emergency situation. These incidences were a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on the 17 June 2015 we found that the provider had taken appropriate action to meet the majority of the shortfalls in relation to the requirements of Regulation 9 described above. We found however that they still required further improvement in order to provide people with individualised care.

We reviewed eight people's care records. We found that risks in relation to some aspects of people's care were not identified or managed adequately. We saw that risks in relation people's care were not always individualised and that risk management actions were sometimes generic. This meant that each person's individual risks had not been fully identified so that specific preventative action could be taken. For example, bed rail risk assessments, outlined the general risks associated with the use of bed rails but did not assess or manage the specific risks relating to each person individual needs, wishes or care.

We also found evidence that risk management actions were not always followed in accordance with the person's risk management plan. For example, two people whose care we reviewed were at risk of developing pressure ulcers. Their risk assessment specified that these risks were to be managed by two to three hourly re-positioning checks. When we asked for the manager and lead nurse for evidence these re-positioning checks had been undertaken, we were told no records were kept. This meant there was no evidence these checks had been undertaken. When asked, the lead nurse and manager were unable to explain how these checks were undertaken, by whom and when.

We did a tour of the building and reviewed people's access to the emergency call bell system. We checked a random but significant sample of bedrooms and saw that every bedroom we checked had an accessible call bell system in place to enable people to call for staff assistance. We saw that there was a generic call bell risk assessment in place for people who may have difficulty using the call bell system. This generic risk assessments failed to identify and manage the specific risks posed to that individual person by the lack of an accessible call bell.

We found that some improvements in relation to the planning and management of people's emotional care had been made. Where people displayed challenging behaviours, care plans now included some information on how to support the person when they became upset or agitated so that this behaviour was either prevented or minimised. A pictoral system was also in place to assist people with communication difficulties. A pictoral system is a set of pictures that are designed to convey a certain meaning or feeling for example, " I am hungry" or " I am sad". They enable people with verbal communication difficulties to communicate their needs, wishes or feelings to staff.

We reviewed the provider's emergency evacuation plans and saw that adequate arrangements were now in place. Each person had a personal evacuation plan and there were clear guidelines on what action staff needed to take in the event of an emergency situation.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Elderholme Nursing Home on 11 and 13 February 2015 we found that staff did not have a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation in order to ensure people's consent to care and treatment was legally obtained. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served the provider with a warning notice in relation to this breach and set a specific deadline of the 18 May 2015 by which the provider had to meet their legal requirements. At our focused inspection on 17 June 2015 we found that the provider had met the legal requirements in relation to the breach identified at the last inspection and the timescales enforced by The Commission but further improvements were required.

We spoke briefly with seven people who lived at the home. All were satisfied with their care. Comments included "The care is good and they ask me if I'm happy with it"; "I like it here. They ask me how it's best to care for me; "It's nice here I've no complaints" and "It's very good, mostly very caring".

We looked at people's care plans and saw that improvements had been made to personalise the information in relation to people's care. Care plans now contained information about the person and how they wished to be cared for. We saw that social histories had been completed and there was information about what the person's life had been like, what they enjoyed and what was important to them.

We saw that consent to various aspects of their care had now been discussed and gained from people themselves rather than their relatives where appropriate. Discussions with regards to advance care directives which advise staff how the person would wish to be cared for in the event of ill health had also taken place with the person themselves and their wishes documented.

Where people lacked capacity, there was evidence to indicate that people's capacity had been assessed and best interest discussions held with relatives and other people involved in the person's care when consent was required.

We found however that some capacity assessments were generic and did not relate specifically to the individual person or the decision to be made and in one instance a decision about one person's capacity had been made before the assessment had been fully completed. We spoke to the manager and the lead nurse about this who agreed that further improvements were required to ensure people's capacity to consent was fully determined prior to decision making.

We saw that there was clear information about which people had their capacity assessed by the provider and that care plans had been developed in accordance with the outcome of these assessments. Where a Deprivation of Liberty Safeguard application had been submitted to the Local Authority in relation to people's care, a copy of the application had been retained and the outcome of the application recorded and adhered to in respect of the person's care. The provider has also ensured that the people who were subject to the DOLs application had been kept informed about the application process and its outcome. Care plans however in relation to people's cognition and mental health required further improvement with regards to personalised information about the decisions some people were able to make and how best to communicate with people to enable this to happen.

Some people whose care records we looked at had delegated the decision making responsibility in relation to aspects of their care to significant others either by an enduring power or lasting power of attorney. Where this was the case, care records now contained clear information as to who these representative were and the type of decision they were able to make.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Elderholme Nursing Home on 11 and 13 February 2015 we found that the provider did not have effective systems in place to identify, assess and manage the risks relating to the health, welfare and safety of people at the home. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 17 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 17 but that further improvements were still required.

For example, at our previous inspection we drew to the provider's attention that there was no evidence that some of the identified risks in relation to people's care had been managed in accordance with their care plan. We also raised concerns about the use and validity of generic risk assessments in the management and prevention of risk. Although some progress had been made in this area, not all of the risks in relation to people's individual care had been properly identified and managed by the provider. This meant that people's risk assessments still required further improvement to ensure the service managed people's risks adequately in the delivery of care.

During the inspection we met a number of staff, most of whom were polite, friendly and helpful. However one or two were openly aggressive towards us. This attitude remained unchallenged by the manager on the day of our visit. This raised concerns that a positive cultural attitude was not being fostered within the organisation by the management team towards The Commission. We concluded that staff did not understand the regulatory function and purpose of the Care Quality Commission. We felt that the staff team would benefit from developing a greater understanding of the Commission and its role in supporting providers to improve their service.

We asked about audits and were shown a variety of audits that had been carried out by the management team. These included audits relating to health and safety, infection control and medication management and administration. We saw that there was a clear audit trail of what had been identified and what action had been taken in response.

We saw evidence to indicate that satisfaction questionnaires had been given to people who lived at the home, their relatives and any visiting professionals to enable the provider to come to an informed view of the quality of the service provided. We saw that the feedback gained from these questionnaires had been collated and displayed in the home. These questionnaires showed that everyone was 100% satisfied with the all aspects of the service. This did not correspond however with the monthly newsletter that was issued to people who lived at the home. The newsletter included a section entitled "You said….we did". Within the monthly newsletters we saw that there were a number of concerns raised by people in relation to their care which had been acted upon appropriately by the manager.