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Elderholme Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 March 2017 and was unannounced.

Elderholme Nursing Home is situated within the grounds of Clatterbridge Hospital on the Wirral. It is a single storey purpose built care home offering both nursing and personal care for up to 61 people. All 61 bedrooms are single occupancy. There are three communal lounges, two main dining rooms and a pleasant garden with seating area for people to access. It also provides short term care for people who require assessment prior to returning home or moving to long term care.
During the inspection, there were 57 people living in the home.

We last completed a comprehensive inspection of Elderholme in February 2015. We found that the provider was in breach of regulations with regard to person centred care, consent and good governance. The service was rated as 'requires improvement.' In June 2015, we conducted a focused inspection to check that improvements had been made. We found that the provider was meeting regulations in relation to consent and good governance. The overall rating for the service was not reviewed during that inspection.

During this inspection we found that care files we viewed were detailed and person centred. They contained information specific to the individual, such as their preferred hobbies, their family history, previous occupations and preferred daily routines. This helped staff get to know people as individuals and provide care based on their experiences and preferences.

Staff we spoke with knew the people they were caring for well. We asked staff about people's preferred foods and specialist dietary requirements and all staff had a good understanding and the information they told us was reflected in people's care plans. The provider was no longer in breach of this regulation.

Most risk assessments we viewed had been completed accurately, however we found that some contained inconsistent information. This meant risk to the person may not have been accurately identified; however we found that appropriate care had been provided. We discussed this with the registered manager and on the second day of inspection, they told us that the risk assessments had been updated. We looked around the home and found that risk was not always minimised. For instance, we saw a fire door wedged open and chemicals were not always stored securely.

Medicines were stored safely and the temperature of the room was monitored daily as well as the medicine fridge and they were within safe ranges. Medicine Administration Record (MAR) charts were not always completed fully as gaps were evident in the recording of medicine administration. We checked the stock balance of one medicine with gaps evident on the MAR chart and found that there were more medicines left than there should have been. Staff had completed training in relation to safe medicine administration and had their competency assessed each year.

We found that staff were kind and caring in their approach when supporting people and we observed staff

respecting people's dignity in a number of ways during the inspection. We found however, that people's privacy and dignity was not always maintained as information specific to individuals and their needs, was visible around the home. This meant that private information about people was accessible to people who did not require to see it and this did not protect people's dignity.

People told us they felt safe living in Elderholme and relatives we spoke with agreed that the home provided a safe environment for their family members to live in. All staff we spoke with were aware of safeguarding procedures and how to raise concerns.

Records showed that staff were recruited safely and most people told us there were enough staff on duty to meet people's needs in a timely way and our observations confirmed this. Call bells were answered quickly and people did not have to wait for support when they requested it.

Records showed that incidents were recorded and reported appropriately and arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. External contracts were in place to help ensure the building and equipment were well maintained.

Applications had been made appropriately to lawfully deprive people of their liberty when assessments showed this was required. Staff we spoke with had a good knowledge of DoLS and how this impacted on people living in the home.

When people were unable to provide consent, records showed that mental capacity assessments were completed. We viewed mental capacity assessments and found that most were decision specific and discussions took place with relevant people to make a decision in the person's best interest when they lacked capacity. We found however, that when people required a capacity assessment for more than one decision, the assessments were not all fully completed.

Staff were supported in their role through an induction when they commenced in post and received regular training. Annual appraisals took place and although regular supervisions were not all clearly recorded, staff told us they were well supported and could raise any issues with the registered manager at any time.

People living in Elderholme were supported by the staff and other external health care professionals to maintain their health and wellbeing. A visiting health professional we spoke with during the inspection confirmed that they received timely and appropriate referrals from staff within the home.

Feedback regarding meals was positive. A menu was on display in the dining rooms and people were asked what meal they would prefer each day. We observed drinks and snacks being provided to people regularly throughout the day and jugs of juice were available in people's rooms.

We observed staff providing support to people in such a way as to promote their independence and people we spoke with told us staff encouraged them to be independent.

Care plans we viewed showed that when able, people were involved in the creation and review of their care plans. The registered manager told us the service writes to family members twice a year to request they visit the home to review their family member's plans of care. We viewed one of these letters.

People told us that their religious needs were respected by staff. Elderholme provides support to people at

the end of their life and care plans contained advance care plans to help ensure people's needs and preferences could be met during these times.

The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with and their relatives, confirmed that they could visit at any time and that they could visit in private if they chose to. For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access.

Care plans were in place to help meet people's individual needs. They had been reviewed regularly and most reflected people's care needs accurately.

There were two activity coordinators employed by the service who provided activities within the home in groups and on a one to one basis, as well as organising day trips in the minibus. During the inspection we saw that a game of dominoes was underway and a church service also took place. A schedule of activities was on display within the home. People we spoke with were satisfied with the activities available to them.

Systems were in place to gather feedback from people and listen to their views, such as resident meetings and quality assurance surveys. A complaints policy was on display and people knew how to raise any concerns they had. The complaints policy and newsletter reflected that the service welcomed complaints and saw them as an opportunity to learn.

The registered manager completed regular audits to monitor the quality and safety of the service provided. When audits identified issues, it was evident that actions had been taken to address these issues. We found however, that these systems were not always effective as they did not identify all of the issues we highlighted during the inspection. We also found that when issues were raised through quality assurance questionnaires, it was not clear that they had been addressed.

A registered manager was in post. 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 asked people their views of how the home was managed and feedback was positive.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Staff told us they were encouraged to share their views regarding the service and felt well supported by the management team.

The registered manager told us they aimed to work in partnership with other agencies to help ensure quality of care provision and joined up care and that the service always volunteered to participate in any pilot projects that may help improve the quality of care provided. Innovation was encouraged and recognised within the service and new ideas implemented to help improve quality.

A range of policies and procedures were in place to help guide staff in their role and ensure they were clear of their responsibilities and aware of the culture of the service. Most of these policies provided detailed and relevant information, however some required updating to reflect the current regulations and local authority contacts. The registered manager was aware these needed updating and told us they would ensure this was completed.

The ratings from the last comprehensive inspection were displayed within the home, in line with

requirements.

CQC had been notified of most events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to monitor information and risks regarding Elderholme.

You can see what action we told the provider to take at the back of the full version of this 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 was not always safe.

Not all risks assessments were completed accurately for people and we found that environmental risks were not always minimised.

Medicines were not always managed safely.

People felt safe living in Elderholme. All staff we spoke with were aware of safeguarding procedures and how to raise concerns.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs in a timely way.

Incidents were recorded and reported appropriately. Arrangements were in place for checking the environment to ensure it was safe.

Is the service effective?

Good

The service was effective.

DoLS applications had been made appropriately and staff we spoke with had a good knowledge of DoLS.

Systems were in place to gain consent from people, though some improvements were required to ensure all mental capacity assessments were fully completed.

Staff felt supported in their role and records showed staff received an induction, regular training and an annual appraisal.

People living in Elderholme were supported by the staff and other external health care professionals to maintain their health and wellbeing.

Feedback regarding meals was positive.

Is the service caring?

Requires Improvement

The service was not always caring.

We found that staff were kind and caring in their approach when supporting people; however people's privacy and dignity was not always maintained.

Staff provided support to people in such a way as to promote their independence.

Care plans showed that when able, people were involved in the creation and review of their care plans.

There were no restrictions in visiting, encouraging relationships to be maintained. For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access.

Is the service responsive?

Good

The service was responsive.

Care files were detailed and person centred and contained information specific to the individual. Staff knew the people they were caring for well and people received person centred support. The provider was no longer in breach of this regulation.

Activities were available to people in groups and on a one to one basis, as well as regular day trips. People we spoke with were satisfied with the activities available to them.

Systems were in place to gather feedback from people and listen to their views, such as resident meetings and quality assurance surveys.

A complaints policy was on display and people knew how to raise any concerns they had.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to enable the registered manager and provider to monitor the quality and safety of the service provided were not always effective.

Policies and procedures were available but some required updating.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Staff were encouraged to share their views regarding the service and felt

well supported by the management team.

The service worked in partnership with other agencies to help ensure quality of care provision and joined up care. The service took part in pilot projects that could help improve the quality of care provided. □

CQC had been notified of most events and incidents that occurred in the home in accordance with our statutory requirements.

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.

This inspection took place on 1 and 2 March 2017 and was unannounced. The inspection team included an adult social care inspector, an inspection manager 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.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service and the local Clinical Commissioning Group.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the chief executive, a member of the maintenance staff, an activity coordinator, four members of the care staff, four people living in the home, six relatives, a chef and two visiting health and social care professionals.

We looked at the electronic care records of five people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Is the service safe?

Our findings

Following a focused inspection of Elderholme in June 2015, the safe domain was rated as 'Requires improvement.' The provider was found to be meeting regulations, however further improvement was required in relation to risk assessments.

During this inspection, the electronic care records we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief and these were available in all of the people's files we viewed. We also found that risk assessments were completed for people when risk specific to the individual had been identified. For instance, one person's records showed that risk had been assessed in relation to the use of call bells as they were unable to use this. Risk had also been assessed for the mobility equipment they used. Another person's file reflected that risk had been assessed in relation to social isolation and use of bed rails, as they spent most of their time supported in their room. We saw that measures had been put in place to minimise these risks and the assessments had been reviewed regularly.

Most risk assessments we viewed had been completed accurately, however we found that some contained inconsistent information. For example, one person's dependency risk assessment reflected that they had a pressure ulcer. Other records however, did not reflect this and the registered manager confirmed they did not have a pressure ulcer. The same person had a risk assessment completed for use of a specialist chair, which stated the person used this equipment for set periods of time each day, however their moving and handling risk assessment reflected that they were cared for in bed at all times and the registered manager told us they were currently supported in bed. This meant risk to the person had not been accurately assessed and recorded. We found however, that appropriate care had been provided. We discussed this with the registered manager and on the second day of inspection, they told us that the risk assessments had been updated to reflect the person's current needs.

We looked around the home and found that a fire door was wedged open. We alerted the registered manager to this and closed the door as it contained electrical equipment. We found however, that on the second day of inspection, it was again wedged open. The registered manager told us they would ensure it was not wedged open whilst they waited for an automatic closure device to be fitted and since the inspection have confirmed an automatic closure is now in place.

We also observed that chemicals were not always stored securely. For instance, prescribed thickening powder used to thicken people's drinks when they had swallowing difficulties, was left unattended on a drinks trolley and a cleaning trolley was observed inside an unlocked sluice room. The registered manager told us that people in these areas were not mobile, but would ensure that all chemicals were stored securely at all times.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available to guide staff. Staff told us and

records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed each year.

Medicines were stored safely in locked trolleys within a locked clinic room. The temperature of the room was monitored daily as well as the medicine fridge and they were within safe ranges. If medicines are not stored within safe temperature ranges, it can have an impact of their efficacy. We also found that controlled drugs were stored securely. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. There were systems in place to help ensure safe management of these medicines, such as daily stock balance checks.

We looked at people's MAR charts and found that they were not always completed fully as gaps were evident in the recording of medicine administration. For instance, one person's MAR chart showed that they were prescribed a medicines six times per day; however on a number of occasions, it was only signed as administered four or five times each day. We checked the stock balance of this medicine and found that there were more medicines left than there should have been. This meant that the person may not have been administered all of their medicines as prescribed. We reviewed this person's MAR chart at 4pm and found that the medicine due at 3pm had not been signed for and was still in the monitored dosage packet. This meant that medicines were not always administered as prescribed. We discussed this with the registered manager who contacted the staff responsible for the administration of medicines on the days where there were gaps in the recording to establish whether medicines had been given and to request they update the records to ensure an accurate record of medicines administered was maintained.

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

All people we spoke with who lived in the home, told us they felt safe living in Elderholme. Their comments included, "Yes, I do feel safe here", "This is definitely a safe place" and "Staff are all nice, when they walk past they pop in to see if I am alright." All of the relatives we spoke with agreed that the home provided a safe environment for their family members to live in.

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were able to explain different types of abuse and how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns, which included local thresholds and contact details for the local authority and the Care Quality Commission (CQC), which enabled appropriate safeguarding referrals to be made. We saw that each area of the home contained a notice board which displayed information on safeguarding and how to report concerns.

We looked at how the home was staffed. On the first day of inspection there were six nurses on duty, including a shift leader and the registered manager, as well as 12 care staff and a senior carer, administration, catering, activity and maintenance staff, supporting 57 people living in the home. Feedback regarding staffing levels was mixed, but mainly positive. Most people told us there were enough staff on duty to meet people's needs in a timely way. However, one person told us, "You tend to wait a while to go to the loo." Most relatives agreed that there were usually sufficient staff available. One relative told us, "There is always plenty of staff during the day" and another relative told us that there were less staff at break times but that they could always find staff when they needed them. Staff we spoke with all told us there were adequate numbers of staff on duty at all times. One staff member told us, "There are a lot of staff" and all staff told us people did not have to wait long when they needed support.

Our observations showed us that there were enough staff on duty during the inspection to meet people's

needs. The call bell was answered quickly and people did not have to wait for support when they requested it.

We looked at how staff were recruited within the home. We looked at three personnel files. Evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. There was also a system in place to monitor professional registrations for qualified nurses and this was checked regularly to ensure staff pin numbers were in date.

We looked at accident and incident reporting within the home and found that these were recorded electronically and that the registered manager received notification of all incidents that occurred. The registered manager reviewed each accident to establish whether any further actions were necessary, such as referrals to other professionals or sourcing equipment. Records showed that incidents were recorded and reported appropriately.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. External contracts were in place to monitor fire equipment, lifting equipment and waste management and internal checks were completed for water temperatures, air mattresses, bed rails and wheelchairs. This helped to ensure that the building and equipment were well maintained. The provider had a business continuity plan in place in the event of emergencies and staff had access to contact details for all contractors should they be required.

We found the home to be clean, though some areas did require refurbishment and the chief executive showed us the plans in place to further develop the home. There were gloves and aprons available to staff and we observed these being used appropriately. We also found that bathrooms contained liquid soap and paper towels in line with infection control guidance. The kitchen had undergone refurbishment recently and the Food Standards Agency had awarded the service five stars which is the highest available. People living in the home told us the home was clean and well maintained. One person told us, "Cleaners are always cleaning, even the door handles and light switches." Relatives we spoke with agreed and their comments included, "I think [staff] make the effort to keep it clean", "Immaculate" and "Definitely, keep it spotless here."

Good

Is the service effective?

Our findings

Following a focused inspection of Elderholme in June 2015, the effective domain was rated as 'Requires improvement.' The provider was found to be meeting regulations, however further improvement was required in relation to how consent was gained.

During this inspection we looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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).

The registered manager maintained records to show when applications had been made to deprive people of their liberty, when they were authorised and when they were due to expire. Care records showed that when a DoLS authorisation was in place, a care plan had been developed to inform staff how this impacted on the person and any conditions put in place with the authorisation. Staff we spoke with had a good understanding of DoLS and were aware who this applied to within the home.

When people were unable to provide consent, records showed that mental capacity assessments were completed. The registered manager told us that they had sought advice from the local authority regarding mental capacity since the last inspection and had made improvements to the systems in place. We viewed mental capacity assessments and found that they were decision specific and when people lacked capacity to make a certain decision, discussions took place with relevant people to make a decision in the person's best interest. For example, one person's file reflected that they were unable to make decisions regarding their end of life care. The person's family member, G.P and staff from the home had met to discuss this care and made best interest decisions on their behalf. If people had legally appointed a person to make decisions and provide consent on their behalf, this was clearly recorded within care plans.

We found however, that when people required an MCA for more than one decision, the assessments were not all completed accurately. The registered manager told us this was because the electronic system had not pulled through the information regarding people's ability to understand, retain and weigh up information and that they would ensure all assessments were reviewed and updated manually. On the second day of the inspection we saw that the MCA had been updated. We found that the outcome to the assessments were appropriate so this did not impact on people's care and treatment.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, before entering a person's bedroom, providing personal care and providing support at lunch time. Records we viewed showed that when able, people signed to evidence their consent in areas such as the use of bed rails, photographs and care planning.

We looked at staff personnel files to establish how staff were inducted into their job role. We found that the induction for new staff reflected the requirements of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers work towards and have their practice assessed and signed off by a senior member of staff. Staff we spoke with told us as well as training, they shadowed more senior staff when they first commenced in post and had time to read people's care plans. Staff also told us they were trained how to use equipment and how to complete people's care records. This enabled that staff to get to know the people they would be supporting and staff told us they felt well prepared for their role.

We looked at on going support available to staff. Records showed that staff received an annual appraisal, although regular supervisions were not always clearly recorded. Staff we spoke with told us they were well supported in their role and could raise issues at any time with the registered manager or senior staff in the home. One staff member told us, "We get support from the management and the board. The door is always open" and another staff member said, "You do get a lot of support here."

Staff told us they received regular training to support them in their role and records we viewed confirmed this. Staff told us they had completed training in areas such as moving and handling, MCA and DoLS, safeguarding, fire safety, medicines management and infection control. A staff member told us about a recent training course they had attended that included more clinical tasks, such as the use of ventilators, humidifiers, tracheostomy tubes and tissue viability. Trained nurses also had access to training to support them in their professional development and maintain their clinical skills. This included syringe driver training, diabetes and end of life care. Records showed that question and answer sessions took place following training to assess staff competency in the area and a system was in place to help ensure relevant training was refreshed annually.

One person living in the home described staff as, "Very knowledgeable."

People living in Elderholme were supported by the staff and other external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, palliative care team, social worker, dietician, podiatrist, speech and language therapist and falls prevention team. Relatives agreed that medical advice was sought timely when needed.
One relative told us, "Yes we are able use the same GP which is good for continuity, we have also had a dietician out recently and had a review with a social worker for [relative]." A visiting health professional we spoke with during the inspection confirmed that they received timely and appropriate referrals from staff within the home.

We joined people for lunch in one of the dining rooms and found that table were set with table cloths, condiments, napkins, cutlery and glasses. A menu was on display in the dining rooms and people were asked what meal they would prefer each day. When asked about the food, people's comments included, "Food is really good", "The food choice is great, plenty of choice", "Really like the food here" and "The meat they use in the food is a good cut." Relatives we spoke with were also positive regarding meals. One relative told us, "Food has always been nice here, they do great roast dinners" and another relative told us that their family member had been quite unwell and lost weight in the past, but that they now look forward to eating.

We observed drinks and snacks being provided to people regularly throughout the day and jugs of juice were available in people's rooms. For people who required support to eat their meals, we observed staff provided this support in a discreet and dignified way and people were not rushed whilst eating. When people needed their intake to be monitored, we saw that records were maintained which clearly reflected what the person had eaten and drank. This helped to ensure that people received adequate amounts of

food and drink.

There were a number of people at Elderholme who were living with dementia. We found that the environment had not been adapted to assist people with dementia with orientation or independence. We discussed this with the registered manager who told us that although some people who lived in the home did have dementia, they were not mobile and would not benefit from the environment being adapted in this way. There was however a plan for further refurbishment of the home to commence later in the year and we were told that this would take into account the needs of people living with dementia, such as lighting and flooring choices. There was a secure garden for people to sit in when the weather allowed and people were supported to access this.

Requires Improvement

Is the service caring?

Our findings

Following a comprehensive inspection of Elderholme in February 2015, the caring domain was rated as 'Requires improvement.' This was because people's dignity was not always maintained. At our last focused inspection in June 2015, the caring domain was not inspected.

During this inspection, we found that staff were kind and caring in their approach when supporting people and we observed staff respecting people's dignity in a number of ways during the inspection. For example, staff knocked on people's doors and waited for a response before they entered people's rooms. Staff we spoke with gave clear examples of how they protected people's dignity when providing support. We found however, that people's privacy and dignity was not always maintained. For instance, we observed notices around the home that provided information regarding people and their needs and these were visible to anybody walking around the home. We saw a list pinned onto the outside of a bathroom door that reflected which people were to be supported to have a bath on certain days. The registered manager removed the sign straight away when this was pointed out to them.

We also saw that most people's bedroom doors were open as we walked around the home and signs within the rooms were clearly visible, advising what equipment the person required to transfer, or what specialist diet they required. This meant that private information was accessible to people who did not require to see it and this did not protect people's privacy. The registered manager told us the purpose of the signs were to ensure that any staff member was able to provide safe and appropriate care that met people's needs. They arranged for these signs to be taken down and put in a more appropriate place before the end of the inspection. People we spoke with told us they could choose whether or not to have their door open and records confirmed that these agreements had been recorded.

We also found that some language used within people's care plans was not appropriate. For example, we saw that bed rails were referred to as 'cot sides'. We raised this with the registered manager who agreed that the wording was not dignified as people were not in cots and that they would ensure this was changed within all care plans straight away. On the second day of inspection we observed that this wording had been changed in the care plan we had reviewed.

A system was in place using coloured dots on people's doors to identify certain care requirements for people. The registered manager told us that the purpose of this was so that staff had quick reference to important information about people. However they also told us that relatives were aware of the meaning of these coloured dots, therefore they would be able to identify care needs of people living in the home, other than their own relative.

We recommend that the service reviews and updates its practices accordingly, to ensure people's privacy and dignity is maintained at all times.

People living in Elderholme told us staff were kind and caring and treated them with respect. Their comments included, "The staff are homely and caring", "You can have a laugh and joke with everyone" and

"Very friendly and interested in what you have to say." Relatives we spoke with agreed and told us, "Oh, yes they are caring", "Absolutely, brilliant staff", "The staff are very approachable" and "Proactive staff, they look after people well."

We observed staff providing support to people in such a way as to promote their independence. For instance, when people got up to mobilise, staff observed them and only intervened if they required assistance. People were provided with mobility aids to assist them to remain independent and one person we spoke with told us they were receiving support from a physiotherapist to help their mobility. People we spoke with told us staff encouraged them to be independent. One person told us, "They encourage me to walk, or ask did I need a wheelchair." Relatives we spoke with agreed and one relative told us, "Some carers really do encourage, especially drinking." Care plans included individual dependency assessments which advised staff what people could do for themselves and what they required support with. One staff member we spoke with gave us an example of how they promoted independence. For instance one person was able to use an electric razor but could not see the mirror, so a table top mirror was provided, enabling the person to shave independently.

Care plans we viewed showed that when able, people were involved in the creation and review of their care plans. One care file reviewed showed that the person had signed to show their involvement and agreement with the content of their plan of care and this was completed annually. The registered manager told us the service writes to family members twice per year to request they visit the home to review their family member's plans of care and we viewed one of these letters. Another care file we viewed for a person who was unable to participate in a review of their care plan, showed that their next of kin had been involved in this on their behalf. Completion of 'This is me' documents and enabling care priorities forms by family members also showed their involvement in care planning.

A service user guide was provided to people when they moved into the home and this contained information regarding the service they could expect to receive at Elderholme. It also included information regarding the company's complaints procedure. People also had access to a monthly newsletter that we saw was displayed around the home. This contained details of activities, upcoming events and any planned celebrations that month. This meant that people were given relevant information regarding the service and their care and treatment.

People told us that their religious needs were respected by staff. The registered manager told us a Roman Catholic nun visits the home each week and an inter denomination church service is held monthly within the home. A church service took place on the day of our inspection and we saw that a number of people attended. The registered manager told us that volunteers from the hospital chapel also came to the home weekly and supported people to access the church.

Elderholme provides support to people at the end of their life and the registered manager told us staff had completed additional training in this area. The service had achieved 'beacon status' for the Gold Standard Framework, which is a nationally recognised programme that includes training and 20 standards for staff to work towards to help ensure they can provide appropriate end of life care. Beacon status is achieved when a service shows innovation and good practice in at least 12 of the set standards. Care files we viewed showed that people had advance care plans in place where appropriate, informing staff how they wished to be supported at the end of their life and families had been involved in these discussions.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with and their relatives, confirmed that they could visit at any time and that they could meet in private if they chose to.

People had access to Wi-Fi within the home, enabling them to maintain contact with family members who were unable to visit regularly.

For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access. The registered manager told us that nobody living in the home currently had an advocate as people had family members to support them, though they had in the past and people would be supported to access these services if necessary.

Good

Is the service responsive?

Our findings

During the last comprehensive inspection of Elderholme in February 2015, the provider was found to be in breach of Regulations in relation to person centred care and the responsive domain was rated as 'Requires improvement.' The responsive domain was not inspected at the focused inspection in June 2015.

During this inspection we reviewed care files and found that they were detailed and person centred. They contained information specific to the individual, such as their preferred hobbies, their family history, previous occupations, things that worried the person, pets and past holidays. Some files contained a social activity profile, for those people who were able to participate in social activities. One person's social activity profile described which radio station they liked to listen to, the type of music they preferred and what they enjoyed watching on television.

Care plans also informed staff of people's preferences in relation to times they liked to go to bed and get up, meals and drinks they most enjoyed and any they did not like. This helped staff get to know people as individuals and provide care based on their experiences and preferences.

Pre admission assessments we viewed reflected whether people had a preference as to the gender of the staff member who supported them with their personal care needs. Although there was nobody in the home at the time of the inspection that had a preference, the registered manager told us when there had been previously, this was respected.

Care plans provided staff with information to help them support people who could not communicate their preferences. For example, one person's communication plan provided very specific details as to how the person may present if they felt sick. The registered manager also told us the service had a set of communication cards that included pictures of basic needs, such as a toilet, a drink, food and moods, such as smiling or sad faces. These were available for staff to aid communication with people who were unable to verbally express their needs or preferences. This helped to ensure that staff were able to identify and meet people's needs.

Staff we spoke with knew the people they were caring for well. We asked staff about people's preferred foods and specialist dietary requirements, such as the amount of thickener a person required in their drinks if they had difficulty swallowing. All staff had a good understanding and the information they told us was reflected in people's care plans.

The registered manager told us the service had helped to arrange and accommodate a wedding for a person living in the home who was unable to access a wedding in any other venue, due to their health needs. This shows that the service provided person centred support to people to meet their individual needs and support them to develop relationships and achieve their aspirations.

The provider was no longer in breach of this regulation.

We viewed care plans in areas such as mobility, personal care, communication, cognition, elimination, safety and wellbeing, end of life and skin integrity. There were also plans in place to meet people's individual health needs. For example, one person's file contained a care plan advising staff how to support them should they have a seizure. Other medical needs such as diabetes, use of a ventilator and percutaneous endoscopic gastrostomy PEG, (a tube inserted through the abdomen directly into the stomach, usually used as a means of providing food), were reflected in care plans. Care plans we looked at had been reviewed regularly and most reflected people's care needs accurately.

We looked at activities available within the home. There were two activity coordinators employed by the service who provided activities within the home in groups and on a one to one basis, as well as organising day trips in the minibus. The registered manager told us that there were also eight volunteers who visited regularly to support people with activities. During the inspection we saw that a game of dominoes was underway and a church service also took place. A schedule of activities was on display and included board games, cards, reminiscence and bingo. The activity coordinator told us that when people were supported in their rooms, they visited them in there and provided individual activities. This included use of a laptop that enabled people to play games, listen to music, watch films or take part in reminiscence activities.

When asked about the activities available, people living in the home told us, "I like to play bingo and they do jigsaws", "When we go out on trips, we take sandwiches, tea and coffee. We went to New Brighton last time" and "I like to listen to music and play games."

We looked at processes in place to gather feedback from people and listen to their views. Records showed that resident meetings took place every few months and that people were given information regarding the service during these meetings and asked for their views. Quality assurance surveys were also issued to people living in the home and their relatives. Not all people we spoke with could recall completing a survey, however one person told us, "I filled in a survey a couple of weeks ago, I didn't have any issues. I am quite happy here."

People had access to a complaints procedure and this was displayed on notice boards within the home as well as within the service user guide and monthly newsletters. People we spoke with told us they knew how to raise any concerns they had and most relatives agreed. One relative told us, "I have not had any complaints but I know they would take it seriously if I did" and another relative said, "I believe they would take it seriously."

There was a complaints log maintained and we found that complaints had been investigated and responded to in line with the homes policy and actions taken where necessary. One person living in the home told us they had made a complaint and were happy with the outcome and how it was managed. The complaints policy and newsletter reflects that the service welcomes complaints and sees them as an opportunity to learn.

Requires Improvement

Is the service well-led?

Our findings

Following a focused inspection of Elderholme in June 2015, the well-led domain was rated as 'Requires improvement.' The provider was found to be meeting regulations, however further improvement was required with regard to quality monitoring systems.

During this inspection we looked at how the registered manager and provider ensured the quality and safety of the service provided. The registered manager attended monthly committee meetings with members of the board, to update them on areas such as complaints, staffing, new admissions to the home, accidents and incidents and the outcome of completed audits within the home. The chief executive officer was based within the home on a daily basis and was in constant communication with the registered manager.

We viewed completed audits in a range of areas such as medicines, care plans, accidents, cleaning, pressure ulcers, bed rails and hand washing. When audits identified issues, it was evident that actions had been taken to address these issues. For example, a care plan audit showed that a number of actions were required to improve the accuracy and quality of care plans reviewed and records reflected that these actions had all been addressed.

We found however, that the audits did not identify all of the issues we highlighted during the inspection. For instance, we viewed an individual medication audit for one person living in the home, which did not identify any issues. However, we viewed the MAR charts for this person which corresponded to the dates of the audit and found that there were a number of gaps evident on the MAR charts. This meant that systems in place to monitor the quality and safety of the service were not always effective. We discussed this with the registered manager who agreed to look at ways of improving the effectiveness of the audits.

Quality assurance surveys issued to residents and relatives were themed and we viewed responses from the most recent themed survey; dignity. Most responses were positive and reflected that people were happy with the support they received. We found however, that when issues were raised, it was not always clear that they had been addressed. One survey we viewed highlighted that a person was not happy with the care they had received at a certain time. We discussed this with the registered manager as further investigation into the comments was required; however the registered manager was unaware of the issue raised.

We recommend the service reviews its governance procedures and updates its practice accordingly, to ensure systems are effective.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. One person living in the home told us, "The manager is very friendly", whilst another person said, "The management have spoken to me and they are friendly and easy to talk to if I had a problem" and another person said the registered manager was, "Good and always has their door open." Relatives we spoke with agreed that the home was managed well. Their comments included, "Very professional. I had a query and they dealt with it very quickly", "They have an open door policy" and "I only know the manager; they are fantastic, always got time for you."

Relatives we spoke with described Elderholme as, "Homely, friendly, like a family", "Homely, relaxed and friendly" and "Love it, I can sit here relaxed and comfortable knowing [relative] is ok." A person living in Elderholme said it is, "A brilliant place." Staff told us they enjoyed coming to work and that, "It is not a chore." Staff described the registered manager as, "Approachable", "Excellent" and "Can go to the manager for anything."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service and we saw that they were issued quality assurance surveys to enable the registered manager to understand their views of the service. The results of these surveys had been collated and most were positive. There were some negative comments observed in relation to staffing levels and the registered manager told us they had employed an additional member of staff and created flexible work patterns in response to these comments.

Records showed that staff meetings took place, although these were not regular. Staff told us that they could request a staff meeting if they wanted one and could go to any member of the management team if they had any concerns. They also told us they knew they could contact the trustees should they need to and knew how they could do this. A suggestion box was available in the home that only the Chairman had access to, so staff could share their views with the board through this.

The registered manager told us they aimed to work in partnership with other agencies to help ensure quality of care provision and joined up care. For example, the service worked closely with professionals from a local hospice to discuss and plan symptom management and end of life care needs for a person living in the home. The registered manager also told us the service volunteered to participate in any pilot projects that may help improve the quality of care provided. For instance, Elderholme was due to commence a telecare pilot through the local clinical commissioning group. This would provide staff with access to 24 hour medical advice and support.

Elderholme had achieved beacon status in the Gold Standards Framework for end of life care. Compliance with these standards is monitored regularly and the registered manager told us they had maintained accreditation for six years. This helped to ensure that people received quality care at the end of their life.

The registered manager told us they were the chairperson of a recently developed registered manager's network group. This involved local registered managers meeting to discuss best practice and learn from each other to help drive forward improvements within their services.

Innovation was encouraged and recognised within the service to help improve quality. For instance, one staff member told us about how they had developed and implemented new practices to improve care for people living in the home who had diabetes. They told us they were supported by the service to make these changes and given time to monitor the impact since they were implemented. This led to improvements in screening, early diagnosis and on going care for people with diabetes, as well as staff training and knowledge.

A range of policies and procedures were in place to help guide staff in their role and ensure they were clear of their responsibilities and aware of the culture of the service. Most of these policies provided detailed and relevant information, however some required updating to reflect the current regulations and local authority contacts. The registered manager was aware these needed updating and told us they would ensure this was completed.

The ratings from the last comprehensive inspection were displayed within the home, in line with requirements.

We discussed notifications with the registered manager. The service had notified the local authority safeguarding team of all un-witnessed falls, in line with the local authority policy. CQC had not been made aware of all of these referrals and the registered manager told us they had not progressed to safeguarding investigations. We found that CQC had been notified of most events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to monitor information and risks regarding Elderholme.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely within the service.