Wirrelderly

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 5, 7 and 8 June 2018 and was unannounced.

Elderholme is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 64 people in single rooms all located on the ground floor. During the inspection, there were 63 people living in the home.

At the last inspection in March 2017, the registered provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always managed safely, risk was not always assessed accurately and we identified some concerns regarding the safety of the environment. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of whether the service was safe, to at least good.

During this inspection, we looked to see if they had made the necessary improvements and found that although some changes had been made, further improvements were required to ensure the provider was fully compliant with Regulations.

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 living in the home and their relatives their views on how the home was managed and feedback was positive.

We could not check the stock balance of some medicines as records did not all accurately reflect how many medicines should be in the home. Not all medicines had been administered as they had been prescribed. Although the registered manager had developed a template for PRN (as and when required) protocols, we found that these protocols were not always in place, or were not accurate. Some medicines were stored securely in people's bedrooms; however the temperature of the rooms was not monitored. The provider was still in breach of Regulation regarding this.

At the last inspection we found that risk assessments contained inconsistent information. During this inspection we found that risks to people had been assessed consistently. We looked at accident and incident reporting within the home and found that they were recorded electronically and appropriate actions were usually taken following any incidents.

CQC had not been notified of all events and incidents that occurred in the home in accordance with our statutory requirements, particularly incidents relating to safeguarding issues raised by other organisations.

Audits were completed to ensure the registered manager could monitor the quality and safety of the service.

Although audits were completed regularly, we found that they did not highlight all the issues identified during the inspection.

People told us they felt Elderholme was a safe place to live. Staff were aware of adult safeguarding and knowledgeable about procedures to follow if they had any concerns and how to whistle blow if they did not feel that concerns were addressed appropriately. Most safe recruitment processes had been followed when staff were employed, but records did not always clearly show when staff were shadowing other staff members as part of an induction.

There were enough staff on duty to meet their needs in a timely way. During the inspection we observed that call bells were answered quickly and staff were available to provide support when needed.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. Staff completed training and were assessed regularly to ensure they were competent in their practice.

Menus were displayed around the home and staff were knowledgeable about people's dietary needs, as well as their preferences. People told us they enjoyed the food and always had a choice.

Applications to deprive people of their liberty had been made appropriately. Staff had a good understanding of the Mental Capacity Act. When able, people had given their consent to the care provided to them. When people were unable to provide consent, decisions were made in their best interest.

People told us staff were kind and caring and treated them with respect. We observed people's dignity and privacy being respected by staff and heard staff speak to people in a warm manner.

It was clear that staff knew people they were supporting well. People told us that although staff supported them, they were encouraged to be as independent as they could be.

Care plans showed and people confirmed, that they and their relatives had been involved in the development of their plans. Relatives told us they were kept up to date and always contacted if there were any changes in their family members care.

People were provided with a service user guide and other relevant information regarding the home. A monthly newsletter was also produced and shared with people. This showed that people were given information and explanations regarding the service to enable them to be involved and make decisions.

Relatives told us they could visit at any time and were always made welcome. For people who did not have family or friends to support them, details of advocacy services were available.

Care plans were in place, were detailed and had been reviewed regularly, however not all plans had been updated when people's needs had changed. Plans provided information regarding people's preferences to help staff get to know people as individuals.

Two activity coordinators were employed and provided a range of activities for people both within the home and in the local community. A minibus was available and people visited local areas such as New Brighton, West Kirby, Birkenhead Park, Hoylake and local garden centres. We were told these trips often included fish and chips or tea and cake.

A complaints procedure was available and was on display within the home. People living in the home were aware of the process and told us they would not hesitate to raise a concern if they needed to. Systems were in place to gather feedback from people regarding the service and actions were taken based on the feedback received.

Staff told us they felt well supported, worked well as a team, enjoyed their roles and were encouraged to share their views. Staff had access to resources to support them to continually learn and ensure they provided support based on best practice guidance.

Any incidents that took place were reviewed and lessons shared with staff with the aim of improving care and treatment. The registered manager had made links with other local providers to share good practice and learn from the mistakes of others.

Ratings from the last inspection were displayed within the home as required.

You can see the 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.

Medicines were not always managed safely.

Safe recruitment procedures were not always clearly recorded.

Accidents and incidents were recorded electronically and appropriate actions were usually taken following any incidents.

People felt Elderholme was a safe place to live.

Staff were aware of adult safeguarding and knowledgeable about procedures to follow if they had any concerns.

There were enough staff on duty to meet their needs in a timely way.

Is the service effective?

Good

The service was effective.

Staff were supported in their roles through induction, appraisal and regular training.

People's nutritional needs were assessed and met and people told us they enjoyed the meals available and always had a choice of meals.

Applications to deprive people of their liberty had been made appropriately.

Staff had a good understanding of the Mental Capacity Act and consent was gained in line with the principles of this Act.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and treated people with respect and we saw that staff maintained people's dignity and privacy.

Staff knew people they were supporting well and encouraged them to be as independent as they could be.

People and their relatives had been involved in the creation of care plans.

Relatives told us they could visit at any time and were always made welcome. For people who did not have family or friends to support them, details of advocacy services were available.

Is the service responsive?

Good

The service was responsive.

Care plans in place were detailed and had been reviewed regularly, however not all plans had been updated when people's needs had changed.

Staff had time to support people in a calm and unrushed manner and technology was in use to ensure people received care in a timely way.

Two activity coordinators were employed and provided a range of activities for people both within the home and in the local community.

People were aware of how to make a complaint should they need to.

Staff received training to enable them to provide effective support to people at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well-led.

CQC had not been notified of all events and incidents that occurred in the home in accordance with our statutory requirements.

Audits were completed, however we found that they did not highlight all the issues identified during the inspection.

Systems were in place to gather feedback from people regarding the service and actions were taken based on the feedback received.

The registered manager had made links with other local providers to share good practice and learn from the mistakes of

others.

Ratings from the last inspection were displayed within the home as required.

Care Quality Commission

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 5, 7 and 8 June 2018 and the first day of the inspection was unannounced. The inspection team included one adult social care inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses 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 to gain their views of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

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

During the inspection we spoke with the registered manager and chief executive officer and eight other members of the staff team who held various roles in the service. This included an assistant activity coordinator, chef, human resources manager, physiotherapist and members of the care team. We also spoke with seven people living in the home and six of their relatives.

We looked at the care files of six people receiving support from the service, seven 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 times during the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in March 2017 we found the registered provider to be in breach of Regulations as medicines were not always managed safely, risk was not always accurately assessed and the environment was not always safely maintained. During this inspection we looked to see if necessary improvements had been made and found that although some changes had been made, further improvements were required to ensure the provider was fully compliant with Regulations.

In March 2017 we found that medicine administration records (MARs) had not always been fully completed and stock balances of some medicines were not accurate which meant that medicines had not been administered as prescribed. During this inspection we saw that MAR charts had been completed fully after each medicine had been administered. We found however, that we could not check the stock balance of some medicines as records did not all accurately reflect how many medicines should be in the home.

We also found that not all medicines had been administered as they had been prescribed. For instance, one person's medicine should have been administered every 12 hours to ensure it was as effective as possible. This medicine was a controlled drug. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation as so require a separate register of administration. We viewed the register and saw that times of administration had not always been recorded, so it would be difficult for staff to establish when to administer the next dose. Records that were available showed that there were not always 12 hours between doses. This meant that the medicine had not been administered as prescribed.

The registered manager had developed a template for PRN (as and when required) protocols. This provided information on the medicine, how often it should be administered and any side effects. The registered manager told us these had been created with the support of a pharmacist. We found however, that these protocols were not always in place, or were not accurate. For example, one person was prescribed a PRN medicine and was unable to inform staff when they required it. The PRN protocol should advise staff what signs or behaviours to look for to indicate that the medicine was required. However, the protocol in place had not been personalised to the individual and informed staff that the person could tell staff when they required the medicine. This meant that there was no clear guidance available to staff to ensure the medicine was administered consistently and when the person required it. Other medicines prescribed on a PRN basis had no protocols in place.

Some medicines were stored securely in people's bedrooms; however the temperature of the rooms was not monitored. If medicines are not stored at the correct temperature, it can affect how they work.

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

At the last inspection we found that risk assessments contained inconsistent information. During this inspection we looked at how risk was assessed and managed. Care plans showed risk had been assessed in

areas such as moving and handling, nutrition, pressure areas and falls. Person specific risks had also been assessed, such as smoking, use of bed rails, use of specialist equipment and isolation. We found that risks to people had been assessed consistently, however some actions recorded to manage those risks were generic and did not relate to the individual. We discussed this with the registered manager who updated the risk assessments we viewed to ensure they only contained information relevant to the individuals and told us they would ensure the risk assessments for all other people would also be updated.

People also had a personal emergency evacuation plan (PEEP) completed. This provided staff with information on what support each person would require should they need to evacuate the home.

We looked at accident and incident reporting within the home and found that they were recorded electronically. The registered manager was made aware of all incidents that occurred within the home and reviewed them monthly to look for any themes or trends and prevent recurrence. We found that most incidents had been recorded and reported appropriately and actions taken to reduce recurrence, such as referrals to the falls team and use of sensor equipment. However, records showed that on one occasion GP advice had not been sought in a timely way following an incident.

A 'lessons learnt' folder was available for staff to review. This included examples of situations that had happened within the home and actions that had been taken to prevent them recurring. External safety alerts were also included, including actions taken within the home to learn from these alerts and help to ensure people living in the home remained safe.

We looked at how staff were recruited within the home. Electronic personnel files contained evidence of application forms, photographic identification when staff possessed this 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. Two of the files we viewed showed that the DBS check had been received after the staff members had started in employment. We were told staff shadowed other staff until their DBS check had been received but there were no records available to evidence this. Systems were also in place to regularly monitor and check the pin numbers of qualified staff to ensure they continued to be fit to practice.

We saw that when risks were identified through the recruitment process, they had been assessed to help ensure there would be no risk to people living in the home. Appropriate actions had been taken by the provider when risks were identified.

The building appeared clean and well maintained and was undergoing refurbishment at the time of the inspection. Systems were in place to monitor the environment and equipment to ensure it remained safe. For example, external contracts were in place to make regular checks on the electricity, gas, lifting equipment, emergency lighting, portable appliances and fire safety equipment.

Records showed that regular internal checks were also completed in areas such as water temperatures, fire alarms, emergency lighting, air mattresses, nurse call bells, bed rails and wheelchairs. The home appeared to be clean and was free from odours during the inspection. Bathrooms contained paper towels and liquid hand soap in dispensers, in line with infection control guidance. Hand gel was available for use to help prevent the spread of infection. Personal protective equipment such as gloves and aprons were also readily available for staff and we saw that they were used appropriately, such as when providing personal care. People living in the home told us the home was always clean. Their comments included, "Yes, they are always doing the rooms; it's a lot of work", "Every morning the room and bathroom gets done" and "Yes, the

laundry is always nice and clean as well as my room." 91% had been achieved in the most recent infection control inspection.

People told us they felt Elderholme was a safe place to live. Comments included, "Yes, I've got my own room and can see people pass (my room)" and "The building has precautions and I can see people pass." One person told us they were, "As safe as Houses." Relatives we spoke with agreed and told us, "Yes, the door is open and people are going by", "Yes, we are all on one level, the doors are open and the bed is in a good position" and "Yes, we have not had any incidents."

Staff we spoke with were aware of safeguarding and knowledgeable about procedures to follow if they had any concerns. One staff member told us, "Safeguarding for me is everything in the home. Making sure the residents are safe. If I had any concerns, I would inform the nurse in charge, or speak to [the registered manager], [the HR manager] or [the Chief Executive]." Staff also told us and records showed that they completed safeguarding training regularly.

A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. People living in the home were provided with information regarding abuse and how to raise concerns in the service user guide and we also saw that surveys had been issued to people to ensure they had an awareness of how to report any concerns. We found that appropriate safeguarding referrals had been made. Contact details for safeguarding teams were also available to people living in the home within the service user information guide, should they need to raise any concerns.

Staff were aware of the whistleblowing policy in place. Whistleblowing is where staff can raise concerns either inside or outside the organisation without fear of reprisals. This helps maintain a culture of transparency and protects people from the risk of harm. Contact details were also readily available to staff should they need to raise any concerns.

People living in the home and staff were protected from discrimination as a clear equality and diversity policy was in place. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. As well as their regular equality and diversity training, staff had recently completed training to discuss the needs of people who are lesbian, gay, bisexual or transgender.

People told us that there were enough staff on duty to meet their needs in a timely way. One person told us, "Yes, there are plenty of carers" and another person said, "Normally [staff] come quickly." Staff also agreed that there were enough staff. Their comments included, "The staffing levels are ok, there are more than in other places" and "The staffing levels are very good." During the inspection we observed that call bells were answered quickly and staff were available to provide support when needed. We viewed the staff rotas and saw that staffing levels observed during the inspection were consistently maintained.

Good

Is the service effective?

Our findings

Care plans we viewed showed that people's needs were assessed holistically. They included information regarding people's mental and physical health needs, as well as their social and emotional needs. Plans also highlighted any equipment people required to ensure they received safe and effective care. During the inspection we saw that a range of equipment was available to people, such as specialist seating, toilet raisers, adapted baths and bariatric commodes.

Staff also had access to relevant legislation and best practice guidance to support them in their roles and enable them to provide the most effective care to people. This included best practice guidance on medicines management, local safeguarding thresholds, mental capacity pocket handbooks and access to mental capacity code of conduct resources.

A system was in place to ensure relevant information was available regarding people's care and treatment to ensure that if a person transferred between services, such as when admitted to hospital, all relevant information was provided to ensure the person could continue to have their needs met.

People at the home were supported by the staff and 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, dietician, mental health team, optician, speech and language therapist and social workers. A local GP visited the home each week to review people's needs, as well as being called out when people were unwell.

Staff completed training in areas such as food hygiene, catheter care, fire safety, moving and handling, confidentiality, accident procedures, managing challenging behaviours, Human Rights Act, equality and diversity, mental health awareness, dementia, medicines, bed rails, infection control and safeguarding. Registered nurses had also completed clinical training in areas such as tissue viability, diabetes and use of percutaneous gastrostomy endoscopic tubes (tube inserted directly into the stomach to allow nutritional and medicines to be provided). Group supervision sessions had been held to update staff knowledge in airway suctioning, end of life care, care of ventilated patients and the general data protection regulation.

Staff told us they received sufficient training to enable them to carry out their role safely. One staff member told us about the training they had completed regarding thickening agents used in drinks for people that had swallowing difficulties. They told us it was very interactive and helped them to understand how it felt to be supported with drinks and meals. People living in the home told us they felt staff were well trained and relatives agreed. Their comments included, "The expertise and care is there" and "Staff are very knowledgeable." A relative told us, "When my [relative] had to go to the hospital, the paramedic said, 'I have never been to a nursing home with a [Registered General Nurse] as knowledgeable as the one assisting me here."

Records showed that staff were assessed regularly to ensure they were competent in their practice in areas such as medicine management, blood sugar monitoring, catheter management, enteral feeding and

tracheostomy care.

When staff started in their role they completed an induction which involved training and shadowing other staff members. Staff told us they felt well supported and received annual appraisals. One staff member told us, "I have a yearly appraisal and a review every couple of months, to go through what you are capable of." Another staff member told us they had the opportunity to express what was important to them during supervisions and appraisals. We saw that group supervisions were held regularly and used as an opportunity to provide updates and refresher training.

Records showed that people's nutritional risk was monitored regularly and referrals were made to the dietician or speech and language therapist if any concerns were identified. Care plans showed that when advice had been received from these professionals, it was usually reflected within the plans of care so all staff were aware of how people's nutritional needs should be met. Diet and fluid intake charts were completed if people were at risk of malnutrition and these were reviewed and signed by a senior member of staff each day to ensure people had received sufficient amounts.

Menus were displayed on notice boards around the home and food surveys were issued regularly to gain people's views regarding the meals and records showed this was discussed during resident and relative meetings. Staff we spoke with were knowledgeable about people's dietary needs, as well as their preferences. We spoke with the chef who described the systems in place to ensure all staff providing meals were kept up to date about people's nutritional needs. They told us they provided a range of diets, such as vegetarian, fortified and diabetic and catered for a person who had specific dietary needs based on their religion.

We asked people if they enjoyed the food available at Elderholme. Comments included, "Very good, I enjoy it", "It's very good, can't fault it. I enjoy most meals. If I don't like what's on the menu they do something else", "Wonderful and its curry and rice tonight, my favourite", "Yes, we get enough to eat and can have a hot drink anytime" and "Yes, I'm never hungry and if I was they'd bring me a piece of toast." Relatives we spoke with agreed that there was sufficient food available, that it was of a good quality and that they could join their family members for a meal if they chose to. One relative told us, "Brilliant, it is cooked on the spot. [Relative] loves it, it is [relatives] main joy." Another relative said, "We have had advice from the Dietician and SALT team. [Relative] will only eat specific things so they do it specially."

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).

Records showed that DoLS applications had been made appropriately. The registered manager told us that three authorisations were in place and a further 11 applications had been submitted to the Local Authority for consideration. The registered manager had created information leaflets which they provided to family members when a DoLS application was made, to help them understand the process. A system was also in place to monitor what applications had been made and when they were due to expire. An electronic system issued a reminder when staff were required to renew the DoLS. We also found that when a DoLS was authorised, this was clearly recorded within people's care plans.

Staff we spoke had a good understanding of the MCA and told us they always asked for people's consent before providing care. We saw that when able, people had provided their consent in areas such as care planning, photography, use of bed rails and for their bedroom doors to be left open.

When people were unable to provide consent, mental capacity assessments were completed and decisions made in people's best interest in line with the principles of the MCA 2005. These decisions involved relevant people depending on what decision needed to be made, but usually included the person's family members, GP or social worker.

We looked to see if the environment was suitable to meet people's needs. One area of the home had recently been refurbished and plans were in place to refurbish the rest of the home. The registered manager told us that the recently refurbished areas included flooring, lighting, handrails and colours that were recommended for people living with dementia. They had also painted toilet doors a different colour to make them easy to recognise. We also saw that people's preferred names were displayed on their bedroom doors. The registered manager told us they had plans to work with and learn from other providers to share best practice to ensure the environment and resources were most appropriate for people with a range of needs.

New garden areas had been developed for people to sit outside and enjoy a safe and secure area. Seating areas had been provided and one garden included a water feature and walking paths for people to use. Another room within the home was in the process of being converted into a sensory relaxation room, which can be particularly therapeutic for people with sensory impairments. The home also had internet available to allow people to continue hobbies and keep in touch with relatives.

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. Their comments included, "They treat me well and nice", "They know me and we can have a laugh", "They help me in a lot of ways and look after me well", "I think they are great" and "Yes, they treat me well." Relatives also told us that staff were kind in their approach. Their comments included, "Care is brilliant, I have two other homes to compare with and this is far superior", "They do 'serious nursing' here and it is wonderful", "The care is very good", "Staff are very aware and nurses are amazing. The care is wonderful. We love it here", "Staff are very friendly, helpful and responsive. Their demeanour is positive" and "They pre-empt everything."

During the inspection we observed people's dignity and privacy being respected by staff, such as knocking on doors before entering and personal care was provided in private areas with doors closed. We heard staff speak to people in a warm manner and in a way that people could understand.

It was clear that staff knew people they were supporting well. We observed a staff member speaking with a person who was unable to express words, but because the staff member had got to know them, they understood the noises and tones that the person made. They could gesture and point and not only get their needs across, but engage in conversation with staff. Relatives told us they felt staff communicated effectively both with them and with their family members and they were always kept informed by staff. One relative told us, "[Relative] can't communicate but regular staff know her and her condition and they know if she is distressed."

People told us that although staff supported them, they were encouraged to be as independent as they could be. Their comments included, "[Staff] encourage me to walk every day", "Yes, I used to go to the toilet in the chair but I go on my own now. Staff encouraged me" and "Yes, I walk here, (lounge) but get the chair back if I'm tired." Relatives we spoke with agreed that their family members independence was promoted at all times. Equipment was also in use, such as bath hoists, cups with lids and large handles, adapted cutlery and walking frames.

The service also employed a physiotherapist who visited the home twice each week and provided physical activities to people, such as chair exercises and games. This enabled people to continue to be as active and independent as possible.

Staff told us they were kept informed if people's needs changed through handovers, reading care plans and the electronic messaging system set up in the home.

Care plans showed that people and their relatives had been involved in the development of their plans. This was evident through signed consent forms and completed 'This is me' documents which reflect people's life histories and preferences. Care files also included 'consultation to care and treatment' plans, which reflected what had been discussed and agreed with people and their family members. People and their relatives confirmed that they were kept informed and felt involved. Their comments included, "Yes, they have talked to us about [care plans]", "We are very much involved", "We have a breakdown of [relatives] care

and are fully informed" and "Yes, they send [care plans] home and I'm kept informed."

We saw that confidential records were stored securely to maintain people's privacy. This meant that only people who needed to view this information had access to it.

People told us they were treated as an individual and records from a recent resident and relative meeting showed that discussions had been held to promote acceptance and mutual respect. The registered manager discussed the necessity of providing an all-inclusive community and minutes from the meeting stated "Elderholme prides itself on being an inter-racial, multicultural workforce with a welcoming 'open door policy' towards residents, visitors and staff members from all walks of life." This showed that the service promoted individuality and was providing support in line with the Equality Act.

When people moved in to the home they were provided with a service user guide and other relevant information regarding the home. This included information on the philosophy of care, complaints processes, fees, pets, services available such as hairdressing and chiropody, meals, activities, useful contact details and fire safety. It also included some health and wellbeing information such as falls prevention, advanced care planning, hand hygiene and common infectious diseases. A monthly newsletter was also produced and shared with people. This contained information regarding activities taking place that month, meetings, updates regarding changes in the home and any national or local events or celebrations. This showed that people were given information and explanations regarding the service to enable them to be involved and make decisions.

For people who required it and did not have friends and family to assist them with decision making, information was available to people regarding advocacy services. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights. We saw this information was provided in the service user guide and the registered manager told us they would support people to access these services if they needed support.

During the inspection we saw relatives visiting at all times throughout the days. Relatives told us they could visit at any time, could speak to their family members in private if they chose to and were always made welcome by staff. One relative told us, "Yes, it's very relaxed and open" and another relative said, "I can visit anytime and stay as long as I want." This helped people to maintain relationships that were important to them and prevent isolation.

Good

Is the service responsive?

Our findings

We reviewed care files and saw that plans were in place to provide support in areas such as medicines, communication, elimination, personal care, wound care, cognition, daily life, diet and skin care. We found that the plans were detailed and most were specific to the individual.

We saw that care plans had been reviewed regularly, however not all plans had been updated when people's needs had changed. For instance, one person's skin care plan advised that they required one fortified milkshake each day to aid wound healing, however their wound healing plan stated they required two milkshakes per day and their dietary needs plan stated they were not to have any milkshakes. This meant that staff did not have clear guidance as to how to meet people's needs. We discussed this with the registered manager who confirmed the person required two milkshakes and that the other records had not been updated to reflect this, but were reviewed and amended during the inspection.

Another person's dietary plan showed that they required their weight to be monitored each week. Records showed that their weight was only being recorded each month. We discussed this with the registered manager who advised that their weight was now stable and there were no concerns regarding their nutritional intake, so monitoring had been changed to monthly. They ensured the care plan was updated by the end of the inspection.

Care plans provided information about people's needs as well as their preferences. They contained completed life histories which included people's backgrounds, family members and past jobs. They also provided staff with information such as when people liked to go to bed, get up of a morning, preferred meals and any foods they disliked, toiletries people liked to use and how they liked to spend their time. One person's care file informed staff that they liked their door open and small light left on overnight. Another person's personal care plan clearly described how they wanted their care to be provided and that they did not like certain products to be used. This enabled staff to get to know people as individuals and provide support based on their needs and preferences.

Plans based on people's health needs were also in place. For instance, a person's file reflected that they had diabetes and there was a care plan to guide staff how to support the person to manage this. It included current best practice information regarding regular checks required to ensure the person received appropriate care. There was also information regarding the condition and signs to look out for which may indicate the condition was not well controlled.

Care files also contained a pre-admission assessment; this ensured that staff were aware of people's needs and that they could be met effectively from the day they moved into the home.

People told us they had choice in how they spent their time, where they had their meals, or if to participate in activities. One person told us, "Yes, I get up when I want and decide what to wear" and another person said, "I decide when to go to sleep." During the inspection we heard staff giving people choices and encouraging people to make decisions. Staff were clear that people should have as much choice and

control over their support as possible. One staff member told us if a person wanted to have a lie in they would always respect that choice.

People told us staff were always available to support them when they needed it. Technology was in use to ensure people received care in a timely way. For instance, we saw that call bells were available to ensure people could call for help if they were in their rooms. People we spoke with confirmed that they were always able to alert staff when they required support. Their comments included, "I can ring in my room or ask in the lounge", "I only pressed it (call bell) once and they all came running" and "My door is open and I can ask staff or I have a buzzer." Sensor mats were also in place for some people who were at risk of falls. These helped to ensure people received timely care and helped them to remain safe as staff were alerted when they got up.

The registered manager showed us a resource they had developed to help staff communicate with people who were unable to communicate verbally. The file contained several tools, such as an alphabet people could point to, to spell out words, pictures of everyday tasks and commonly used questions to show people if they are unable to hear staff. A hearing loop system had also been installed within the home and a large computer screen was available for people to use that may have visual impairment. This all helped to ensure that communication with people was effective as it could be.

Two activity coordinators were employed and provided a range of activities for people both within the home and in the local community. Activities included bingo, board games, indoor gardening, hand massage, cards and crafts. A minibus was also available and trips out took place three times per week. People told us they visited local areas such as New Brighton, West Kirby, Birkenhead Park, Hoylake and local garden centres. We were told these trips often included fish and chips or tea and cake.

We saw that one to one activities were also provided to people who chose not to, or were unable to participate in group activities. This included reading books to people, painting, pamper sessions or shopping trips. A hair and nail salon was also available in the home.

A complaints procedure was available and was on display within the home. Information on how to make a complaint was also provided in the service user guide and records showed people were reminded how to raise any concerns during meetings. People living in the home were aware of the process and told us they would not hesitate to raise a concern if they needed to. Relatives told us they had not had to make a complaint but felt sure it would be addressed if they did. One relative told us, "No, no concerns. We've had the odd query but it's always answered. Staff check things and explain." The registered manager maintained a log of any complaints received and we saw that they had been investigated and responded to appropriately and actions were taken to try to prevent similar issues being raised.

Elderholme had previously held a nationally recognised award for care provided at the end of their lives, but this had recently expired and staff were in the process of completing a locally recognised end of life training scheme. Care plans showed that people had discussed their preferences regarding the care they wanted to receive at the end of their life. This enabled staff to provide the most appropriate care at this time. The registered manager wrote to family members following bereavements to request their feedback regarding the support they and their family member had received. This was done with the aim of constantly improving the service provided.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not notified the Care Quality Commission (CQC) of all events and incidents that occurred in the home in accordance with our statutory requirements, particularly incidents relating to safeguarding issues raised by other organisations. This meant that CQC were not able to monitor information and risks regarding Elderholme. We discussed this with the registered manager and confirmed what incidents needed to be reported and when and the registered manager is now fully aware of this. Since the inspection we have received appropriate notifications as required.

We looked to see what systems were in place to ensure the registered manager and registered provider were able to monitor the quality and safety of the service. We saw that regular audits were completed in areas such as accidents, infection control, care planning, safety of the environment, mealtimes, weight monitoring, recruitment, diabetes management, bed rails and tissue viability, Audits were completed by various members of the staff team but all were reviewed and signed by the registered manager to ensure they were aware of the findings.

Although audits were completed regularly, we found that they did not highlight all the issues identified during the inspection, such as those relating to medicines management and accuracy of some care plans. We discussed this with the registered manager and reviewed the tools used to complete the audits. They agreed to adapt the audits to ensure they covered all areas necessary to be complaint with regulations.

The chief executive officer is based within the service and so has daily updates and involvement in any issues. The registered manager told us they reported any complaints, health and safety issues and safeguarding concerns to them immediately. They also told us that the chairman visited the service weekly and spoke with people living in the home. A monthly board meeting was also held and recorded, during which the registered manager provided a full update of the service. A member of the board also walked around the home and had informal chats with people after each board meeting.

Systems were also in place to gather feedback from people regarding the service. We found that themed surveys were issued to people each month. These covered topics such as dignity, safety and care and meals. Most comments recorded were positive, but when an area for improvement was identified, it was clear that actions had been taken to address this. For instance, in response to one comment on the food survey, the registered manager sent an email to all staff with feedback from the survey and actions for them to follow to improve the meal time experience. Relative we spoke with told us about a suggestion they had made and how it had been actioned quickly, which they were pleased about.

Records also showed that regular resident and relative meetings took place. We reviewed the minutes from these meetings and found that people could share their views and that feedback about the service was encouraged.

The home had a registered manager in post. We asked people living in the home and their relatives their views on how the home was managed and feedback was positive. Comments included, "Very impressive,

[registered manager] gives a very good impression", "Couldn't be better. [Registered manager] keeps me informed of everything, the door is always open, very approachable" and "[Registered manager's] door is always open. She is pro-active and speaks to me." The registered manager told us they felt well supported by the board, staff, people living in the home and their relatives. They told us, "[The job] would be impossible without that support."

When asked about the atmosphere within the home, people told us, "It is like coming into a family, the staff are great", "It is good", "It's fantastic. Pleasant, supportive and reassuring. It's kind and safe" and "Really nice, happy and homely. I don't mind coming in, it's just a lovely place. It's totally changed my opinion of nursing homes."

Staff told us they felt well supported, worked well as a team, enjoyed their roles and were encouraged to share their views. On staff member said, "I feel really listened to and supported. That is one of the reasons why I wanted to come and work here full-time. I have a yearly appraisal, but we also have regular feedback on how we are doing." The human resources manager told us they also focussed on the mental wellbeing of staff and had started drop in sessions to enable staff to raise any issues they may have. Staff were aware of this and one staff member told us, "[Name] deals with staff morale. If we need to talk to her about anything, it is fine."

A range of policies and procedures were in place to guide staff in their role and we saw that these were detailed, reflected good practice and had been reviewed and updated. 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 had access to resources to support them to continually learn and ensure they provided support based on best practice guidance. Staff told us they were encouraged to continue to develop their knowledge and skills. The registered manager explained, "Everybody here wants to make a difference. People specialise in different things that they are passionate about."

Any incidents that took place were reviewed and lessons shared with staff with the aim of improving care and treatment. The registered manager had made links with other local providers to share good practice and learn from the mistakes of others. The registered manager told us they were keen to be involved in any groups, meetings or forums that would help them to drive forward improvement within the service. They told us they had recently been to visit another service that had been rated as outstanding and had adopted some of the practices seen there.

Ratings from the last inspection were displayed within the home as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

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.