Care UK Community Partnerships Ltd

Elmstead House

Inspection report

171 Park Road
Hendon
London
NW4 3TH

Tel: 02082026177
Website: www.elmsteadhousehendon.co.uk

Date of inspection visit:
25 October 2018
26 October 2018

Date of publication:
05 December 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 October 2018 and was unannounced.

We last inspected the service on 6 and 17 July 2017 and found the service to be in breach of Regulations 17 and 18 of the Health and Social Care Act 2008. Issues identified included staff not receiving regular supervision to support them in their role and the lack of regular monitoring and auditing to ensure that health care checks and monitoring were appropriately completed.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the ratings of the key questions of effective and well-led to at least good.

Elmstead House 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.

Elmstead House accommodates up to 50 people across two separate units, each of which have separate adapted facilities. One unit supports elderly people some of whom were living with dementia. The other unit is a functional mental health unit which supports people with recovering and enduring mental health problems. At the time of this inspection there was 37 people living at Elmstead House.

A manager was in post at the time of this inspection and had submitted an application to the CQC to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
At this inspection we found that the service had made improvements to address previous issues that we had found. However, further improvements were required in relation to staff receiving regular, formal supervisions and annual appraisals.

Staff that we spoke with confirmed that they felt supported in their role and received regular supervisions and annual appraisals. However, records seen did not always confirm this. The newly appointed manager was aware of this and had plans in place to ensure all staff received regular, formal supervisions and an annual appraisal.

People and their relatives told us that they felt safe living at Elmstead House. All staff demonstrated a good understanding of safeguarding people from abuse and the actions they would take to report their concerns.

People's care plans contained comprehensive information about identified risks associated with their health and social care needs and clear guidance for staff on how to support people to be safe and free from harm.

Staffing levels were determined based on individual people's levels of need. We saw that there were sufficient number of staff available around the home.

Recruitment processes ensured that only those staff assessed as safe to work with vulnerable adults were recruited.

People received their medicines safely, on time and as prescribed. Medicine policies and processes in place supported this.

Accidents and incidents were recorded, reviewed and analysed to ensure that where things had gone wrong improvements and further learning were considered and implemented.

Staff received a comprehensive induction when they first started work at the home with regular on-going training which enabled them to deliver effective care and support.

People's needs and preferences were assessed prior to their admission to Elmstead House so that the home could confirm that these could be effectively met.

People had access to a variety of snacks, drinks and regular meals which helped them to maintain a healthy and balanced diet. Where people had specialist diets and support needs in relation to their dietary intake this was appropriately catered for.

People were supported to have maximum choice and control in their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had access to a variety of health care professionals to ensure they were able to maintain a healthy lifestyle. The service worked effectively within as well as with other healthcare professionals so that people had access to specialist and relevant services which addressed and met their identified health and care needs.

We observed positive and caring interactions between people and staff. Staff knew the people they supported well and treated them with dignity and respect at all times.

People were supported to be involved in all aspects of the delivery of their care and support where possible. Relatives also confirmed that the home always involved them in every aspect of their relative's care.

Care plans were detailed and person centred which gave specific information and guidance to staff on how to meet people's identified needs and wishes.

People and relatives knew who to speak with if they had any concerns or complaints to raise and were confident that their concerns would be dealt with appropriately.

Management oversight processes in place ensured that the manager and provider monitored the quality of care people received. Where issues were noted, an action plan was compiled with details of the actions taken and lessons learnt.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and their relatives told us they and their relative felt safe living at Elmstead House. Staff knew how to recognise signs of abuse and how to raise their concerns.

Risk assessments identified people's individual risks and gave guidance to staff on how to minimise risk to keep people safe.

People received their medicines safely and as prescribed.

Recruitment processes ensured the service only recruited staff that were assessed as safe to work with vulnerable adults. The service ensured there were enough staff working to keep people safe and meet their needs?

Accidents and incidents were documented, reviewed and analysed to ensure that future occurrences could be prevented.

Is the service effective?

Good

The service was effective. Staff told us that they received regular and appropriate training and that they regularly received supervision which supported them in their role. However, we were unable to evidence that supervisions had taken place as records were not always available to confirm this.

People's needs were assessed prior to admission to the home to confirm that the service could effectively meet their needs.

People were supported to eat and drink and maintain a healthy diet. People had access to a variety of meals, snacks and drinks throughout the day.

People had access to a variety of healthcare professionals which supported them with their health and medical needs.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and clearly demonstrated how these principles were put into practice when supporting people especially where they lacked capacity.

Is the service caring?

Good

The service was caring. People were observed to have developed caring relationships with staff.

Staff were kind and respectful and were seen to uphold people's privacy and dignity at all times.

People were seen to be involved in day to day decisions about their care and support needs. People's preferences and wishes about their care and support needs were clearly documented within their care plans.

Staff supported people to maintain their independence as far as practicably possible.

Is the service responsive?

Good

The service was responsive. Care plans were person centred and detailed. Information within the care plan enabled staff to provide care and support that was responsive to people's needs.

All complaints were documented and included details of the complaint, the action the service took and their response to the person complaining. People and their relatives knew who to speak with if they had any concerns.

People's end of life wishes and preferences were clearly documented within their care plan.

Is the service well-led?

Good

The service was well-led. The newly appointed manager had submitted the appropriate documentation to become the registered manager of Elmstead House.

People and relatives were highly complementary of the new manager and felt that significant improvements had been implemented since their arrival.

Management oversight processes ensured that the provider and manager regularly monitored the quality of care people received.

People and their relatives were regularly engaged through resident and relative meetings, informal chats and annual satisfaction surveys so that they felt able and empowered to provide feedback about the service they received.

The service worked in partnership with other agencies and the community to support the provision of holistic care and support.

The provider's vision and values were clearly understood by all staff that worked at the service. Staff stated that they tried their best to ensure the values were reflected in all that they did.

Elmstead House

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 25 and 26 October 2018 and was unannounced.

The inspection team consisted of one inspector, one CQC specialist advisor nurse and two experts-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 the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also looked at action plans that the provider sent to us following the last inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we observed how staff interacted and supported people who used the service. We spoke with five people using the service, 13 relatives and 16 staff members which included the regional operations manager, the operations manager, the manager, the clinical lead, the chef, three lifestyle co-ordinators, two nurses, two team leaders and five care staff.

We also contacted a number of health and social care professionals to obtain their feedback about the service. We received responses from two health and social care professionals.

We looked at the care records of 13 people who used the service and medicines administration record (MAR)

charts and medicines supplies for 10 people. We also looked at the personnel and training files of 10 staff. Other documents that we looked at relating to people's care included risk assessments, handover notes, quality audits and a number of policies and procedures.

Good

Is the service safe?

Our findings

People and their relatives told us that they and their relatives felt safe and comfortable living at Elmstead House. Comments from people included, "Yes, I feel safe", "Pretty much so. If I ask for some help, I always get it", "I do feel safe. It's really good here. I am having a good day" and "I feel safe. The staff are very sensible." Relatives told us, "Yes he is safe. Staff are really good at dealing with his challenging behaviour", "Yes, she is safe, and I feel very comfortable" and "Yes, absolutely 100% perfect care. There's always someone with her. She's at risk of falls so she's a one-to-one and they're all lovely."

Management, nurses and team leaders understood their role in reporting safeguarding concerns to the relevant agencies including the local authority and the CQC. Where concerns had been raised these had been clearly documented with details of the service's internal investigation and actions, to ensure people remained safe whilst in the care of Elmstead House.

Records confirmed that all staff had received safeguarding training which was refreshed on an annual basis. Care staff we spoke with were able to describe the different types of abuse people could be subjected to, the signs to look for and the actions they would take to report their concerns. One staff member told us, "I would report it to the manager. I have to follow the provider's policy. We are here to protect our service users." Care staff understood the meaning of whistleblowing and listed names of agencies including the CQC, police and the local authority who they could contact to express their concerns without fear of recrimination.

Care plans contained detailed information on identified risks associated with people's health, medical and care needs. Where risks had been identified, clear guidance was available to care staff on how to minimise those risks so that people were enabled to be safe and free from harm at all times. Identified risks that were assessed included moving and handling, falls, behaviours that challenged, choking, and use of bed rails. Risk was also assessed for people with specific health and medical conditions such as diabetes, urinary tract infections and epilepsy or where a high risk medication had been prescribed. Risk assessments were reviewed on a monthly basis or sooner where significant change had been noted.

People and their relatives told us that there were enough staff available to meet people's needs. Staffing levels were determined based on people's assessed level of need. Some people had been allocated one to one staffing due to specific identified needs which the service had implemented in addition to staffing allocations that had been set overall. One relative told us, "There seems to be more than enough staff. That is what has impressed us more than anything else." Another relative stated, "Certainly when I've been there it looks like there are enough staff; I go in the mornings at the weekends." Throughout the inspection we saw sufficient numbers of care staff available and they were not rushed.

The provider carried out a series of checks when recruiting staff to ensure that only those staff assessed as safe to work with vulnerable adults were employed. Documents seen included a criminal records check, conduct in previous employments, proof of identification and nurses' registrations with the Nursing and Midwifery Council (NMC).

People received their medicines safely and as prescribed. Medicines were stored securely and medicines stocks were well managed. 'As required' (PRN) medicines were administered safely following clear directions on when and how they should be administered. PRN medicines are administered on an 'as and when required' basis and include medicines such as pain relief.

A number of people received medicines which were disguised in food or crushed. Where this was the case mental capacity assessments with best interest decisions had been completed for people lacking capacity to make this decision, which involved the home, the GP, the pharmacist and the person's relative. Clear guidance had been documented on how the covert medicine should be administered. Controlled drugs were stored appropriately and were signed by two staff when administered. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

We looked at medicine administration records for people living at the home and found these to be clear and fully completed. The records showed people were getting their medicines as prescribed and any reasons for not giving people their medicines were recorded. Nurses responsible for the administration and management of medicines had received regular training in safe medicine management which included the completion of a competency assessment on an annual basis. Senior managers completed weekly and monthly medicine audits which identified and addressed any gaps in recording or errors to ensure the safe administration of medicines.

Accidents and incidents were clearly documented. Each accident record detailed the nature of the accident, how it happened and the actions taken as a direct response to the incident as well as any follow up actions taken. Each accident or incident was then recorded within the provider's system where the manager and senior manager held regular oversight. This enabled them to review and analyse to ensure that improvements and further learning could be implemented to prevent future re-occurrences.

We observed that the home was clean and free from malodours. All staff received infection control training and had access to a variety of Personal Protective Equipment (PPE) such as disposable gloves and aprons. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella and hoisting equipment were undertaken.

Individualised Personal Emergency Evacuation Plans (PEEPs) were in place for each person and the provider had a clear plan to help ensure people were kept safe in the event of a fire or other emergency.

Good

Is the service effective?

Our findings

At the last inspection in July 2017, we found that staff were not receiving regular supervisions and annual appraisals to support them in their role. At this inspection we found some improvement in this area. Records confirmed that some staff had received regular formal supervision, but this was not the case for all the staff records we looked at. The newly appointed manager had been in post four weeks at the time of this inspection and explained that she was very aware this was an area where further improvements were required. We were shown action plans in place to ensure all staff received regular supervision as well as an annual appraisal over the coming months which would fall in line with the provider's policy.

However, staff that we spoke with felt very supported by their respective line managers and told us that they received regular supervision and had received an annual appraisal. They also stated that nurses, team leaders and the manager were always available and approachable. Feedback from staff included, "Good supervision which I had recently with the manager. We do feel supported, we can discuss any issues. I find it useful", "I had one recently. We can talk about anything, it is supportive. You know which part you are failing and what you are good at. We have supervision every three months" and "We have supervision every three months but if I feel I need more I can ask. We always talk about what I like and training. I find it very supportive."

Care staff told us and records confirmed that a comprehensive induction was delivered to all newly employed staff prior to them starting work delivering care and support. The induction period was for two weeks and covered training in mandatory topics such as moving and handling, safeguarding, the Mental Capacity Act 2005 and first aid. The induction also allowed the new staff member to shadow a more experienced staff member before working independently with people. Staff told us that the training was very good and effectively equipped them to carry out their role. One staff member told us, "The training has helped me, coming from a different background. My induction was nearly three months and included shadowing day and night before coming on the floor. I definitely feel able to go and ask for special training if needed."

The service completed a comprehensive assessment prior to admitting a person to the home so that it could be ascertained that the home could effectively meet people's care needs and choices. The assessment gathered information about the person, their life history, their medical history, behaviours, care needs, moving and handling and their likes and dislikes. Once the service confirmed that they would be able to meet the person's needs, a person centred care plan was compiled detailing how support and care was to be provided in each of the assessed areas as per the person's choices and wishes.

At the last inspection we noted minor issues around the recording of people's specialist dietary requirements, especially where people were required to have their meals fortified, and the monitoring of people's fluid intake especially during the night. At this inspection we found that these concerns had been addressed. People's specialised dietary requirements were clearly recorded within their care plan and within an overview table which listed all their requirements and support needs related to their nutrition and hydration needs. The chef held a copy of this overview for each person, which was updated regularly

especially where change was noted.

Where concerns were identified with anyone's food and fluid intake, monitoring charts were in place. We did note that fluid intake was not always consistently recorded after 11pm until the next morning which suggested that people may not have had any fluid after this time. We also noted that where low fluid intake had been noted, details of the actions taken to address this were not always recorded. We highlighted these minor omissions in recording to the manager who stated they would discuss these issues with the staff team to ensure going forward recording was clear and reflective of the support the person actually received.

However, throughout the inspection we observed that people had access to a variety of drinks and snacks in addition to their scheduled meals. People were supported to eat and drink in a personalised way which enabled them to be as self-supporting as possible enabling them to maintain their dignity. During the inspection we observed the dining experience for people. We saw care staff serving the meals in a considerate and timely fashion. Menus were available to inform people of the meal choices and people were also offered visual choices of which meal they wished to have. People's care plans reflected their likes, dislikes and cultural requirements in relation to their meals and drinks. Where people had been assessed as requiring specialist or one to one support with their meals this had been documented within the person's care plan and we observed appropriate support was provided.

People's and relatives' feedback about the meals provided and the way in which people were supported with their nutrition and hydration needs was very positive. Comments from people included, "The food is excellent" and "The food is fine." Relatives' feedback included, "She is well nourished here. If she refuses food, staff always persist in trying to persuade her to eat", "The quality of the food has picked-up. The cooks come from our Asian culture and the food helps to maintain my father's dignity as it's the one pleasure he can enjoy" and "The food is brilliant. I would like them to feed him. At the moment he's using his hands to finish off his food, he loves his food!"

The service ensured clear communication and information exchange within the staff team and with external health care professionals and organisations so that people's needs were addressed and any required treatment could be provided in an effective and timely manner. Daily handovers and weekly manager, nurses and team leader meetings enabled discussions about people's care and support, specifically highlighting concerns or changes in need and the actions that needed to be taken to meet the desired outcome for the person. Where required we saw referrals had been made to dieticians, social workers and the mental health team where specific and specialist input was required to address identified concerns. Staff also maintained daily records for each person which detailed the support that had been provided, changes in people's wellbeing, activities that people had participated in and how well they had eaten.

People's health and medical needs were effectively met so that people could maintain and live a healthier lifestyle. Records confirmed involvement of GP's, dieticians, opticians, dentists, social workers, speech and language therapists and physiotherapists. Where visits and appointments with these professionals had taken place, details of the reason for the visits and any follow up actions were clearly documented.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In

care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. At Elmstead House we found that full consideration had been given to the key principles of the MCA and DoLS authorisations had been requested and where authorised, these had been clearly documented within the person's care plan, along with any specific conditions that needed to be adhered to.

Care plans did not always evidence that where people had capacity, they had been given the opportunity to consent to their care and support provision. We brought this to the attention of the manager who agreed to address this going forward. Where people lacked capacity, assessments had been completed and best interest meetings conducted to further determine the level of support that the person would require that would be in their best interest. This included decisions around administration of covert medicines, do-not-resuscitate authorisations and support with personal care. Records confirmed the involvement of the home, relatives and any associated health care professionals in best interest decisions.

All staff demonstrated a good understanding of the MCA and DoLS and gave clear examples of how people were supported in line with the key principles of the MCA. One care staff explained, "We always presume people have capacity, we give them the chance and opportunity to act otherwise we have to do so in their best interest. We have to give them the choice to do what they want. We cannot trample over their rights even though sometimes their decisions may not be right." Another care staff told us, "We ask people what they want, we give them preferences, they have a choice as soon as they wake up. People make choices for themselves to the best of their ability, even through facial expressions."

The home was adapted in a way which supported people's individual needs. A lift enabled people to access all areas of the home. Where specific moving and handling equipment was required including hoists, wheelchairs and adapted shower chairs and baths, these were available. People's rooms were personalised as they so wished. Use of dementia friendly signage and pictorial aids were visible around the home.

Good

Is the service caring?

Our findings

People and their relatives told us that care staff were kind and caring and always treated them with respect. Comments from people included, "They are very friendly. They have really helped me" and "I like it here very much. I am very lucky to be here." Relatives' feedback included, "Yes they are caring. The ones that I know and see when I visit unexpectedly, sitting with her and holding her hand", "They are caring. I think they respect her like their own mother" and "The staff here are very kind and caring."

We observed that people had established positive relationships with the care staff. There was affection and mutual trust expressed between people and care staff. We saw care staff giving people individual attention. For example, one member of staff was reading a book to one person. In a communal area another care staff member had started a spontaneous sing-along with people. Interaction between staff and people created a warm family atmosphere. Care staff expressed their joy and happiness at working with people who were living at Elmstead House and always placed people at the heart of everything that they did. One staff member said, "I am very happy here. It's like a family here." Another staff member stated, "I'm happy to be in this job as I am helping people to fulfil their lives."

Care plans detailed people's preferences on how they wished to be supported. We saw care staff ensure that each person was involved in making all decisions in relation to their care and support where practicably possible. We observed care staff asking people's permission where a specific task needed to be completed. We heard care staff explaining to people what they were doing and how they were going to support them, encouraging them to be involved in the process. Care staff were also seen listening to people when they were expressing their needs and wishes and were observed to respond accordingly. Relatives confirmed their involvement in the care planning and delivery of care and support for their relative. One relative told us, "I have a lot of input into his care plan and the execution of his care plan is going well."

Throughout the inspection process we saw that people's privacy and dignity was respected and promoted through actions and interactions such as knocking on people's bedroom doors before entering, asking people's choices and maintaining confidentiality. People and their relatives confirmed that their privacy and dignity and that of their relatives was always maintained. One relative told us, "They absolutely respect her." Another relative stated, "Yes they do preserve his privacy and dignity. They take him away to his room to change him."

Care staff demonstrated a good understanding of how they were to respect people's privacy and dignity. Examples given by care staff included, "We always ask people's consent, inform them of what we are doing, cover them during personal care and always offer them a choice of whether they would like a male or female carer to support them" and "We make sure when doing personal care we close the door and make sure the blinds are closed."

Care staff were keen to promote people's independence so that people could be supported to lead a fulfilling and active life where possible. We asked care staff how they achieved this and were told, "If I have a resident who has a routine, we try and keep to that routine. We don't do things to them, we let them try to

do things themselves" and "We give them choice, give them opportunity to do things, we encourage them to walk and use the available facilities to walk, we don't restrict them, don't always automatically use equipment, we promote their independence."

Care plans were reflective of people's cultural, religious and personal diversity and staff were clearly aware of people's individual needs and how these were to be met. Weekly church services took place within the home for people who continued to practice their faith. Care staff told us that they promoted equality and diversity within the home and were able to support people's individual needs regardless of their personal diversity which included supporting people who were lesbian, gay, bi-sexual or transgender (LGBT). Comments from care staff included, "We make sure we know about people's cultural requirements. We support people equally; we do not discriminate. We support you according to your wish" and "It doesn't make a difference to us, everyone is an individual, we are taught about diversity and individuality, we are like family."

Good

Is the service responsive?

Our findings

Care plans were detailed and person centred. Each person's care and support needs were clearly defined with details of how they wished to be supported, their likes and dislikes and how care staff were to support them in a way which was responsive to their needs. Information and guidance included in the care plan covered moving and handling, personal care, eating and drinking and mental health needs. Care plans were reviewed on a monthly basis or sooner where any changes had been noted.

Where specific needs or concerns about people's health and care had been identified we saw monitoring charts such as for food and fluid intake, re-positioning charts and well-being, which enabled care staff to monitor people's identified concerns and provide responsive care and support as required. These records enabled care staff to continually monitor the person and where required increase or decrease the level of monitoring, care and support based on how the person was responding.

People's care plans, daily notes and records such as incident reports were kept and updated on an electronic system. The electronic system was a live document which could be viewed at any time and would provide staff with the most up-to-date information. In addition, a paper record folder was available for immediate access which held relevant documents such as the care plan, DNACPR's and DoLS authorisations. This was specifically helpful to care staff when supporting people in the event of an emergency.

Relatives confirmed that they were aware of the care plan, that the care and support that their relative received was responsive to their needs and that the home always kept them updated when any significant change was noted. Care staff recognised the importance of the information contained within the care plans and told us that they always read the care plan and made sure they were up to date with any changes in people's needs. One care staff told us, "The care plans tell you what you need to know. Even before we start the job we have to look at care plan. It tells us about the risks some people have including choking, risk of falls. The care plan gives direction." A newly employed care staff explained, "I am just starting to read the care plans now. It is most beneficial to know people's background. So far I am getting a good idea of understanding what the person is like."

Where people and their relatives had expressed agreement in giving information about themselves and their life events, a person centred life story booklet had been completed which gave detailed information about the person and included their family tree, their wishes and aspirations, their working life, hobbies and interests, what they enjoyed doing most days and memorable dates and special days. Their life story then continued to chart their life now in a care home. Information was written as well as pictorial. The information not only enabled care staff to gain a better understanding and appreciation for the person that they were caring for but also equipped them to provide care and support that was responsive to the person's needs and preferences.

Lifestyle co-ordinators employed within the home were responsible for organising activities and ensuring people were supported to lead a fulfilling and engaging life which promoted their well-being. Activities

organised included outings, puzzles, entertainers, prize bingo, baking and one to one sessions with people who did not want to participate in group activities. Activities that took place during the inspection included baking, making decorations for Halloween, singing and people being taken for lunch to the pub. One person who was seen to be supported to go for a walk around the local area. The manager told us of a new initiative where people were able to tell the home about their wishes and aspirations that they wanted to achieve which was then recorded on a 'Silver Wish Tree'. Every month the home would ensure that one person's wish was granted. The manager also told us about plans to have a fully functioning sensory room accessible to people living with dementia who would further benefit from sensory activities and a fully accessible vegetable patch which people could attend to. One relative told us, "The activities programme is now much better."

End of life preferences and wishes were noted within people's care plans. Details included the person's wishes, religious and cultural preferences on what they wanted to happen following their death and pre-agreed funeral arrangements. We saw evidence that these discussions had taken place involving the person, their family and a multidisciplinary team where appropriate.

A complaints policy was available and displayed around the home which detailed the processes in place for receiving, handling and responding to comments and complaints. People and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. Relatives' comments included, "If I had to complain I would ask to speak to the manager", "Yes, I've complained and asked for one person to be responsible for actions related to my relative's care. Things are improving" and "I know how to complain. I noticed things in the past. A lot of bad things. She is better where she is now."

Good

Is the service well-led?

Our findings

The newly appointed manager started their employment with the provider one month prior to this inspection. They had submitted an application to the CQC to become the registered manager of Elmstead House and was progressing through the process of becoming the registered manager.

At the last inspection in July 2017 we found some concerns around gaps and omissions and the inconsistency of recording on people's monitoring charts. This specifically included recording of people's repositioning requirements especially where they were at risk of developing pressure ulcers, welfare checks, food and fluid charts and the recording of food fortification. During this inspection we found that the service had addressed these concerns. The service was no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Our detailed findings of the improvements made have been referred to under the key question of 'Effective'.

People and relatives that we spoke with knew the newly appointed manager and were so far complementary of the way in which the manager ran the service and the changes that had been implemented so far. One person told us, "Yes, could not complain. Would rate it as ten out of ten." Relatives' comments included, "We've met briefly. She's [manager] lovely, visible and accessible", "Yes I meet her and yes, they would be responsive; she's good" and "It's very well run. He is well looked after. If anything happens, they take care of it."

At the previous inspection, staff morale was low and some staff felt that their concerns were not always addressed satisfactorily by management. During this inspection we found that staff morale was positive, they felt supported in their role and were also complementary of the new manager. Feedback from staff included, "The new manager is very approachable, seems to care about staff", "The new manager, she is really good, very friendly, we are settled. Staff morale is very very good. We are happy. We are like a family" and "This manager is very open, one to one and approachable, she is fantastic. She has an open door policy, she is doing her best. For the past few weeks morale is okay, we have that rapport, we get that zeal and encouragement to do the job, we need that. She [manager] is really giving us that opportunity. Staff morale has gone up."

Care staff told us and records confirmed that they were supported through supervisions and annual appraisals, however, these were not always formally recorded in line with the frequency as stated within the provider's supervision policy. The new manager was aware that the timely completion of supervisions and appraisals was an area that needed their attention and showed us schedules and plans in place to address this going forward. The staff team were also supported through regular team meetings, clinical lead meetings and daily handovers. Care staff confirmed that they felt able to contribute at the meetings with their ideas and suggestions and that these were listened to. Topics discussed at staff meetings included, health and safety, infection control, activities, dining dignity, record keeping and individual people's care and support needs.

Care staff were aware of the provider's vision and values and ensured that these were followed, so that

people received care and support that was person centred, open, transparent and achieved positive outcomes. One care staff told us, "Residents are at the heart of everything we do, we have to fulfil lives make sure people go about their business as they wish." Another care staff stated, "I think we do good care here."

The provider and manager had various processes in place to ensure constant and continuous monitoring of the quality of care people received. The processes in place enabled senior management to identify and address issues and concerns as well as implement improvements and learning outcomes in order to prevent future re-occurrences. Daily and weekly checks and audits were completed in areas such as medicine and health and safety. The provider had developed monthly themed audits that the manager was to complete and covered areas such as medication, dementia documentation, DoLS/MCA, mealtime experiences and nutrition, skin integrity management and night time visits. Results of these were monitored by the provider and any concerns or issues identified were analysed and reviewed at quarterly monthly quality assurance forums.

People, their relatives and staff members were all supported and encouraged to engage with the service to give their feedback, ideas and suggestions on how to improve the service. We saw records confirming regular relatives and residents meetings where discussion on topics such as staffing, activities, communication, the environment and change of managers were discussed.

People and their relatives were encouraged to complete the provider's annual satisfaction survey asking them a series of questions around the quality of care and support that they and their relative received. Telephone surveys had been completed between the months of June and August 2018. Results were overall positive with areas for attention that the service were looking at. The results of the survey were displayed on the notice board in one of the main corridors and detailed the results under headings of 'What you said', 'We listened' and 'What we did'.

During the inspection we were given information about reward initiatives for staff working at Elmstead House. This included a monthly Going the Extra Mile (GEM) award and an Angel award which recognised staff contribution and good practice. This ensured that staff morale was always maintained at a high level and that they felt valued and recognised for the work that they do. In addition the completion of annual staff surveys enabled the provider to obtain insight into how staff felt about working for the service and where required initiate required improvements in areas that care staff identified through the survey.

The service worked in partnership with a variety of healthcare professionals and community organisations. We noted that that the service maintained positive links with healthcare professionals including the GP, physiotherapists, speech and language therapists, psychiatrists and social workers. The service encouraged visits from the local community and had recently agreed for a children's nursery to visit the home on a two weekly basis for young children to come and engage and interact with people living at the home. This combined partnership approach ensured that people living at the home had access to a range of holistic services which supported their health and well-being. The service also engaged with the local authority quality team to work together in monitoring and improving the quality of care and support people received.