Lakeglide Limited

Ersham House Nursing Home

Inspection report

Ersham Road
Hailsham
East Sussex
BN27 3PN

Tel: 01323442727
Website: www.ershamhousenursinghome.com

Date of inspection visit:
22 May 2019

Date of publication:
20 June 2019

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?	Requires Improvement

Summary of findings

Overall summary

About the service:
Ersham House provides accommodation and nursing care for up to 40 older people, who lived with a range of general health problems, such as strokes, dementia, diabetes, heart problems, Parkinson's disease and general mobility problems. At the time of the inspection there were 16 people living at the home. It is a purpose-built home with level access throughout for those with mobility problems.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:
People said, and we observed that they were safe and well cared for and their independence was encouraged and maintained. Comments included, "Good place to live, I feel safe," and "The staff are nice and kind."

The service had made improvements since our last inspection. This meant people's outcomes had improved in respect of risk and medicine management. However, whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. For example, updating the care plan when peoples' needs had changed and ensuring medical equipment was ready for use.

There were sufficient staff to meet people's individual needs who had passed robust recruitment procedures that ensured they were suitable for their role. There were systems in place to monitor people's safety and promote their health and wellbeing, these included health and social risk assessments and care plans. The provider ensured that when things went wrong, these incidents and accidents were recorded, and lessons were learned.

Staff received appropriate training and support to enable them to perform their roles effectively. Visitors told us, "Staff are really helpful, they know what they are doing," and "The staff are great." People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff knew people's likes and dislikes. People gave very positive feedback about the food. Comments included, "Nice home cooking." Staff treated people with respect and kindness at all times and were committed to providing a quality service that was person centred.

People were encouraged to live a fulfilled life with activities of their choosing and were supported to keep in contact with their families. People's care was now more person-centred. The care was designed to ensure people's independence was encouraged and maintained. Staff supported people with their mobility and encouraged them to remain active. People were involved in their care planning. End of life care planning and documentation guided staff in providing care at this important stage of people's lives.

Improved audits and checks had been put in place to ensure the service was continuously striving to

improve. Areas identified as needing improvement during the inspection process were immediately taken forward and action plans developed.

The service met the characteristics for a rating of 'Good' in four of the five key questions we inspected, with the well-led question remaining 'Requires Improvement.' Therefore, our overall rating for the service after this inspection has improved to "Good".

Rating at last inspection:
At the last inspection the service was rated Requires Improvement (report published 01 May 2018).

Why we inspected:
This was a planned inspection based on the rating at the last inspection. At our last inspection of the service in April 2018, improvements were needed to ensure that medicines were managed safely, that there were sufficient trained staff to deliver person centred care and that quality assurance systems were fully embedded.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner. We will follow up on our recommendations at the next scheduled inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Ersham House Nursing Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors.

The service is required to have a registered manager:
The service had a manager who was registered with the Care Quality Commission. However, they had recently left the service and were in the process of de-registering. A new manger was in day to day charge of the service and had started the process of registering with CQC. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided at this time.

The service type:
Ersham 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. Ersham House can accommodate up to 40 people in one building.

Notice of inspection:
We did not give the provider any notice of this inspection.

What we did:
Before the inspection we reviewed the information, we held about the service and the service provider,

including the previous inspection report. We looked at the action plan provided to CQC following our last inspection. The registered 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 improvements they plan to make. We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with:
10 people and observed care and support given to people in the dining room and lounges
four people's relatives/visitors.
Seven members of staff
Four external healthcare professionals.

We also reviewed the following documents:
Six people's care records
Records of accidents, incidents and complaints
Four staff recruitment files and training records
Audits, quality assurance reports and maintenance records

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

At the last inspection on the 09 April 2018, we asked the provider to take action to make improvements to ensure that sufficient trained staff were consistently deployed and that medicines were managed safely. This action has been completed.

Assessing risk, safety monitoring and management:
• People felt safe. Comments included," Very safe, I came here because I wasn't safe at home," "It's very clean and safe here," and "I get the help I need."
• Processes were in place to protect people from avoidable harm. Risk assessments were completed to identify risks to people's health and safety, such as their risk of falls or risk of choking whilst eating. Staff reviewed the risk assessments monthly and put actions in place to reduce these risks. For example, People who were at risk of choking were provided with a pureed diet and modified texture fluids.
• People who were identified at risk from falls had had an assessment that highlighted the risk and described the actions staff should take to reduce that risk. One person told us, "I had lots of falls when I was at home, I was very unsteady, I've had a few falls since I've been here but not as many."
• For people who remained in their room, there was guidance that staff check them regularly at least two hourly and this was confirmed by the daily records. Staff also said, "We check more regularly, just pop in and say hello." A visitor told us, "I talk to the staff regularly and I know my relative is safe and cared for."
• The environment and equipment continued to be well maintained. People told us that any issues were dealt with straight away. One person said, "My room is always clean, everything is looked after here." Some carpets were in need of deep cleaning and the manager was aware of this. The carpet cleaner had been loaned to a sister home but was due back for this essential work.
• There were fire risk assessments, which covered all areas in the home. People had Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported in the event of a fire. These were specific to people and their needs.
• Premises risk assessments and health and safety assessments continued to be reviewed on an annual basis, which included gas, electrical safety, legionella and fire equipment. The risk assessments also included contingency plans in the event of a major incident such as fire, power loss or flood.

Using medicines safely:
• This inspection found that the managements of medicines had improved. People did not have any concerns regarding how they received their medicines. One person said, "My medicines are given to me right on time, just as I did at home, they also make sure I don't run out." Another said, "I have my medicines checked by the doctor regularly, along with my pain tablets."
• Medicines continued to be stored, administered and disposed of safely. People's medication records confirmed they received their medicines as required.
• Staff who administered medicines had the relevant training and competency checks.

• There were protocols for 'as required' (PRN) medicines such as pain relief medicines, which included recording the effectiveness of the medicine.

Systems and processes to safeguard people from the risk of abuse:
• People were protected from the risks of abuse and harm. There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority.
• Staff were aware of the signs of abuse and how to report safeguarding concerns. They were confident the management team would address any concerns and make the required referrals to the local authority. A staff member said, "We have mandatory training." Another staff member said, "We all get training regularly and we are trained to ask questions if we see something that is not right."
• The management team had followed safeguarding procedures, made referrals to their local authority, as well as notifying the Care Quality Commission. There was a safeguarding folder that contained the referral and investigation document. It also contained the outcome of the investigation with action plans where required. Feedback from the local authority included "They have always worked with us."
• Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. The Provider had an equalities statement prominently which recognised their commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age.

Staffing and recruitment:
• Staff numbers and the deployment of staff had ensured people's needs were met in a timely manner and in a way that met their preferences. Care delivery was supported by records that evidenced that people's needs were met. Food and fluid charts were completed when required as were turning charts and continence records. This meant staff could monitor and ensure people's needs were consistently met.
• Staff told us that there were enough staff to do their job safely and well. Staff told us, "We have enough staff, we do get busy but we all work as a team," and "We have pretty good staffing levels, but we only have 16 residents at the moment." People told us, "I can use the call bell and staff come to help me," and "Yes, enough staff." Relatives said, "I'm impressed with the staff numbers " and "When Mum needs help, she gets it quickly" and "There is always someone in here (lounge) and if they (residents) need help, they get it" "Seems to be enough staff on duty" And "There seems to be plenty of staff about."
• We looked at four staff personnel files and there was evidence of continuing robust recruitment procedures. All potential staff were required to complete an application form and attend an interview, so their knowledge, skills and values could be assessed.
• Registered nurses are required to register with the Nursing and Midwifery Council and the provider had systems in place to check their registration status.
• The provider continued to undertake checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Preventing and controlling infection:
• Ersham House was well-maintained, clean and free from odour. People told us the home "Is always clean, no nasty smells here."
• Staff continued to have access to personal protective equipment (PPE) such as disposable gloves and aprons.
• Staff confirmed they had received training in infection control measures. Staff could tell us of how they managed infection control and were knowledgeable about the in-house policies and procedures that govern the service.

Learning lessons when things go wrong:

• Accidents and incidents were documented and recorded. We saw incidents/accidents were responded to by updating people's risk assessments. Any serious incidents were escalated to other organisations such as the Local Authority and CQC.

•The provider had a system in place to facilitate the analysis of incidents and accidents and the registered manager used this to identify themes and learning. For example, if incidents were occurring at a specific time of day or in one place. The provider then took appropriate action such as looking at staff deployment or one to one support. This was seen during the inspection.

• Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented.

•Staff knew how to report accidents and incidents and told us they received feedback about changes and learning as a result of incidents at group supervision and on an individual basis.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

At the last inspection on the 09 April 2018, we asked the provider to take action to make improvements to ensure that sufficient trained staff were consistently deployed. This action has been completed.

Staff support: induction, training, skills and experience:
• This inspection found the provider had provided staff with regular training to ensure they had the right knowledge and skills to carry out their roles.
• Staff confirmed they had completed essential training such as infection control, moving and handling and safeguarding. They also told us that they had had specific training, such as understanding dementia, catheter care, epilepsy and equality and diversity. The training records confirmed that training had been completed.
• Registered nurses had received clinical training to ensure that their skills were up to date and met peoples' health needs. This included venepuncture and syringe drivers. These training sessions also supported RN's with their revalidation process to renew their registration with the NMC.
• People told us, "Staff know what they are doing and look after me well." A second person told us, "Staff know what they are doing, really good and kind." A third commented, "Staff are on the ball, they pick up when I'm not myself and get the doctor if I need it."
• The staff spoke positively about the training sessions they had received. One staff member told us, "The training is really good."
• There was a combination of e-learning and face-to-face training.
• Records showed staff supervision had taken place regularly and the staff we spoke with felt supported.
• Staff received an induction and shadowed experienced staff before they worked with people on their own. The organisation had created their own version of the Care Certificate. This was used as part of the induction process to promote good practice. The Care Certificate is an identified minimum set of standards that health and social care workers adhere to in their daily working life.

Ensuring consent to care and treatment in line with law and guidance:
• The 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The provider had a good understanding of the Act and were working within the principles of the MCA. People were not unduly restricted and consent to care and treatment was routinely sought by staff. Staff asked people for their consent before moving them, and before assisting people with drinks and food.
• Staff understood when a DoLS application should be made and the process of submitting one.
• We were told that not everyone currently living at the home had the capacity to make their own decisions about their lives and were subject to a DoLS. There was a file kept by the manager of all the DoLS submitted and their status. The documentation supported that each Dols application was decision specific for that person. For example, regarding restricted practices such as locked doors, covert medicines and the use of bed rails.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care:
• A range of multi-disciplinary professionals and services continued to be involved in assessing, planning, implementing and evaluating people's care, treatment and needs.
• Links with other organisations to access services, such as tissue viability services and speech and language therapists (SaLT) continued to ensure effective care. This was clear from the care planning documentation and the professional visiting logs. A visiting healthcare professional told us, "Staff contact us when they need advice."
• People were assisted with access to appointments. People told us, "When I have had an appointment, someone goes with me," and "Staff organise appointments for me."
• Information was shared with hospitals when people visited. Each person had an information sheet that would accompany the person to hospital. This contained essential information about the person, such as how they communicated, mobility and medicines.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Staff continued to apply best practice principles to care delivery, which led to effective outcomes for people and supported a good quality of life.
• Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practices, which contributed to good outcomes for people. Staff had access to NICE guidance which included the British National Formulary (Medicine guidance). This enabled staff to ensure medicines were safe for the people they supported.
• People's needs continued to be comprehensively assessed and regularly reviewed. Care plan reviews took place at least monthly, or as and when required.
• People's past life histories and background information were also recorded in the care documentation.
• People continued to be involved in their care planning and the people we spoke with confirmed this. We asked people if they were involved in planning their move to the service. One person told us, "They asked me about what care I needed and they do check with me if it's working." Another person said, "My family helped me to choose but it was my decision."

Supporting people to eat and drink enough to maintain a balanced diet:
• People's food preferences were considered when menus were planned. Comments from people included, "Usually good, we do get a choice," "The food is generous," "They offer choices and I can choose what I want." Visitors told us, "Very good variety, always nicely presented."
• The chef knew the people they prepared food for. She visited people to discuss their dietary requirements and knew who required special diets and fortified food.
• There were appropriate risk assessments and care plans for nutrition and hydration.
• Choking risk assessments were completed where a risk was identified. Referrals to a speech and language therapist (SALT) had been made when necessary.
• People had correctly modified texture diets and fluids where there were risks of choking. All meals were

attractively presented to encourage people to eat. Staff assisted those that required assistance with eating in an unhurried way.
• Staff monitored peoples' weights and recorded these on the nutritional assessment. The manager had a 'tracker' which noted people's weights and malnutrition scores and these were reviewed regularly and could be tracked over time to check whether there were any risks and flag staff to request a dietitian's input. Staff could tell us who was at risk from malnutrition and dehydration. They could also tell us what actions they needed to take such as encouraging drinks and fortified food.

Adapting service, design, decoration to meet people's needs:
• Ersham House was purpose built. It had been built and designed to provide a spacious and comfortable environment over two floors.
•. People could choose to spend their time in any of the communal areas which included an activity room, lounge, dining areas and smaller quiet lounge on the second floor.
• People's rooms remained personalised and individually decorated to their preferences. We saw that people's rooms reflected their personal interests. For example, one person had lots of photographs, pictures and extra shelving to make it feel like home.
• The garden areas were well designed and safe and suitable for people who used walking aids or wheelchairs.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

People continued to tell us they received good care from caring staff. One person told us, "Staff are very caring, they treat everyone with respect." A second person commented, "Staff are very good, nothing is too much trouble."

Ensuring people are well treated and supported; equality and diversity:
• Staff had good relationships with people, and appeared to know them well, including their likes and dislikes. Staff were seen to be caring towards people, and respected people's wishes.
• People were treated with kindness and were positive about the staff's caring attitude.
• We asked people what they thought of the staff and responses continued to be positive. One person said, "I think that the staff are lovely," A second person told us, "Staff are very kind and polite."
• We saw friendships between people were encouraged and enabled to spend time with their friends when they want to."
• Equality and diversity continued to be promoted and responded to well. We observed people eating different foods in line with their cultural and religious preferences. We also saw staff supported people to wear clothes of their choosing and helped them with their hair and make-up.

Supporting people to express their views and be involved in making decisions about their care:
• People and families continued to be involved in reviews. People told us they had been involved in planning their care. One person told us, "They keep me informed of any changes made to my care, for example, I had a GP appointment and I needed to see a consultant and staff arranged it."
• Records confirmed regular meetings were held with people and their relatives to discuss care.
• We saw evidence of multi-disciplinary meetings being held and saw people were involved in these meetings to discuss their needs and make decisions about the care.
• We asked people if they were involved in planning their move to the service, one person told us, "It was my decision to move here, I know the area."

Respecting and promoting people's privacy, dignity and independence:
• People's right to privacy and confidentiality remained respected. One person told us, "Staff respect my privacy and at the same time they knock on my door and ask if I am okay." A visiting professional commented, "I've never had any concerns about the staff, they respect people's privacy when I visit."
• Staff encouraged people to be independent. People told us "Staff promote my independence and I can do what I want. I can choose when I get up and go to bed; I like to get up early and staff pop in if I need any help." A second person said, "Staff are very caring and help me to stay independent. I manage my own money and staff assist if I need to make appointments with the bank."
• We observed staff treat people with dignity and respect and that they provided support in an individualised

way.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

At the last inspection on the 09 April 2018, we asked the provider to take action to make improvements to ensure that care plans consistently reflected peoples' needs. This action has been completed.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People were supported to exercise choice and control in their day to day lives and were empowered to make their own choices about what they do with their time. One person said, "Staff are so good, they support me to live a normal life, they know I like to get up late and dress nicely." Another person said, "The activities are good, entertainers visit and we have a dog that visits regularly."
• People's needs assessments included information about their background, preferences and interests. This information aided staff to initiate topics of conversation that were of interest to people. We were told conversations with people about their history and background reassured people, particularly if they had difficulty with their memory.
• Some people were able to tell us they were involved in planning their care. One person said, "Staff ask me about how I want things done, If the doctor changes my medicine, they tell me and explain everything." A care staff member said, "We involve people as much as we can, some people don't want to be involved and some people can't because of their health." They provided examples of people choosing to have a wash, shower or bath according to preference, the time people wished to go to bed and get up, the clothes they liked to wear and the food and drink they preferred.
• Where people had specific health care needs, these were clearly identified and showed how people should be supported. Staff could explain where and how this support should be provided. For example: people who lived with diabetes had a person specific care plan that identified clearly what action and insulin was required according to their blood sugar range.
• Reviews took place to ensure people's needs were accurate and were being met to their satisfaction and involved of their family or legal representative. Where an advocate was needed, staff supported people to access this service.
• Staff spoke knowledgeably about people's needs as well as their interests, which was accurate according to people's care assessments and plans. One staff member said, "We all read and discuss peoples' lives so we know what to talk about without upsetting them."
• People and relatives told us they were impressed with the range of activities provided and spoke highly of the activity co-ordinators and the work they did. People commented, "I love the quizzes," and "Really nice things to occupy me."
• There was a wide range of activities organised and these included, flower arranging, visits from the dog pet and arts and crafts. Which people told us they enjoyed. We saw people participate in bingo which they all thoroughly enjoyed. People told us, "Really enjoy our baking sessions, and the dog visits."
• Care plans demonstrated consideration was given to people's individual religious and cultural needs. Clergy from various faith groups attended the home on a regular basis and staff told us they would support

people to attend a local church of their choice.
• Notice boards were covered with information about up and coming events or something interesting or attractive to look at.
• The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals. For example, people who were non-verbal had detailed plans on how to communicate. This included pictorial menus, choice of activities and pain charts.
Documents had been created to go with people go to hospital and had people communication needs clearly documented.
• There were specific details in people's care plans about their abilities, needs and preferred methods of communication. There was pictorial signage around the home to help orientate people.

Improving care quality in response to complaints or concerns:
• There were processes, forms and policies for recording and investigating complaints.
• There was a complaints policy. People also had access to the service users guide which detailed how they could make a complaint.
• The provider kept a complaints log which showed that complaints were taken seriously, responded to appropriately. There was also evidence that complaints were analysed and lessons taken forward to improve care.

End of life care and support:
• All staff attended palliative/end of life care training and there was a provider policy and procedure containing relevant information. Staff demonstrated that they felt prepared and understood how to support people at the end of their life.
• Care plans identified people's preferences at the end of their life and the service co-ordinated palliative care in the care home where this was the person's wish.
• Care plans for one person who had an end of life care plan contained information and guidance in respect of when pain control may be required to ease their symptoms. These are known as 'Just in case medicines' (JIC).
• Staff demonstrated compassion towards people at the end of their life. They told of how they supported them health and comfort wise. This included regular mouth care and position moving. We were also told that families were supported and that they could stay and be with their loved ones at this time.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Aspects of leadership and management did not consistently assure person-centred, high quality care.

At the last inspection on the 09 April 2018, we asked the provider to take action to make improvements to the quality assurance systems. At this inspection, we found steps had been taken to drive improvement; however, these improvements were still not fully sustained or embedded. Therefore, this question remains Requires Improvement.

Understanding quality performance, risks and regulatory requirements:
• Since the last inspection the provider and manager had implemented some improved quality assurance processes. These included audits of care plans, staff files, complaints, safeguarding concerns, incidents and accidents, and quality satisfaction surveys.
• However, as discussed with the management team during the inspection, the systems had not identified some of the shortfalls we found. For example, there were some areas within care plans that had not been updated to reflect changes to peoples' health. For example, one person's care plan stated that passive exercises for a person's lower limbs should be undertaken, however a deterioration to the person's lower limbs would find this painful and therefore it was not appropriate care.
• Feedback had been sought from people but there was no clear documentation as to what was done as a result of the information received. For example, one visitor told us that they had raised issues about the cleanliness of their relatives' bedroom carpet. This had not been actioned or a reason shared of why this had not been dealt with. The manager confirmed that this would be addressed.
• The training programme identified some discrepancies and these were discussed. We were assured that the training was ongoing. For example, basic life support was booked for July 2019.
• Emergency equipment such as suction machines were kept in the locked clinical room but were not ready for use and staff had not checked they were working. The service supported people who were at risk of choking and those who were at their end of life, so this equipment needed to be ready and fit for use.
• These were areas that required further improvement.

Managers and staff were clear about their roles, and understanding quality performance, risks and regulatory requirements:
• People and relatives were positive about the leadership of the service. One person told us, "It's a very open culture here, someone is always about to talk to." Another person told us, "If I have to live in a home, I am happy its here." A relative said, "I believe it's well-led, they keep us informed ."
• Staff were equally as complimentary about the leadership at the service. One told us, "It's a great place to work," and "Very supportive, things are better here, really good communication now, lots of meetings."
• There were quality assurance systems in place to monitor the quality of care being delivered and the running of the service. The provider's management team undertook regular audits that looked at all aspects of care including clinical care, care planning, meal times, staff training, activities, the environment and

cleanliness.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• People and their relatives felt that communication between them and the home was open and transparent. One relative told us, "I feel consulted and involved. They contact me if my relative is unwell or if there has been an accident any sort of accident."
• Regular care staff meetings and department meetings were held and encouraged effective communication and gave staff an opportunity to raise concerns, make suggestions and share good practice.
• People were supported to complete surveys and attend resident meetings to capture their views and opinions. Evidence of changes to menus and activities indicated people's feedback had led to changes in some areas. In this way the service could find out people's preferences and involve them with how the service worked. The manager said
• Staff meetings were held and discussed topics including equality and diversity, MCA, expectations within employee roles, time sheets, and handover and communication sheets. The manager told us they had discussed changes to the mental capacity act and handed out leaflets for staff to refer to.
• Staff told us that they felt supported and were encouraged to progress within the service. One told us that they were in the process of applying for their nurses' registration and that this had been supported by management at the service.
• Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager had informed the CQC of significant events including significant incidents and safeguarding concerns.
• This ensured we could effectively monitor the service between our inspections. When needed, the management team provided information to us to help with our enquiries into matters.

Continuous learning and improving care:
• Throughout our inspection we saw evidence the provider and the manager were committed to drive continuous improvement.
• The provider and manager were open and transparent when discussing the areas to further develop and immediately started to put actions into place. For example, all pressure relieving mattresses were checked and a new check list introduced to reduce risk.
• A member of staff told us the organisation encouraged learning. The team were able to access career development opportunities and qualifications, and ideas were shared from other services within the organisation. The staff member believed this had contributed to their learning and skills had improved and good practice ideas shared.
• The manager facilitated coaching sessions and reflective opportunities, and staff confirmed this. One staff member said, "If there is a medicine error or incident/accident, we discuss it as a team and look at actions we can take to prevent it happening again."
• The service valued sharing information and team meeting minutes covered various topics such as people's changing needs, falls, incident debriefs, evening activities and engagement and fire drill practices to build confidence.

Working in partnership with others:
• Ersham House continued to work in partnership with the local community, other services and organisations.
•Health and social care professionals confirmed that the service communicated and worked effectively with other agencies to benefit people using the service.
• Staff continued to hold multi-disciplinary team meetings to discuss people's needs and wishes. A visiting

professional told us, "I've held reviews here with the person, GP and families and have always been made welcome."
• The service had a good working relationship with the local authority and contract monitoring officers and took the initiative to seek feedback from the safeguarding team. The manager welcomed feedback as a learning tool to prevent re-occurrences of incidents.