Zion Care Homes Limited

Elvaston Lodge Residential Home

Inspection report

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Alvaston
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Derbyshire
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Tel: 01332572444

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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

About the service:
Elvaston Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elvaston Lodge accommodates up to 44 people in a purpose built building. At the time of the inspection there were 32 people in residence who were aged over 65 years.

People's experience of using this service:
● We found improvements had been made following the previous inspection of Elvaston Lodge by the Care Quality Commission.
● We found Elvaston Lodge met the characteristics of a 'Good' service.

● People told us they felt safe and had confidence in the staff who provided their care.
● Potential risks were assessed on an ongoing basis when people's needs changed. This reduced risk and ensured people's needs continued to be met. This promoted people's health, welfare and safety.
● People were supported by staff who had undertaken training and were knowledgeable about people's needs and who had their competency assessed.
● People's needs were regularly reviewed with their involvement or that of a family member. Where people's needs changed, referrals were made to the relevant health care professional, which included the review of prescribed medicines.
● People lived within a well-maintained environment, which took account of people's needs and provided signage to help them navigate around the service.
● People's rights and choices were promoted on an ongoing basis. Where people were not able to make informed decisions, then decisions were made in their best interest. Family members were consulted about their relative's health as part of best interest decisions.
● People's equality and diversity was respected and their privacy and dignity maintained.
● People spoke positively about the meals provided. Mealtimes were seen as an important social event, with staff eating their meal at the dining table to promote conversation. Family members were encouraged to join their relatives for meals.
● Staff spoke positively about the staff. We observed positive examples of staff interacting with people. However, we did note missed opportunities for staff to engage people in conversation and ask them if they required any assistance.
● Staff provided consistent care by following people's care plans.
● Staff had effective systems in place to share information about people so they could respond to people in a timely and coordinated manner, which included the verbal sharing of information and the recording of information electronically.
● People's views and that of their family members were sought. The registered manager implemented

changes based on the feedback they received.
● Staff, people and family members spoke positively about the management of the service.
● The provider had systems in place to monitor the quality of the service through auditing. Audits in a range of topics and areas were undertaken by members of the management team. Action plans were developed following audits to drive improvement.
Rating at last inspection: Requires improvement. The last report for Elvaston Lodge was published on 07 February 2018.

Why we inspected:
This was a planned comprehensive inspection based on the rating from the previous inspection.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

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

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 well-led

Details are in our Well-Led findings below.

Good

Elvaston Lodge Residential 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 was carried out by two inspectors 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.

Service and service type: Elvaston Lodge is a 'care home'.

Elvaston Lodge had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: Inspection site visit activity took place on 13 March 2019 and was unannounced.

What we did: We used the 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.

Our planning took into account information we held about the service. This included information about incidents the provider must notify us about, such as abuse; and we looked at issues raised in complaints and how the service responded to them. We obtained information from the local authority commissioners.

We spoke with two people and seven family members who were visiting their relative.

We spoke with the registered manager, deputy manager, operational manager, administrator, three members of care staff, a catering assistant and the activity co-ordinator.

We looked at the care plans and records of four people. We looked at three staff records, which included their recruitment, induction, on-going monitoring and training. We looked at the minutes of staff meetings and records related to the quality monitoring of the service, which included complaint investigations carried out by the provider.

Good

Is the service safe?

Our findings

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

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

At our previous inspection of 13 and 29 November 2017 we found the registered person had not ensured risks to the people using the service were mitigated and robust infection control systems were in place. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had been made.

Assessing risk, safety monitoring and management:

- People told us why they felt safe. One person said, "I feel safe because there's always somebody here if I need them."
- We asked staff for their views as to how people's safety was promoted. A staff member told us, "Every department working together is what makes it safe. We have risk assessments which reduce risk. For example, sensor mats let us know if anyone is moving around who might be at risk of falling."
- Potential risks to people were assessed, which included a range of topics for example; falls, skin integrity, nutrition, mobility, eating and drinking. Where potential risk were identified, measures were put in place to minimise risk. For example, the use of equipment to support people such as a hoist or walking frame.
- An individual risk assessment had been undertaken which identified the level of risk to the person should they be required to evacuate the service in an emergency. The personal emergency evacuation plan (PEEP) was colour coded dependent upon the level of risk. For example, increased risk due to the need for equipment or for more than one member of staff to provide support. PEEPs were stored in a central location so they could be easily accessed in an emergency.
- People's capacity was considered when decisions were made about potential risk to ensure any restrictions on people to promote their safety were implemented in their best interest.
- Information held about people was electronically stored and password protected. Staff were responsible for the updating and reading of people's records. This ensured information was up to date and safely secured.
- A 'sun screen station' was located on the wall by the door of the ground floor lounge, which gave access to the garden area. Information about the protection of skin from the sun, a dial to indicate the daily UVA, along with a mirror provided. The display included a sun lotion dispenser attached to the wall to encourage people and staff to consider skin safety before going outside.
- The registered manager informed relevant agencies, such as the local authority, the Care Quality Commission (CQC) or a health care professional when a person sustained an injury as a result of an accident or incident. For example, from a fall.
- Robust systems were in place to ensure equipment within the service was maintained. For example, fire systems, moving and handling equipment and utilities such as electrical appliances and installation, gas and water.

Preventing and controlling infection:
● Anti-bacterial gel and hand lotion dispensers were sited throughout the service for staff and visitors to use.

● Staff were seen to wear personal protective equipment (PPE) including gloves and aprons when they supported people with personal care and when serving meals and drinks.
● Audits were undertaken to ensure infection control measures were effective, which included a visual check on equipment such as mattresses to ensure they were in good working order, free from stains or tears.
● Policies and procedures on preventing and controlling the spread of infection were in place.
● Staff underwent training on the prevention and controlling of infection.
● The food standards agency had visited in June 2018 and awarded the kitchen a 4-star rating of Good. (The ratings go from 0-5 with the top rating being '5').

Systems and processes to safeguard people from the risk of abuse:
● There were safeguarding and whistleblowing policies and procedures to guide staff on what action to take should they have any concerns. These are laws that protect whistle-blowers from being unfairly treated for reporting misconduct.
● The registered manager was proactive in ensuring alerts were sent to safeguarding teams and informed other relevant organisations such as the CQC.
● Systems to track the progress and outcome of safeguarding referrals were overseen by the registered manager, which included any action taken in response by the registered manager. For example, additional staff training or supervision.
● Information about safeguarding was displayed on notice boards within the service.

Staffing and recruitment:
● Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people, which included a completed application form, full work histories, references and a record of their interview.
● Prior to commencing in post staff had a Disclosure and Barring Service check (DBS). The DBS assists employer to make safe recruitment decisions by ensuring the suitability of individuals to care for people.
● People told us they didn't have to wait long for staff to assist them. One person said, "You don't have to wait if you press the buzzer. They [staff] come quickly."
● The registered manager determined staffing levels by assessing the dependence of people. This enabled them to calculate the number of hours of support people required and the number of staff needed to provide safe care.
● The registered manager used three staff from an agency when staffing levels could not be met by the service due to staff absence. However, the use of agency staff was minimal with staffing levels being maintained by staff employed by the provider.
● The registered manager, consistent with the providers' policies and procedures monitored unplanned staff absence.

Using medicines safely:
● People confirmed staff managed their medicines safely. One person said, "I get my medicine on time and it has never run out. And if you need painkillers they'll give you some."
● A medicine policy and procedure was in place, which was linked with good practice guidance and legislation. This included guidance on the action the service was to take when people did not have the capacity to make an informed decision about the administration of their medicine.
● The service had a dedicated clinic room and we saw that suitable systems and checks were in place to ensure people's medicine safely and securely stored.

● People's medicine was managed safely. Medication administration records were accurately completed and stocks of medicine were correct.
● Staff sat and spoke with each person while they took their medicine, to ensure they took their medicine and that the person had a drink.
● People's records showed that where a person did not have capacity to make an informed decision about their medicine a best interest decision had been made. This included where people's medicine had been authorised to be given 'covertly' (without the persons knowledge) and the circumstances as to how. For example, to be included in food.
● Staff received training in the management of medicine and their competency to manage medicine was regularly reviewed, this was confirmed by staff we spoke with. A member of staff told us, "I had to be observed by a manager and complete a work book. They [manager] watched me until they were 100% confident, I have to check and recheck before giving medicines and make sure they have been taken before signing the sheet."

Learning lessons when things go wrong:
● Audits were undertaken in key areas for example falls. Each fall was documented and tracked to determine if there were any patterns to falls. For example, increased falls for an individual, or a time of day or location. We saw that where a person had had increased falls, people's risk assessments and care plans were reviewed. Appropriate referrals were made to health care professionals to determine if there were any underlying reasons such as an infection.
● The registered manager when they received safety alerts or recalls from external companies for example on equipment. Checks were undertaken to see if the service had any of the equipment identified and if so guidance as detailed within the alert was followed.

Good

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
- People's needs were assessed by commissioners of the funding authority or by the registered manager to determine whether the service could meet their needs.
- Assessments covered all aspects of people's health, care and well-being and people's needs were regularly reviewed and used to develop and update their care plans.
- Audits were undertaken to ensure everyone's assessment had been reviewed as a result of any changes to their wellbeing, for example following a fall or a period of ill health.

Staff support: induction, training, skills and experience:
- Records showed staff have received a full induction and had the opportunity to work alongside experienced members of staff. A recently recruited member of staff spoke of their induction. They said, "Brilliant induction, we met with the manager, she showed us around and went through policies. The manager then worked with a group of new staff telling us what was what, policies and procedures, making sure we know what to do if there are any concerns."
- The registered manager had recently introduced a 'buddying system'. The purpose is to provide further support and a learning opportunity for staff to work alongside other staff who have been identified as having key skills to share and good practice.
- Staff were positive about their opportunities to feedback through supervisions. A staff member told us, "We give feedback on our training at supervisions and if we want any fresher training, we can ask and it is provided."
- Staff who had not previously worked in care completed the Care Certificate. The Care Certificate covers an identified set of standards which health and social care workers are expected to implement to enable them to provide safe and effective care.
- Staff work towards attaining vocational qualifications in care. In addition, staff receive training in key topics to promote people's health, safety and welfare. Staff learn key skills to enable them to meet people's individual and specific l needs, for example training in dementia awareness and food and nutrition.
- Staff within the handover, where information about people's care and health were discussed and shared when staff arrived on duty, showed a good understanding of people's needs. This included understanding how the different types of dementia affected people. Staff were able to talk about people's specific behaviour and link in with the health. For example, a person waving their hands in front of their face, which was probably due to them experiencing an hallucination.

Supporting people to eat and drink enough to maintain a balanced diet:
- People spoke positively about the food. One person told us, "The food is good, there's always two choices. For breakfast I can have an egg – poached, boiled, scrambled or fried with bacon. Sometimes the chef tells

me he's got some mushrooms and do I want them." They went onto say, "If I sleep in I can have a late breakfast."

● Assessments identified people's needs with regards to food and drink. Specialist diets to meet people's needs were provided. For example, diets to support medical conditions such as diabetes.

● Risk assessments identified people at risk in relation to eating and drinking so that measures could be put into place to ensure people had sufficient to eat and drink. For example, those at risk of poor food or fluid intake had their daily intake monitored and their diet tailored to meet their needs, such as a high calorie diet.

● People at risk of choking were referred to a speech and language therapist and their recommendations to provide a soft diet and thickened fluids were implemented.

● People were regularly offered hot drinks throughout the day along with snacks, which included biscuits, crisps and fruit. Jugs of cordial drinks were available in the lounge/dining rooms. However, we saw missed opportunities for staff to respond to people when they asked for a drink. For example, one person told us "I'm so thirsty, I would like to have a drink of that [pointing to a jug of juice] The person wasn't able to tell staff as they were too far away. The registered manager told us they would speak with staff about the importance of encouraging fluids.

● Menus in written and picture format were placed on each dining table. People were offered each day to make a choice from the menu. At lunchtime people were offered a squash or wine, where people requested a hot drink this was provided.

● Mealtime were very much seen as a time to promote social interaction. The registered manager and staff sat with people to eat their meal to encourage conversation. Family members were encouraged to join their relative at meal times, we saw relatives took the opportunity to share a meal with their relative.

● Assistance to eat and drink was provided by staff where required and people were provided with adaptive cutlery and crockery where required to enable them to eat and drink independently.

● Catering staff were aware of people's dietary needs, their dislikes and preferences. Any changes to people's dietary needs were effectively and timely communicated to catering staff.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:

● People had regular contact with a range of healthcare professionals to promote their health and welfare. Contact with healthcare professionals, which included opticians, district nurses and doctors were recorded as with the outcome of the consultation.

● A community psychiatric nurse joined the staff handover to share information about their consultation with one person. This showed how staff actively worked with other health care professionals to share information so they could support and care for people.

● Concerns about people's health and welfare were shared in staff handover meetings and actions agreed. For example, contacting a doctor to query information on a person's hospital discharge sheet.

● A 'red grab bag' was in place, which accompanied people when they accessed emergency health care. The bag included information about the person's medicine and an outline as to their care and health needs. Where possible staff accompanied the person in the ambulance to provide information directly to hospital staff.

Adapting service, design, decoration to meet people's needs:

● Elvaston Lodge was purpose built. Both the ground and first floor provide a lounge/dining room, bedrooms and bathing and toilet facilities.

● The ground floor lounge/dining room provided flat level access to the courtyard to the side and rear of the service. The courtyard provided a secure and safe place for people to sit, which included a summer house. The courtyard had areas of interest for people to look at, which included raised planters, bird feeding

stations and garden ornaments.
● An activity room was in process of being developed to provide a separate area for people to engage in activities, in addition to the communal rooms.
● Signage was in place throughout the service to help people in finding their way around. Signage was in a pictorial and word format, and included signs advising people as to the route to communal rooms, toilet and bathing facilities. People's bedrooms had a photograph of them to assist people.
● Areas of interest were sited throughout the service, which included interactive puzzles such as O and X's game and number games attached to the walls of corridors. This supports people living with dementia to engage in activities whilst they walk around Elvaston Lodge.
● The walls of corridor included photographs of local points of interests, alongside was written information about the photograph and in some instances its link to people at the service.
● We noted that the layout of comfy chairs in the communal rooms meant people sat in two rows, directly looking at each other. The layout did not promote people to speak with each other and restricted the view of the television for some, which was on a wall. The registered manager said they would take our feedback into consideration and look as to how, with people's involvement and consent changes could be made.

Ensuring consent to care and treatment in line with law and guidance:
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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● People's capacity to make informed decisions about their health, care and welfare were assessed and regularly reviewed. Where assessments had identified people did not have the capacity to make an informed decision, then a best interest decision was made on their behalf, which involved health and social care professionals where appropriate and family members.
● A number of people at the service, who did not have the capacity to make an informed decision had an authorised DoLS in place, which placed restrictions on them, for example leaving the service without being accompanied, as this would place the person at risk.
● Records showed, some people had a 'paid persons representative' (PPR) whose role is to monitor the DoLS authorisation. The PPR visited the person and reviewed their records to ensure the DoLS was being appropriately applied.
● We found records did not provide evidence to support and reflect how the decision that a person did not have capacity had been arrived at. The registered manager said they would make improvements to record keeping.
● Staff had received training on the MCA and our observations showed that staff always sought people's consent before providing care and support.
● We found staff to be knowledgeable about capacity and the promotion of choice. A recently recruited member of staff said. "Capacity, is about decision making and always making sure that people make as many choices for themselves as possible and when they can't making decisions for them in their best interest."

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

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

Ensuring people are well treated and supported; respecting equality and diversity:
- People told us staff provided support when they needed it. One person said. "Staff here are good, if they see you they'll speak to you. I would recommend it here to anybody."
- A person told us how staff had supported them, they told us. "On Remembrance Day [activity organiser] took me to a memorial service in my wheelchair. We went on to the Legion and had a drink. I had mentioned to them that no one was taking me so she arranged it. She's like that, she [activity organiser] gets things and sorts it. I really enjoyed the day."
- We observed some positive interactions between people and staff. For example, one person had a loose thread on their trousers, which was agitating them. Staff asked the person what was upsetting them and they removed the thread.
- Staff were seen to steer a conversation in an alternative direction when a person made judgemental comments about a person's appearance. This promoted a positive conversation about choice and celebrating people's differences.
- To assist with communication, the service has a communication board including symbols and pictures to support people in expressing their needs.
- Notice boards were used to share information which included information as to equality and diversity. A notice board contained a fact sheet about 'transgender in older life' published by Age UK.
- We saw several occasions where staff responded to people who became upset. Staff spent time sitting with the person and providing reassurance.
- All staff we spoke with demonstrated a commitment to providing high quality care and spoke with affection about people at Elvaston Lodge. This included staff discussions about people's welfare during staff handover.
- Staff had completed training in equality and diversity and we observed staff supported people in a non-discriminatory way.

Supporting people to express their views and be involved in making decisions about their care:
- There were opportunities to share and support people in relation to care decisions. Staff, which included the registered manager and deputy manager were seen speaking with family members when they visited. Staff spoke about people's health and well-being, which included sharing information when people had been discharged from hospital.
- The registered manager was heard to consult with people's family members by telephone, when decisions about people's care were made when the person themselves did not have capacity to make an informed decision.

Respecting and promoting people's privacy, dignity and independence:

● People were supported to maintain relationships; family members and friends were encouraged to visit. Visitors were offered a drink and in some instances shared a meal with their relative.

● People were dressed in clothing of their choosing and their dignity was promoted by ensuring people were presented well and clothing changed as and when required.

● People were encouraged to personalise their rooms, for example with photographs and other items from home.

Good

Is the service responsive?

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support:

- People's care plans were person centred and contained individualised and specific details to ensure people's care needs were met.
- The providers understanding of communication and its importance to those who used the service demonstrated that they understood and met their obligations to support people in line with the requirements of the Accessible Information Standard (AIS). The AIS makes it a legal requirement for all providers who support publicly funded care to ensure people's communication needs, including access to information are understood and met. Signage and information, for example menus was provided in word and pictorial format.
- People's care plans provided information as to how people communicated. We saw staff provide clear verbal instructions when supporting someone with a sight impairment. Staff informed the person when they sat down that a table had been placed in front of them and the location of their drink.
- Information about people's care was shared in a timely manner. Staff took part in 'handovers' where information as to people's health and welfare was shared between staff. This enabled staff to respond to people's needs as they changed. For example, information was discussed at the lunchtime handover as to how to encourage a person to eat and drink, who had declined food and drink during the morning.
- Family members were invited to attend meetings to review their relatives needs to be recorded within their care plan. Where people were not able to attend people's, views were sought via the telephone or e-mail. This was confirmed my family members we spoke with.
- Opportunities for people and family members to talk about their wishes should they became unwell were provided. People's wishes were recorded and any actions as a result of their comments were actioned. For example, some people had in place a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).
- Staff provided end of life care and followed a care plan, which was agreed by the person and their family members. At the time of the inspection no one was receiving end of life care.
- The service had received thank you cards. A majority of these were from family members thanking staff for the care shown to their relative, who had passed away.
- A document entitled 'This is about Me recorded key background information about people. For example, their work and family life and information as to their hobbies and interests and their beliefs.
- A person told us how staff had purposefully set up a table with their watercolour paints and palette so that they could continue with their interest in painting.
- Staff told us how information gathered from people helped then to support people. A staff member said, "We have several people who worked at Rolls Royce at about the same time. They didn't know each other then, but they like to talk about the old times and share their memories of things that went on, like times in the canteen."

● People were encouraged to take part in activities, however staff did not always maximise the opportunities available to them to spend time and engage with people. For example, we noted staff sitting in the dining and lounge area by themselves, whilst people sat in armchairs.
● We did see a member of staff, who danced and sang along to several tunes whilst they provided care. People were seen to smile and laugh along with the staff member.
● People were asked what music they wished to listen too or the television programme they wished to watch. However, due to the layout of the lounge and the positioning of the television, not everyone could see the screen.
● An activity organiser was in post. However, the opportunity for them to encourage people to take part in activities was limited by the number of people at the service, and by people spending their day on either the ground or first floor, with some people choose to spend their time in their bedroom. The registered manager and operations manager told us they would reflect upon our comments and review the staffing arrangements to see if additional resources could be made available.
● People who spent time with the activity organiser enjoyed their time. One person enjoyed a long conversation on many topics. Staff were seen to be encouraging to others to take part in a group conversation, where a range of topics which included grandchildren, tattoos and ice-cream.
● Activities were provided by external organisations who visited the service. For example, theatrical and musical events, animal shows which included a dog under the Pets As Therapy (PAT) scheme. A mobile library visited monthly and children from a local school visited.
● A local Chaplin visited Elvaston Lodge weekly and a Church service was held every fourth week on a Sunday, which was facilitated by a local Christian Church.

Improving care quality in response to complaints or concerns:
● A family member told us they had had raised two concerns, which were dealt with and that they were happy with the response they had received. They told us there had been no reoccurrence of the issue that had caused them concern. Everyone we spoke with felt able to raise concerns with the registered manager or staff, and felt that any issues would be addressed.
● The provider had a complaints procedure, which was displayed on notice boards throughout the service. The complaints procedure included information about external agencies which could support people with complaints.
● Complaints were investigated and action was taken to address the issues and prevent reoccurrence in the future where possible.

Good

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

Good:The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
● People and staff spoke positively about the management of the service and made reference to the new registered manager. A member of staff told us, "The home is much better since [registered manager] came. There is more in place and she gets the staff on board. She asks for suggestions, I said I wanted some practical training for things like moving and handling. She arranged it for us."
● The management team had systems and processes in place to monitor the day to day culture of the service, which included monitoring of the staff through supervision and appraisal.
● The registered manager was visible within the service. This was achieved in part by an audit known as 'walk the floor', where they recorded their observations and provided feedback to staff, which included action points for improvement.
● The registered manager and deputy manager undertook unannounced 'spot checks' during the evening and at weekends to ensure the quality of care people received was consistent and not dependent upon the time of day and whether managerial staff were onsite.
● The registered managers office had been moved to the entrance foyer to make it easier for visitors to speak with them.
● The registered manager ate their lunchtime meal with people, to provide a further opportunity for people and visitors to speak with them and to spend time with staff.
● The provider and registered manager responded to complaints and concerns in line with the Duty of Candour. We found letters of apology had been written to complainants.
● The registered manager wrote to people using the service and family members about changes to legislation with regards to the storage and sharing of personal information. This was to comply with the General Data Protection Regulation (GDPR). People or their family member were asked to confirm their continued consent.
●The provider had a Certificate of Assurance confirming the safety and security of the electronic system.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
● The registered manager was supported by the operations manager and regional manager, who regularly visited the service in line with the key areas of responsibility. Audits were undertaken by the operations manager and regional manager. Action plans were developed to address any shortfalls and to continually improve the quality of the service being provided. For example, it was noted improvements were needed to ensure staff spoke with people and recorded information to promote respect and dignity. Staff training in communication and its importance had been planned.

● A robust system was in place for the management of people's monies for everyday expenditures, such as the purchasing of newspapers, toiletries or for accessing services such as chiropody or hairdressing. Each person had an electronic running record of monies held and receipts were kept of all expenditures.
● The registered manager and the management team provided staff with constructive feedback through team meetings, supervision and appraisal. To acknowledge staff who go above and beyond in improving the quality of life for people, the provider was launching an 'employee of the month award'. Nominations for the reward were through visitors and family members and staff. The recipient of the reward received an extra day paid leave. Their achievement to be displayed within the service on a notice board, which detailed why they had won the award.
● The provider had a business continuity plan in place, which detailed how the people's needs were to be met in the event of an emergency, for example if the service experienced a utility failure or a flood.
● We found the provider had displayed the rating from inspections awarded by the Care Quality Commission (CQC), both within the service and on their website, which is a legal requirement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● Staff meetings regularly took place and were used as an opportunity to share information for improving the quality and care of people.
● People's views and that of their family members were regularly sought through the sending out of questionnaires and were a key factor in the development of the service.
● A notice board, displayed the outcome of the questionnaire and the actions taken by the registered manager. For example, an activity co-ordinator had been employed as questionnaires had made reference to the lack of opportunities for people to engage in daily activities and conversation. Photographs of people's participation in activities had been displayed in response to people's comments. And the corridors within the service were also in the process of being decorated following comments in questionnaires.
● Meetings involving people and their families were regularly held. The minutes of recent meetings had recorded people's enjoyment of recent entertainments, which included children from a local nursery school visiting to join in arts and craft sessions with people at Elvaston Lodge.

Continuous learning and improving care; Working in partnership with others:
● The management team had in place action plans to ensure the service continually developed for the benefit of people at Elvaston Lodge. Developmental plans included a training suite for staff to support in them in their development and learning.
● The registered manager had links with external health care professionals, which included a community matron who provided staff with training in key areas to maintain and people's health and welfare.
● The registered manager told us they attended meetings with local commissioners and other providers to identify areas for improvements and aims for social care provision in the future.
● The registered manager accessed information from external organisations to keep up to date with good practice.