Care UK Community Partnerships Ltd

Elizabeth Lodge

Inspection report

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 15 and 16 November 2016 and was unannounced. Elizabeth Lodge Care Home provides accommodation for 87 people who require nursing and personal care. On the day of our inspection there were 75 people using the service. The home has three floors with units located on the lower ground, ground and first floor.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on September 2015, we found that some aspects of medicines management were not safe. The service could not demonstrate that staff members had received an appraisal. These resulted in breaches of Regulation 12, and 18 of the Health and Social Care Act 2008.

During this inspection we found that appropriate actions had been taken and improvement had been made to ensure the safe management of medicines. The registered manager had also completed appraisals for the last year for all staff employed.

Although the home had organised activities which took place centrally within the home, we found very little activity or stimulation on the individual units especially involving those people who were unable to leave the unit due to mobility or health conditions.

People and relatives that we spoke with highlighted concerns around the low staffing levels within the home. Appropriate level of need assessments had been completed, which determined the staffing levels. We observed there to be sufficient staff available to support people. However, due to the way staff were deployed and allocated to work on the units, there were occasions where staff were not visible on the units and people were left on their own for a certain period of time.

People were provided with a healthy and balanced diet which allowed for choice and preference. However, some people, on particular units, who were supported in their own bedrooms had to wait up to 30 minutes before a staff member assisted them with their meal.

Risks associated with people's care and support needs had been identified and these had been assessed giving staff instructions and directions on how to safely manage those risks. However, where people had been diagnosed with a specific health condition that would potentially affect their mobility, this had not been risk assessed or linked into their moving and handling assessment to ensure that care staff had the appropriate guidance on how to support the person and ensure their safety especially when mobilising.

The registered manager, senior managers and care staff demonstrated a good level of understanding of the

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications to the local safeguarding authority for each person who required an authorisation to ensure that people were legally being deprived of their liberty which was in their best interest. However, where an authorisation had been granted with conditions that the service had to adhere to, these had not been reflected within people's care plans to ensure staff were aware of the actions that needed to be taken to meet those conditions.

Mental capacity assessments and best interest decisions had been completed for people depending on the specific decisions that needed to be made. However, these were not consistently available in all care plans that we looked at especially where decisions had been made for people to have a valid 'do not attempt cardio pulmonary resuscitation' (DNACPR).

All staff that we spoke with confirmed that they felt supported within their role and received regular supervision. Staff also confirmed that they had received an annual appraisal which discussed their performance and development plans. However, staff files that we looked at did not confirm that supervisions were taking place at the frequency stated within the provider's supervision policy.

Care plans were detailed, person centred and specific to each person and their needs. People's likes, dislikes and care preferences had been noted.

On both days of the inspections we observed some caring and person-centred interactions between staff and people living at the home. We especially noted the positive interactions between the chef at the home with people and their relatives.

Systems were in place which monitored the quality of service provision with a view to making improvements. This including regulatory governance audits and quality surveys completed by people using the service and their relatives. Improvement plans were in place which detailed the issues, the actions to be taken and a date by which these actions needed to be completed. This ensured that lessons were learnt and steps had been taken to minimise re-occurrence.

People told us that they felt safe and were happy with the care that they received at Elizabeth Lodge. Care staff were aware of what constituted abuse and the actions they would take if abuse was suspected.

Safe and appropriate recruitment processes had been followed by the home. This included obtaining criminal record checks from the disclosure and barring service, previous employment history and references from previous employment confirming past conduct especially when working with vulnerable adults.

Most people and relatives knew who the manager was and felt comfortable in approaching the manager if they had any concerns or issues that they needed to raise. Care staff told us that they enjoyed working at the service and that their priority and focus was that of the people they supported.

A complaints policy was available and procedures on how to complain were on display at various points around the home. People and relatives that we spoke with were clear about who to complain to.

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. Staff were aware of what constitutes abuse and what steps they would take to protect people. Risks to people were identified and managed to ensure people were safe. However, where people had been diagnosed with a specific health condition this had not been linked into the relevant risk assessments.

During the inspection we saw that there were sufficient numbers of staff to meet people's needs. However, due to the way staff were deployed and allocated to work on the units, there were occasions where staff were not visible on the units and people were left on their own for a certain period of time.

Safe recruitment processes were followed and the required checks were undertaken prior to staff starting work.

People were supported to have their medicines safely.

Is the service effective?

Good

The service was effective. People were provided with a healthy and balanced diet which allowed for choice and preference. However, some people, on particular units, who were supported in their own bedrooms, had to wait up to 30 minutes before a staff member assisted them with their meal.

Staff received training to provide them with the skills and knowledge to care for people effectively. Supervisions and appraisals formed part of each staff members support and development programme. However, not all staff received supervisions in line with the provider's policy.

The registered manager and staff members had sound knowledge of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and its importance. However, where conditions had been set as part of the authorisation this had not been reflected in the person's care plan.

People had access to health and social care professionals to make sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring. People were treated with kindness and compassion. We observed positive and caring interactions between staff, the people that lived at Elizabeth Lodge and their relatives.

People were treated with respect and dignity.

People and their representatives were supported to make informed decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was responsive.

The home had organised activities which took place centrally within the home. However, we found very little activity or stimulation on the individual units especially involving those people who were unable to leave the unit due to mobility or health conditions.

Care plans were person centred and reflected how people were supported to receive care and treatment in accordance with their needs and preferences. The registered manager had recently introduced life story booklets, which were to be completed by the person living at the home and their relative.

The home had a complaints procedure and people and their relatives were aware of who to talk to if they had any concerns.

Is the service well-led?

Good

The service was well-led. Relatives and care professionals informed us that the registered manager was approachable.

Staff were positive about the management of the home and felt supported in their role. Staff told us and minutes confirmed that regular staff meetings were taking place.

The quality of the service was monitored as regular audits had been carried out by the registered manager and the provider.

Elizabeth Lodge

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 15 and 16 November 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist nurse advisor 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 we visited the home we checked the information that we held about the service and the provider including notifications and significant incidents affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asked the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at action plans that the provider had sent to us following the previous inspection on September 2015.

We contacted the local commissioning team and a number of health and social care professionals in order to obtain their feedback about the home and the service that it provides to people.

During the inspection we observed how staff interacted and supported people who used the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

During the two day inspection we spoke with 15 people, 19 relatives, the registered manager, deputy manager, two quality improvement managers, the chef, four nurses, seven care staff and one receptionist.

We reviewed 18 care plans, ten staff files, training records and records relating to the management of the service such as audits, resident, relative and staff meeting minutes and a number of policies and procedures.

Good

Is the service safe?

Our findings

Most people and relatives that we spoke with told us that they felt safe living at Elizabeth Lodge. Relatives that we spoke with told us, "I am sure she is safe" and "Safe, Yes he is."

People and relatives that we spoke with throughout the inspection told us that they believed the home to be short of staff and that there was a need for more staff to be allocated on each unit. Comments we received from people and their relatives included, "Sometimes shortage of staff" and "There seems to be a shortage of staff especially at lunchtime." Our observations, during the inspection, were that staff did not appear to be rushed, the atmosphere within the home was calm and relaxed and people's needs appeared to have been met. We also looked at how staffing levels were determined within the home. The registered manager explained how the level of needs assessments had been completed for each person living at the home. The assessment took into account people's care and support needs including the level of support they required with moving and handling and their cognitive behaviours. Based on the answers a score was given which calculated the number of hours support required per person, which culminated into a guideline of how many staff should be allocated per unit.

From our observations we found that there was an issue around the deployment of staff on each unit, their visibility and availability. There were occasions when we had entered the unit and could not see any visible staff available, especially where there were four to five people sitting in the communal lounge with no staff available, if support was required. We walked around the unit and found that staff were in people's rooms supporting them with their care needs. This was confirmed as some people had a sign outside their door stating "I am being assisted." We highlighted this to the registered manager and stated that the lack of visible staff available on the units may be the reason why people and relatives were complaining about the shortage of staff. The registered manager confirmed that she would look into how staff are deployed on the units and provide lead nurses and team leaders with a guideline of how staff should be visible and available with a view to improving the situation.

Staff files demonstrated that the provider followed safe recruitment practices. We looked at ten staff recruitment records. Records showed the provider collected two references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Staff members were not offered a post without first providing the required information to protect people from unsuitable staff being employed at the home.

Risks associated with people's care and support needs had been identified and these had been assessed, giving staff instructions and directions on how to safely manage those risks. Risk management plans were specific to the individual and were clear and evidence based. These covered areas such as moving and handling, falls, use of call bells, epilepsy, skin integrity and health and safety. Risk assessments listed information on how to mitigate risks, directions to staff on what they should do to minimise risks and triggers that could lead to specific incidents such as an epileptic seizure or behaviours that challenged. Where a person demonstrated behaviours that challenged, de-escalation techniques were available to staff ensuring that the person was supported appropriately and safely. Risk assessments were reviewed every

month or more frequently if required and were updated when there was a change in a person's condition.

However, where people had been diagnosed with a specific health condition that would potentially affect their mobility, this had not been risk assessed or linked into their moving and handling assessment to ensure that care staff had the appropriate guidance on how to support the person and ensure their safety especially when mobilising. We spoke to the registered manager and deputy manager about this, who confirmed that they would address this oversight immediately and ensure all risk assessments were re-visited to ensure significant health conditions, where appropriate, were linked into the appropriate risk assessments.

Skin integrity was assessed using Waterlow charts to determine risk levels. Waterlow charts are a tool for assessing the risk of developing pressure ulcers. Records showed that the charts had been completed and the level of risks were being determined. Action plans and risk assessment had been created for people at risk of pressure sores. Records showed one person had a pressure sore, which had healed. There was a comprehensive action plan in place to minimise the risk of the pressure sores returning. This included four hourly re-positioning, recording fluid and food intake and applying creams. Records showed that this was being completed. The nurse allocated to the unit was able to tell us how to prevent and manage pressure sores such as reporting any redness in people's skin, repositioning regularly, offering drinks and keeping people active.

Staff were aware of what constituted abuse and the action they would take if abuse was suspected. Staff told us that they would report any allegation of abuse to the registered manager. One staff member told us, "Safeguarding is about protecting vulnerable adults and we would immediately report any concerns to the management." Another care staff told us, "When a resident is vulnerable and you think they may be being abused. I would report this straight away." All staff had received training in safeguarding adults and this was reviewed annually. Staff understood the term 'whistleblowing' and to whom this must be reported to. Staff were aware that they would need to report this, even if this involved a colleague with whom they worked with. They were also aware that they could report any concerns to the local authority safeguarding department and the Care Quality Commission (CQC). The service had a safeguarding policy and whistleblowing policy which included details of the local safeguarding team and the CQC.

At our last inspection on September 2015, some aspects of medicines were not being managed safely. A number of issues had been highlighted which included information about people's allergies had not been appropriately recorded, accurate records had not been kept of when people's medicines had been administered, appropriate legal processes had not been followed where people were administered medicines covertly and records of people's personal details had not been disposed of confidentially.

During this inspection improvements had been made with medicine management. We found that people's medicines were managed safely to ensure they were protected against the risk of unsafe administration of medicines. We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that appropriate supplies were available to enable people to have their medicines when they needed them.

As part of this inspection we looked at the Medicine Administration Records (MAR) for 31 people. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. Allergy information was also recorded on the MAR chart.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual when required protocols were in place. These protocols informed staff about when these medicines should and should not be given. This meant there was information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they needed them and in way that was both safe and consistent.

On one unit we saw two people received medicines which were disguised in food or crushed. However, there were no best interest assessments in place to support this decision. We brought this to the attention of the registered manager and deputy manager who were able to locate the documents, which were appropriately placed on the person's medicine record the same day. On the second day of the inspection we again looked at a further two people's care plans and medicine records, where they were noted to receive their medicines covertly, to confirm that the appropriate paperwork was on file to support this decision. We saw that a Mental Capacity Assessment (MCA) and a best interest decision had been completed and appropriate paperwork had been completed by the GP and pharmacist supporting the decision.

We saw medicine was stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature. Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

Records showed that all qualified staff had completed medicines management training and that medicines competency assessments had been completed for those staff who administered medicines. We also saw the provider did monthly checks to ensure the administration of medicine was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

All accidents and incidents were recorded within the homes electronic system. We looked at accidents and incidents that had been recorded for September and October 2016. Each record contained details of the person, details of the incident or accident that had taken place, the actions taken, any investigative action taken and any lessons that were learnt. An overview was held centrally by the registered manager who held responsibility in overseeing each entry that was made and ensuring that appropriate actions were taken. Monthly reports were also sent to the Community and Health Access Team (CHAT) who supported the home with the health and clinical needs of the people living at the home. The CHAT is an initiative which supports nursing and residential homes in the London Borough of Enfield to reduce and prevent hospital admissions and enable services to support people with their health and medical needs within the home.

Weekly fire tests and regular evacuation drills were carried out that recorded the response times and any concerns. Risk assessments and checks regarding the safety and security of the premises were completed. There was a daily fire safety checklist, which included checking escape routes, emergency lightings and evacuation equipment's.

Personal Evacuation Emergency Plans (PEEPS) had been completed using a traffic light system that indicated the level of support people would require in the event of an emergency evacuation. Fire evacuation slide mats had been installed on the upper floors and on the basement, which was near the stairs. There were instructions on how to use the mats. Staff were confident on how to use the mats and two staff demonstrated to us how to operate the mat. One staff told us, "The mats are easy to use." There were clear signs around the home on where the fire exit was. Fire extinguishers were placed around the home and had been refilled. The registered manager told us that the evacuation mats had not been used during evacuation drill but would be used during the next drill to ensure all staff were aware and refreshed on how

to use the mats.

Appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were undertaken on portable appliances and lifts to ensure people living at the home were safe. Checks on hot water were being completed regularly to ensure the temperature were within acceptable limits.

During our visit we checked communal areas of the service which were all clean and well maintained. There were detailed infection control procedures and staff and nurses demonstrated a good understanding of infection control and how this should be managed within the home. Staff were observed making use of personal protective equipment efficiently. Posters demonstrating effective handwashing techniques were on display around the home. Housekeeping staff kept records of their daily cleaning activity and monthly deep cleaning records.

Good

Is the service effective?

Our findings

Relatives told us that the care people received was good overall and that staff generally knew what they were doing and how to support people which took into consideration their individual needs and requirements. One relative said, "My relative's care has been good. An improvement from the last place he was at." Another relative stated, "The care has been pretty good" and "Yes, they are skilled and trained to do the job." However, one person living at the home did state that, "Staff need to be trained not by the head office personnel but from the experienced ones who know the routine."

At the last inspection on September 2015, we found the provider in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not see documentation showing that all staff were supported to fulfil their roles and responsibilities and address their personal development needs through an annual appraisal. During this inspection, we found that the registered manager had addressed this breach. Records showed and staff spoken to confirmed that they had received an annual appraisal. An overview was also available informing the registered manager of when appraisals were next due. We also saw records confirming that an appraisal was also completed for all new starters to ensure that their personal development and training needs could be identified and opportunities could be made available for new staff to develop from the start of their employment.

Staff confirmed that they felt adequately supported and received regular supervision with their line manager. One care staff told us, "Yes, I feel supported. I receive regular supervision and we talk about development and what we can improve." Another care staff said, "Yes, we do receive supervision. We talk about the residents and what the home can do to help us." We also saw records of ad-hoc supervisions taking place with staff which were called 'Reflection and Coaching Meetings.' These meetings looked at and discussed any issues or concerns that were identified during a shift giving the staff member an opportunity to reflect and learn from their actions. The registered manager held an overview of the supervisions that had taken place for staff members and when their next session was due. We looked at supervision records for 11 staff members. However, we did note that some of the records did not have all the supervision records attached which would show that supervisions were taking place on a regular basis and as per the provider's supervision policy. The registered manager assured us that they would address this immediately to ensure records were updated.

Mandatory training was provided in the following areas: manual handling, first aid, health and safety, infection control and dementia awareness. A training overview was available which showed all mandatory training and essential training available to all staff members. It also showed the date the training had been completed and when the training was next due to be refreshed. Essential training courses included basic life support, diabetes, pressure care and wound care. Training records that we looked at confirmed that staff had completed training in these additional areas. Staff confirmed that they had access to all available training which was delivered either through face to face training or through an online training programme. Each online course could only be completed and certificate issued once the staff member had completed the online competency test.

All newly appointed care staff were required to attend an induction programme which covered areas such as orientation to the home, health and safety, residents and policies procedures. Care staff were then required to attend training in mandatory topics and the essential topics such as safeguarding, moving and handling, basic life support, fire awareness and health and safety. As part of the induction all new care staff were attached to a 'buddy' so that they could shadow them in order to gain experience on the job. The 'buddy' would generally be a team leader on a particular unit. This would be overseen by a mentor who would be the unit nurse in charge.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. During this inspection, we found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards. Where any person living at the home lacked capacity, we saw evidence that a mental capacity assessment had been completed and a Deprivation of Liberty Safeguard authorisation had been made to the local authority. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire to ensure that re-authorisation could be requested.

We saw authorisations where conditions had been set for the managing authority to action. Examples of conditions included, "More opportunities for activities" and "Managing authority to arrange greater access to the house cat." The registered manager and deputy manager were in the process of updating the care plans so that the conditions would form part of the care planning process and that staff would be aware of the conditions that had been set and how they were to ensure these were met. The deputy manager showed us the care plans on which he had already updated the relevant information. One week after the inspection we received further examples from the registered manager of care plans that had been updated to reflect the DoLS authorisation and conditions where any had been set.

The registered manager and staff members demonstrated a good understanding of the MCA and DoLS and issues relating to consent. Staff were aware that when a person lacked the capacity to make a specific decision, people's families, staff and others including health and care professionals would be involved in making a decision in the person's best interest. One staff member told us, "You don't assume that someone is not able to make decisions until it has been confirmed through an assessment. Not having capacity today does not mean that the situation may not change in the nearest future." Another staff member stated, "It's about whether the person is able to say yes or no and where they can't make decisions for themselves you would apply for a DoLS." A third staff member said, "DoLS are in place to protect people who can't make decisions."

18 care plans that we looked at showed that consent to care was sought from people thus giving people the opportunity to be involved in all decision making processes where appropriate. Where this was not possible people's representatives were involved in any decision making process. We did note that for two care plans, where a 'Do Not Attempt Cardiopulmonary Resuscitation' had been applied, we were unable to locate the supporting paperwork for this decision. We told the registered manager about this, who stated that the documents would be located and attached to the care plan.

Staff told us that they always sought consent from people regardless of whether they lacked capacity or not. One care staff stated, "I am always polite and nice to people and ask if they need my help. I always ask for their consent." A second staff member said, "I always ask people and give them choice."

Most people and relatives spoke positively about the food provided. Comments made by people about the food included, "Its fine" and "We have enough." Relatives that we spoke with had mixed reviews about the food. One relative stated, "The food is much nicer here than [Name of previous home] and the chef visits regularly." Another relative said, "Food is pretty good." A third relative told us, "The food looks very much the same but it is nicely presented" and a fourth relative commented, "In regards to the food, they don't have much choice. I tend to bring my relative food. There is repetitions. Two choices only on the trolley and the patients choose."

Meal times within the home were protected whereby any visiting professional were advised to avoid visiting the home during the designated meal time. A pictorial menu for the day was on display in the main reception area as well as on the individual units and their dining areas. We saw that the meals stated on the menu's was the same as what was served on the day.

Our observations during the inspection were that food was well presented and looked and smelt appetising. The chef prepared two demonstration plates of the meals on offer so that people were offered a visual choice at the time of the meal. We saw people were able to choose the meal that they wanted. We observed one person refused to eat the meal they had chosen and was demonstrating behaviours that challenged the service. The staff and the nurse responded promptly and spoke to the person in a calm way and asked the person if they would prefer an alternative meal. The person expressed their choice and although this was not on the menu, the meal was still prepared and given to the person.

People were not rushed and we saw some good interactions between people and staff who communicated with people and encouraged people to eat when required. We observed that food was placed within easy reach of people and staff helped clean people's mouth, when needed. Towels were provided and tucked into people with their permission. Drinks were available and were offered to people. Staff asked if people had finished their drink before removing them. There was a relaxed atmosphere during meal times. Relatives were able to visit at lunchtime and support their own relative with their meal and people were encouraged to sit next to each other so that they could socialise with each other. We saw that there were a variety of drinks and snacks available on the units from which people were able to choose what they wanted. We also saw that drinks were available in people's rooms.

Some people required support with their meal in their room. On the first day of the inspection we observed on one particular unit that people had to wait up to 30 minutes before they were supported with their meal. Staff were seen to support people who were in the dining room first before they were deployed to support people who were in their own room. However, people's meals were only served from the hot trolley as and when they were ready to be supported. This meant that people received a hot meal even though they may have had to wait before being served and supported. This issue had been highlighted at the last inspection on September 2015 where people were seen to wait for up to one hour before they were supported with their meal on the same unit. We again highlighted this to the registered manager who assured us a system would immediately be put in place to ensure people within their own rooms were supported appropriately and in a timely manner.

The chef manager was aware of what soft and pureed diets should consist of and these were prepared fresh on a daily basis and presented on the plate whereby people could identify what each food item was. We saw that menus were set by the head chef based on people's likes and dislikes. These were then presented to

people and their relatives at the residents and relatives meetings for comment and feedback. The chef was also visible and available around the home and went round, during lunch time, to speak with people and relatives to get their feedback on how the food was. During the inspection we saw the interaction and engagement between the chef and people and their relatives. It was extremely jovial and warm. Relatives confirmed that this particular chef visited on a regular basis to talk to people and to ask them how their meal was and whether they enjoyed the meal.

People's weights were checked and monitored on a monthly basis. Where weight loss or excessive weight gain was noted, charts were completed to monitor food intake as well as appropriate referrals made to help ensure that people's nutritional needs were met. Where people required professional input in relation to dietetic services or the speech and language therapists, we saw records of referrals that had been made. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

The kitchen was clean and we noted that sufficient quantities of food were available. Further, we checked a sample of food stored in the kitchen and saw that they were all within their expiry date. Food that had been opened was appropriately labelled with the date they were opened. The kitchen had designated food preparation areas for preparation of meat and vegetables. The service had also received a five star rating for the Environmental Health Agency as a result of their last inspection.

People were supported to maintain good health and had access to a variety of healthcare services which included GP's, opticians, chiropodists, physiotherapists, psychiatrists and tissue viability nurses. Records were also seen of physical health checks which included results of blood tests, monthly blood sugar level check for people that were diet controlled diabetics and weekly blood pressure checks. We also saw evidence that following appointments, people's care plans were updated accordingly.

Good

Is the service caring?

Our findings

Comments from people about the staff and how caring they were included, "They are very helpful" and "They do their best." Relatives that we spoke with were overall happy with the care that their relatives received. One relative told us, "The care staff are lovely, they have managed his care really well." A second relative stated, "There are some really good staff here. They try very hard and are very caring." A third relative told us, "Staff are great."

During the inspection, we observed interaction between staff and people living in the home. People were relaxed with staff. Some staff interacted positively with people, showing them kindness, patience and respect while others were more practical and task focused. Some staff took their time and gave people encouragement whilst supporting them. People had free movement around the home and could choose where to sit and spend their recreational time. People were able to spend time the way they wanted to and were encouraged and supported to socialise with other people living at the home. We saw that people had built positive relationships with each other.

Life history booklets had been completed for some people living at the home. The registered manager stated that this was an on-going piece of work which they would like relatives to be involved, in completing them. The booklets included information about their life from childhood, their choices, likes, dislikes and preferences. Although, only approximately 7 to 10 people living at the home had completed life history booklets, care plans for all people included a section called "Active Living". This contained information on people's background, what people enjoyed doing and key memories that they held that were significant to them. These plans provided staff with information so that they could care and support people in accordance with their choices and wishes.

People and relatives told us that they were involved in making decisions about the care they and their relatives received and that staff always supported them in the way in which they wanted to be supported. One person told us, "Staff communicate with us and my relatives are involved in my care management plan." Relatives commented, "I feel involved with the care planning" and "I am involved in my mum's care." The home had a variety of leaflets available for relatives and visitors which included information on advocacy services, financial support and information about dementia and bereavement services where required.

Staff understood that people's diversity was important and something that needed to be upheld and valued. Care plans took account of people's diverse needs in terms of their culture, religion and gender to ensure that these needs were respected. This information was detailed in people's care plans. We saw arrangements were in place for the local priest or vicar to visit the home on a regular basis. People confirmed this and told us that a representative from the church visited the home. People also had the option to have mass held within the privacy of their own room.

We saw people being treated with respect and dignity. We noted that people were always asked about their choice or preference. Signs were available in people's rooms which were put on the door to notify others

that they were being supported with personal care. Privacy, respect and dignity were of high importance to the care staff that we spoke with especially when delivering care and support. Care staff were able to give a number of examples of how they maintained and respected people's privacy and dignity. One nurse explained, "We always respect their privacy. I ensure personal care is done in private areas. We will close the door." One care staff stated, "I would make sure that the door is closed when providing sensitive personal care and put the tag outside." A second staff member told us, "This is their home, you give them all the privacy, respect and dignity at all times." We also observed staff respecting people's privacy through knocking on people's bedroom doors before entering.

People had end of life care plans as part of their main care plan. These were detailed and well documented outlining people's choice and preference for their end of life care.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that the staff were responsive to their needs and the needs of their relatives living at the home. One person stated, "I can always speak to staff." One relative told us, "You can tell the staff what you need." Another relative said, "We can get help when we want it."

The home employed three activity co-ordinators. In the reception area, there were photos on display of the most recent activities that had taken place within the home. An activity planner was also available outlining what activities had been scheduled over the week. We saw that the activities that were noted on the activity plan did take place and were held centrally on the ground floor communal area. We received positive feedback about the level of activities that took place within the home. One person told us, "They encourage me to do activities." A relative said, "She [the relative] does lots of activities." Another relative explained, "There are activities which [the relative] can go to and he is more stimulated here." On both days of the inspection, we observed that the activity co-ordinator who was on duty had established good relationships with people, understanding their needs and their characters.

However, throughout the inspection we observed very little in terms of activities taking place on the individual units. People were seen to be brought into the lounge and sat in front of the television with very little conversation or stimulation taking place and people who were unable to leave their bedroom, received very little one to one interaction unless the activity was task focused such as receiving personal care.

During the inspection, we observed how staff interacted and supported people. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing. During the SOFI we saw that there were four people sat in the lounge where they were either passively watching television or dozing off to sleep. The observation lasted for 30 minutes and during that time there was one staff member working on the computer. This staff member did not interact with people throughout the 30 minute timeframe. We saw staff members walk in and out of the lounge again not interacting with any of the people in the lounge. After 10 minutes one staff members spoke with two residents by greeting them and asking them how they were. After a further 10 minutes three people in the room were offered a drink. The fourth person in the lounge received no interaction or engagement throughout the 30 minute observation.

Similar observations of little activity, interaction and engagement was noted by the experts by experience as well as the specialist advisor nurse. One expert by experience noted, "People that I found in the lounges in the morning and lunch hours were the same I found in the afternoon. They were all in the same position which seems to mean that there was no stimulation whatsoever for them." The specialist advisor nurse recorded, "Staff were observed interacting with residents though no activities observed going on except most of them just sitting and watching television for quite a long period of time."
A sensory room had been created for people and relatives to use as and when they chose. The room had been sensitively decorated with mood lighting, soft music playing, comfortable seating and a warm

ambience. There were scented candles as well as creams and oils that people and relatives could use to give people a calm and relaxed experience, especially for those living with advanced dementia who are unable to communicate or participate in the home activities. However, there was no planned and structured use of this room which would make sure that those people who experienced less in the form of stimulation and activity would have planned and structured access to the sensory room to aid with their positive well-being.

However, we did note the positive impact the chef had on people when they entered the units during mealtimes. They spoke to each person individually, asked them how they were, whether they enjoyed their meal and was very warm and affectionate towards people. The chef was able to communicate with certain people in their first language and also tried to teach other people the language. We observed the positive impact this had on people and how this left people in positive well-being.

Whilst walking around the home, the registered manager told us that they had introduced recognition plaques for people who had been living at the home for five years or more. We saw that these plaques had been placed on the person's bedroom door and stated the name of the person, the date they moved into the home and a key characteristic or piece of information describing the person. We found this to be extremely person centred and validated the fact that Elizabeth Lodge was their home.

Pre-admission assessment documents were available on file for people whose care plans were looked at. Prior to admission each person was individually assessed by a member of the management team. The registered manager explained to us that these assessments were important as it helped determine whether the home was able to meet the person's individual needs.

People's needs and preferences were understood. Care plans were personalised and person centred to people's needs and preferences. Care plans were seen to be comprehensive, needs were clearly stated and were focused on the individual. Information provided included communication, behaviour that challenges, maintaining a safe environment, medical conditions, administration of medicines and pressure area care. Care plans were reviewed with people and their relatives on a monthly basis or regularly where significant changes had been noted.

There was evidence that people and their relatives were involved in completing their care support plan. Relatives that we spoke with also confirmed that they were involved in care planning. We saw that care plans had been signed by people or their relatives to show that they had agreed to the care they received.

Each person, as part of their care planning document had daily log sheets which were completed by nurses and care staff on duty on a daily basis. Information about the person and how they had been on the day and any significant change was recorded within this book on a daily basis. This document was also used as part of staff handover when there was a staff shift change.

Staff were aware of what person centred care was and were aware of individual needs when asked about the care people required. Staff spoken with gave examples of how they delivered person centred care and how they tried to ensure people's independence was promoted. One staff told us, "Person centred care is all about the person that you are caring for." A second staff member said, "Each person is different and each person has their own choices. Each person is special." A third staff member stated, "I would always encourage people to walk. Some don't like to drink, we always encourage them to drink by themselves."

The home ran an initiative called 'Resident of the day' for one person from each unit within the home. This

meant that the focus of the day would be on the identified person. As part of that focus, the person's care and support needs would be looked at as well as ensuring that the person was at the centre of everyone's attention. During the day, the person's care plan and risk assessments would be reviewed, the chef would visit the person and have a chat with them about the menu and their likes and dislikes, their room would be deep cleaned, the activities co-ordinator would have a one to one session with the person and the maintenance man would visit the person to check if there were any areas in their room that needed addressing. The care plan would also be discussed with the person's next of kin.

People and relatives were of aware of who to speak to if they wanted to raise any issues or concerns. One relative told us, "I feel able to raise any issues or concerns with the unit lead." Another relative explained, "I feel able to complain. If I was unhappy I would go and see [name of registered manager]." All complaints received were recorded and held in a central complaints file. Each complaint logged included information about the nature of the complaint, what steps were taken to resolve the complaint and the response provided to the complainant. Information about how to make a complaint was on display at the entrance of the home.

A compliments folder had been set up by the home which held details of all compliments that were received. One compliment received from a health care professional stated, "[Name of relative] was so happy with the care her mother is receiving. She couldn't speak highly enough so thank you." Another compliment received from a relative expressed, "We would like to thank you all but especially the [name of unit] for the loving care you gave to [name of person] while he was with you and to us as his family."

Residents and relatives meetings were noted to take place every three to four months. The registered manager told us that recently in addition to holding general resident meetings, they were holding unit based meetings to ensure maximum participation. On reviewing recent resident meeting minutes, we saw that items discussed included care issues, language barriers, laundry, food and activities. People who were unable to attend these meetings were spoken with on a one to one basis so that their point of view could be obtained.

Good

Is the service well-led?

Our findings

People and relatives overall confirmed that they knew who the registered manager of the home was. Some people that we spoke with told us that they did not know the manager but knew of the 'ward manager.' Some relatives also stated that they were yet to meet the registered manager but knew who they could speak to if they had any concerns or issues that they needed to raise. One relative told us, "I know who the manager is but I have not met her yet." Staff also spoke positively about working at the home.

A common issue which had been identified through feedback from people, relatives and visiting health care professionals was around the communication systems within the home especially where relatives or professionals were calling the home to speak to someone on a specific unit and were unable to do so. During this inspection, we found that a number of systems had been put in place to improve this. At the reception desk there were a number of notices giving relatives, visitors and health care professionals a number of options in order for them to be able to speak to the appropriate member of staff. This included direct telephone numbers for each unit, a mobile phone number which would be allocated to the nurse in charge on the units, email addresses as well as a designated telephone number for staff to call if they were unable to attend to their allocated shift.

Staff told us that the management was open to receiving feedback and always available to support. Staff also stated that they were very happy with their job and the interaction with the management was very good. One nurse told us, "I like the management, they are very supportive." One care staff member said, "The manager is very nice, very friendly and open." A second care staff member commented, "[Name of registered manager] is so good its untrue, she is very supportive."
Visiting care professionals also spoke positively about the registered manager and the management within the home. A visiting matron told us, "The manager is very effective and is always willing to discuss issues and look at how care can be improved. She has managed the staff well and made difficult staffing decisions to improve the residents care."

Staff told us that morale within the home was good and that the team worked well together. They also told us that the registered manager and management overall were approachable and they could discuss problems and care issues with them. There was a clear management structure in place and the registered manager and care staff were aware of their roles and responsibilities.

At the entrance of the home, photographs had been displayed of all staff members including the senior management team and nurses, the activity team, the kitchen team and the domestic team so that people, relatives and visitors could identify staff visible around the home. A notice board was also visible on entry to each unit which displayed the day, date and names of all the staff on duty on that particular unit.

We found that there was clear communication between the staff team and the managers of the home. Alongside daily handover sessions the deputy manager also held daily briefing sessions with the unit leads. These meetings discussed the nominated 'resident of the day', and people's immediate medical or care issues that had been identified and needed action.

Regular team meetings were held with the nurses and team leaders for each unit as well as care worker meetings. At the nurse and team leaders meeting the registered manager would carry out a quiz which checked staff members knowledge and awareness on topics such as DoLS, MCA, whistleblowing and the importance of completing residents charts correctly. At care staff meetings, the agenda comprised of health and safety, e-learning, handovers and residents charts. Care staff confirmed that they regularly attended meetings that were organised.

There were systems in place to ensure that the service sought people's, relatives and staff views about the care provided at the home. Surveys for people and relatives covered areas such as food, activities, feedback about the care and support provided, cleanliness of the home and access to healthcare professionals. These surveys were carried out every six months. The results of the surveys were collated and an action plan was devised to ensure that any negative comments or suggestions that had been made were looked at and addressed which ensured continuous learning and improvement.

Staff surveys were carried out on an annual basis and questions asked were on areas such as my work, my immediate line manager, my contribution and my development. An action plan had been developed to look at the areas that required improvement with timeframes.

The provider, registered manager and deputy manager between them undertook a range of checks and audits of the quality of the service and took action to improve the service as a result. Audits completed covered areas such as medicine management, care plans, health and safety, bi-monthly night checks, accidents and incidents. We saw that after each audit had been completed, where issues had been identified, an action plan was in place to address the issues within a specified timeframe. The registered manager held oversight of these audits and action plans to ensure that these were adhered to.