Churchlake Care Ltd

# Elizabeth House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 13 and 14 November 2018. The first day was unannounced.

This was the first inspection of Elizabeth House since it was registered under new owners. At the last inspection in February 2016 we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff recruitment procedures were not sufficiently robust. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question 'is the service safe' to at least good.' At this inspection we found improvements had been made and the service was no longer in breach of this regulation.

Elizabeth House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It is registered to provide care and support for up to 18 people. At the time of our inspection 16 people were living at Elizabeth House. The home has two floors, with bedrooms on both the ground and upper floor.
The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The people who lived at Elizabeth House told us they felt safe. There were enough staff to meet the needs of the people who currently lived there, and appropriate precautions were taken to ensure that staff had the right character to work with vulnerable people. The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

The building was secure, clean and well maintained, and staff ensured any environment hazards were minimised. However, the layout of the building was unhelpful, as narrow corridors made manoeuvring wheelchairs difficult, and the service could not easily accommodate people with difficulty mobilising on the upstairs landing.

Care records were well kept and easy to follow. They gave a good indication of resident's abilities and provided a good description of their likes and dislikes. Where risk had been identified, risk plans were in place to minimise the risk of harm occurring. Senior staff were trained to administer medicines and we saw people were assisted to take their prescribed medicines in a way they were comfortable with by staff who understood their needs.

People were supported by a stable staff team who knew the residents well. We saw that the staffing ratio reflected the needs of the people living at Elizabeth House. The people we spoke with believed the staff were competent and knowledgeable. We saw from training records that all new starters received a thorough

induction and ongoing refresher training to maintain their competence.

Staff communicated well with each other and we saw that information was exchanged between staff informally throughout the working day, and a detailed handover meeting took place at the start and finish of every shift. This ensured that care staff were aware of any change in peoples' needs and of any tasks which might need to be completed.

The registered manager and the care staff we spoke to, demonstrated a good understanding of capacity and consent. When people were being deprived of their liberty the correct processes had been followed to ensure that this was done within the current legislation.

People liked the food provided, and attention was paid to their dietary needs and preferences. However, the choice of main meals was limited. Lunchtime was not a sociable occasion and there was little conversation as people ate their meals.

Care staff at Elizabeth House monitored people's general health, and where specific healthcare needs were identified the service liaised with health care professionals to provide an appropriate level of support.

We saw people were comfortable and well cared for. Staff were vigilant to people's needs and were able to respond in a timely way to people's requests for assistance. They respected people's need for privacy, but understood the risk of social isolation and ensured supervision and regular checks were made when people retired to their rooms.

Regular reviews showed that people's needs and abilities were closely monitored and any changes were noted and amended in care plans. There were some activities, and stimulation was provided at a pace conducive to people's needs. The service supported people to plan for the end of their life and considered their needs and wishes ensuring their comfort and dignity.

Staff worked well together and encouraged a culture of mutual respect. They recognised that Elizabeth House was people's home and understood their role to support vulnerable people.

The registered manager was respected by staff, people who used the service and their relatives, and had a visible presence throughout the home.

The service sought feedback from people and some monitoring systems were in place, but information collected by the service could be used more effectively to improve the quality of the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People told us they felt safe and staff understood how to protect people from harm.

Where risks were identified, appropriate care plans instructed staff on how to minimise the risk.

There were systems in place for the safe management of medicines.

### Is the service effective?

Good

The service was effective.

Care and support was delivered by well trained and knowledgeable staff.

Referrals to other health and care professionals were made to ensure care and treatment met people's individual needs.

The management and staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA) and deprivation of Liberty Safeguards (DoLS).

### Is the service caring?

Good

The service was caring.

Staff were warm, friendly, and kind, and showed a good understanding of people's likes and dislikes.

Privacy and dignity were respected.

The service provided a calm and unhurried atmosphere.

### Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs and wishes.

How people wished to be supported at the end of their life was considered.

The service had a complaints policy and people told us they knew how to make a complaint if they wished.

## Is the service well-led?

Good

The service was well-led.

The service promoted a family atmosphere and staff worked well together.

There was a registered manager in place who was respected and understood their responsibilities.

All the people and staff we spoke with told us they felt supported and could approach the manager when they wished.

# Elizabeth House

**Detailed findings**

## Background to this inspection

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

This was an unannounced inspection and was conducted by two adult social care inspectors on 13 and 14 November 2018.

We requested and received a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this document to help us with our inspection planning.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We also asked Bury local authority commissioning and safeguarding team and Healthwatch Bury for their views of the service. They did not have any concerns.

We spoke with four people who used the service, the registered manager, the cook, maintenance officer, and five members of staff.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records of six people. We also looked at the recruitment, training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

# Is the service safe?

## Our findings

People told us that they felt safe at Elizabeth House. They told us, "I like living here. I'm safe and well looked after", and "Its warm and friendly. I feel safe and comfortable here".

There were no restrictions on people's movements on each of the floors, with the only exceptions being to areas where it may not be safe, such as the laundry and kitchen. To ensure the safety of all the people who used the service, stairwells had key codes, but this did not restrict any access as people were able to use the passenger lift to move between floors. The front entrance was kept locked, with access via a secure key code. This would help to ensure that unauthorised people would have difficulty entering the home, and that staff were aware of who was in the building at any time. We were asked to sign the visitors book when we entered the building and produce our identity badges.

A safeguarding policy was in place and protocols and procedures were in line with the local authority guidelines. Information about whistle blowing, safeguarding and complaints was displayed in the staff/visitor toilet by the front entrance. Where safeguarding allegations had been raised, we saw that appropriate action had been taken, with full protective measures in place and investigations carried out.

When we spoke with staff they told us that they received good training around the protection of vulnerable adults, with regular refresher training and updates. They showed an understanding of how to protect people from harm, and could tell us what they would do if they suspected a person was at risk of abuse. They also told us that they understood the organisation's whistle blowing policy. Whistle blowing is the disclosure of information which relates to suspected wrongdoing or dangers at work.

The service undertook regular checks to ensure that any environmental hazards were identified. The registered manager and maintenance officer conducted regular checks and identified any risk regarding the environment, including the communal lounges and bathrooms. On the first day of our inspection we saw the maintenance officer was considering how to minimise the risk presented by a lip to the doorframe, to allow safer wheelchair access to the rear of the building.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The manager kept a schedule which showed when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cooker. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring, such as a fire or utility failures.

We looked at six care records which showed that risks to people's health, welfare and safety had been assessed and were closely monitored. Risk assessments were regularly reviewed and where needs changed care plans reflected these changes and identified follow up action. For example, one person had difficulty swallowing. Acting on the advice of a speech and language therapist (SALT) the care plan instructed staff to

ensure the person had pureed meals and sat in the correct posture when eating. Another person's mobility had reduced, and with their permission they moved to a previously unoccupied room closer to the main lounge and dining area. Appropriate equipment was put in place, such as crash mats to reduce the consequence of falls. Some people who used the service required assistance with moving and handling using mechanical aids, such as hoists or stand aids. We saw that equipment was clean and well maintained. Staff were able to use this equipment effectively and took care to ensure that transfers were safe.

We saw that bedrooms had call bells to summon help if required. One person told us, "I have a call bell, they always respond. I've had a few falls, but [the staff] come very quickly". However, they told us that they did not have a call bell in their en-suite bathroom and felt this would be useful. We raised this with the registered manager who agreed to look into the possibility of arranging this.

When we last inspected Elizabeth House in February 2016 we found systems for recruiting staff were not always safe, as staff files did not include full employment histories and there was no explanation for any gaps in employment. During this inspection we looked at four recruitment files. We found there was a safe system of staff recruitment in place and all necessary checks were completed. Where employment gaps were identified a written explanation was recorded. Each person had two references and a Disclosure and Barring Service (DBS) check was noted. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff being employed.

We looked at staffing rotas and saw that there were generally three care staff on duty during the day, with two waking night staff. This was the case on the second day of our inspection but on the first day there were only two care staff working. The registered manager told us that she had intended to work as the third member of staff, and we saw that they assisted, particularly at busy times such as lunchtime. When we asked, people told us that they believed there were enough staff and staff told us they felt they were able to meet the needs of the people who lived at Elizabeth House. One care worker who was working on both days told us, "There were only two of us yesterday, but we can manage. It's ideal with three, like today." We saw that the staffing ratio reflected the needs of the residents and ensured that people's day to day needs were addressed. Staff felt they were kept busy. One care worker told us, "I look forward to working. It might be long hours, but the time goes by so fast, we are always on the go". They told us that tasks were shared and that this helped provide some time to spend with people.

Medicines were stored and administered safely. All medicines were kept in a locked trolley stored in a treatment room. Senior care staff and deputy managers were trained to administer medicines, and they ensured medicines were managed effectively. Each month orders were made and checked with the pharmacist on delivery to ensure the correct medicines were provided. Any unused medicines were also checked, recorded and returned to the pharmacy. This ensured that there was no overstocking of medicines. The service recorded fridge and room temperatures. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

Controlled drugs were appropriately stored in a further locked cabinet. These are medicines named under misuse of drugs legislation which restricts how such medicines are stored and recorded. The controlled drug register was countersigned when controlled drugs were administered.

We looked at medicine administration records (MAR) and found they had been completed accurately with no gaps in recording. The medication counts were consistent with the recordings on the MAR. Where medicines were prescribed to be taken 'as required' there were instructions which gave details including the

name and strength of the medicine, the dose to be given, the maximum dose in a 24-hour period, the route it should be given and what it was for. Regular audits and checks by the registered manager ensured safe management of medicines.

Bedrooms and communal areas such as bathrooms, toilets, dining areas and lounges were clean, well lit, and free of any unpleasant odours. Good standards of hygiene and cleanliness were maintained, and the most recent infection control audit conducted by the local authority's infection prevention and control team gave the service a 97% rating in infection prevention. Staff we spoke with told us that they had received training and understood the importance of infection control measures and hygiene. These included the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. We saw staff used protective equipment when dealing with personal hygiene or serving food. Communal toilets and bathrooms had a supply of liquid hand wash and paper towels and each had knee or foot operated pedal bins to prevent the spread of infection. The laundry was small but had separate areas for clean and soiled items to ensure that there was no cross contamination. The kitchen was clean and well organised, with food stored appropriately and fridge and freezer temperatures recorded daily to ensure that any perishable items were kept at the right temperature.

Each person who used the service had a personal emergency evacuation plan (PEEP) which informed any emergency services what support each person needed to leave the building safely. The fire alarm and call bell systems were also checked monthly to ensure they were working correctly. There was a record of fire drills, with staff being taught evacuation of the premises. The fire break points were checked on rotation to ensure they were working.

Good

# Is the service effective?

## Our findings

Prior to their admission into Elizabeth House, people received a full assessment of their needs with consideration of how their needs and wishes could be met, and how they would fit in with the other people who lived at Elizabeth House. This ensured that care was planned in line with up to date guidelines and best practice. When we looked at care records we saw that they included the views of other people who may have been involved in care and support; records included any assessments completed by health and social care professionals such as social workers. This information was then used to formulate a care plan, so staff would understand the needs and wishes of the person and how best to meet these needs from the moment of admission. We saw important information, such as dietary requirements, were passed to the appropriate staff to ensure their needs were met. Each person new to the service would help to complete their 'Care passport'. These contained a good level of detail about the person and their care and support needs, likes and dislikes. They all included a summary of the person's social history, baseline information about communication, mobility behaviour, skin, and hygiene. Staff told us that they reinforced to people that Elizabeth House was their home. One care worker told us, "We understand it's their home and we make it homely as we can. We get to know them and their relatives, their background and history, and what they like, for instance, if they like a shower in the morning or the evening".

The service supported staff to access training and kept a matrix to show when people had completed any mandatory training or required refresher courses to keep their knowledge up to date. We looked at this matrix which showed that most staff had completed the required coursework to develop and maintain their skills. Copies of any certificates were kept in their personnel records. The staff we spoke with confirmed that they had attended training, and that this had assisted them to provide people with the support they required. One care worker told us, "We've all done a lot of training, it helps us to do or job better. They went on to say that the registered manager and the provider would support them if they identified any training needs, and that they had been assisted to enrol on a college course around dementia. A senior care worker told us that they had been enrolled on a higher level National Vocational Certificate (NVQ) in Care.

All new staff completed an induction programme upon commencing employment with Elizabeth House. This gave staff the information they need regarding policies and procedures to enable them to do their job. During their probationary period they would shadow a more experienced member of staff, and complete mandatory courses including the Care Certificate, which is a nationally recognised qualification designed to equip staff to deliver all aspects of care.

Supervision meetings provided staff with an opportunity to speak in private about their training and support needs, as well as being able to discuss any issues in relation to their work. People told us that they received regular supervision and records we looked at confirmed this. Staff completed pre-supervision forms to help them identify any concerns and we could see that the registered manager would address these concerns or issues as part of the supervision. Staff also received an annual appraisal which focused on achievements and plans for future development.

We saw that staff worked well together, shared tasks equally and communicated effectively during their

shifts. One care worker told us, "We are a small team so we all get on together", and another said, "We get on well as a group, even the night staff. They'll pick up on any tasks we haven't completed, like the laundry". Staff were updated about people's needs through a daily handover following each shift and handover books noted people's needs, any changes throughout the day or any actions carried forward, such as arranging appointments. A care worker told us, "I look forward to coming into work and don't notice the time because we work well together. I go home knowing [people] are well looked after by my colleagues when I am not here".

People told us they enjoyed the food provided at Elizabeth House. One person told us, "The food is good here, very good cooking and not over facing". A daily menus board displayed the meal of the day, but there was no picture format. Menus were on a three-week rota and changed from summer to winter. There was only one choice of main meal and dessert, but people could choose what they wanted to eat if they did not like or fancy the option on the menu. Each day carers would remind people what was on the menu and ask if they would prefer something different. Where a dislike was known (for example someone who did not like green vegetables, cheese or mash potato) the cook would already have prepared an alternative. We saw that people had been consulted about their food preferences and had chosen mainly traditional meals. On the first day of our inspection, for example, people enjoyed the 'tater 'ash' offered. Portions were changed according to individuals' appetite (smaller potions for those with less appetite) and people were offered more.

The cook had good knowledge of what people liked and how to meet their dietary needs. They told us, "Carers communicate with us and about updates…they are brilliant". They were notified of any changes in dietary need, for example, if a person at risk of malnutrition required fortified meals, and kept an up to date file about peoples likes and dislikes and food allergies. They maintained a stock of products which were suitable to people on gluten free and diabetic diets. One person had asked for gluten free fruitcake for their breakfast and this was provided. The kitchen was clean, cleaning schedule and checks completed appropriately. The cupboards, fridge and freezer were all well stocked. Options would be available for staff to prepare for supper and if anyone was hungry at night. Nobody required assistance with eating their meals, but staff wore tabards to prevent the spread of infection and supervised mealtimes to ensure that people at risk from poor nutrition or swallowing problems were safe. However, lunchtime was not a sociable occasion. Staff presented each person with their meal served on small plates with appropriate cutlery, but there was little conversation as people ate their meals.

There were systems in place to ensure people's health and well-being were monitored and reviewed. We saw staff documented any changes to people's health conditions and contacted the relevant professionals, for example, speech and language therapists (SaLT) or continence nurses, for advice. Changes were easily identified within their care plans. People were supported to attend health care reviews, and hospital appointments.

People told us, and we saw documentation in care files, that people were supported to see other health professionals when required. One visiting relative told us that they believed the staff were vigilant to any changes, and that one member of staff in particular had a 'radar' and knew instinctively when something was not right with a person. During our visit the service called out a doctor to visit a person who was not well.

The service recognised the shortfalls of the building design. Elizabeth House was originally built as five separate town houses and had been knocked through and converted into a residential home. Bedrooms led

off narrow corridors, allowing for larger bedrooms, but made manoeuvring wheelchairs difficult. This meant that the service could not easily accommodate people with difficulty mobilising on the upstairs landing. There were some bedrooms on the ground floor, so when people had reduced mobility they could be placed in these rooms, if available. The staff had attempted to overcome the shortfalls of the building design, and people were encouraged to bring personal items from home to give the service a homelier feel. However, there was little evidence of this; bedrooms were standardised and impersonal. People had been encouraged to bring in items of their own, but few people had done this. Some dementia friendly alterations had been made, such as signage and low shadow lighting. Bedroom doors were painted in different colours to resemble terraced housing doors with large numbers to assist people to orientate themselves and easily find their rooms.

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. The service had a detailed MCA policy. Staff had been provided with training in this legislation and were able to feedback how they put it in practice.

Staff were able to explain the best interests process and when it was required and were able to give examples of where they made decisions for people and where people were supported to make their own decisions.

We saw that people had signed their care records where possible. Where they were unable to sign, the reason was recorded, for example, one care record we looked at stated, 'unable to sign due to dementia'. The care records we looked at had individual capacity assessments for people's needs and this was reflected in care plans. Capacity assessments were decision specific and documented what decisions people were able to make for themselves, such as what to wear, or when to go to bed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had an effective system for monitoring any applications and authorisations to ensure they were reviewed appropriately. Capacity assessments were held on people's care files to demonstrate that a formal capacity assessment had been carried out before the DoLS application was made. Best interest meetings had been held to support the decision-making process for people who could not make decisions for themselves, and staff were aware of when a DoLS had been authorised, or if there were any conditions attached to the authorisation. One care worker told us, "We get to know what they understand, and check care plans. Some are on a DoLS, but it depends on decisions. If we have any questions we will always check the care plans".

Care staff were aware of the importance of asking people for consent before undertaking any care. When we asked if they were offered choices, one person who used the service told us, "Always. If I want a shower I can get one. I can go out on my own, no restrictions, I let them know if I'm going out for a walk". A care worker told us that they always sought consent, and we saw that choices were always offered. For example, even though the staff knew people's preferences for tea and coffee, and how they liked it, they still offered choice of either, and with or without sugar.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that

people with a disability or sensory loss are given information in a way they can understand. We found the provider was meeting this requirement by identifying, recording and sharing the information and communication needs of people who used the service with carers and staff, where those needs related to a disability, impairment or sensory loss. This meant staff understood how to best communicate with people. People could receive information in formats they could understand, such as in easy read or large print and the service could provide information in other languages if required.

Good

# Is the service caring?

## Our findings

Everyone we spoke to was complimentary about the manager and staff at the care home. One person who used the service told us, "Staff are really nice and care for us well. I've no complaints". People told us that they were looked after by kind and caring staff who were mindful of their needs and wishes. A notice board contained cards and messages of thanks, complimenting staff on their kind and caring nature.

People who used the service told us that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported. One staff member told us, "We recognise it's a big change when they come into care. We try to get to know them in their own time, recognise the impact and make it a smooth transition, introduce others and help them settle in. We always make sure they are comfortable". Care records included a life history which helped guide staff and gave them an understanding of a person's background, culture and social norms.

People were well dressed and groomed. We saw that staff addressed people by their preferred names, and spoke to them in an unassuming way, making eye contact and touch when appropriate. Staff formed positive relationships with people and demonstrated a good knowledge of their physical, social and emotional needs. People told us they thought the staff listened to what they had to say and made time to speak with them. They told us that their interactions with staff were positive, and staff showed genuine care for people. One care worker said, "We are all very person centred. It's homely, friendly and relaxed. We go at their pace". We saw that there was a calm and unhurried atmosphere throughout our site visit.

People's care records made clear what people required support with and what they could do independently. People and their representatives were encouraged to discuss goals about what they would like to achieve, and individual needs were recognised and accommodated. Care plans were written in a person-centred way and gave clear instructions to inform staff how best to respond and meet people's needs. Staff understood how people liked to be treated and supported them in a professional but caring manner. One person told us, "I'm well looked after but try to be independent. When I am in my room they always come and check on me".

A care worker, reflecting on how they supported people, remarked, "We can't help but get attached, but understand our role. We are here to support. The result is a family atmosphere where we can all muck in to help each other out." Staff were supportive and showed a caring attitude. For example, we observed a care worker encouraging a person to 'have another spoonful' as they finished their main course at lunch on the second day of our inspection, but not insisting before they brought them their dessert.

We saw people were encouraged to form friendship groups and talked with one another. On the second morning of our site visit we conducted a short observational framework intervention (SOFI) to observe the mood and behaviour of people and any interactions with the staff. We saw people were relaxed and content and talked with one another, sharing a joke with the staff. People were settled; one person reading a newspaper commented on a story and began a conversation with another person. Staff told us that the people who lived at Elizabeth House got on well together and would look out for each other.

Staff treated people and their belongings with respect and understood their need for privacy. Information held about people, including all care records were securely stored in the manager's office when not in use, but staff had access and we saw that they regularly consulted care plans and assessments to ensure that they were providing appropriate care and support.

Relatives we spoke to told us that they felt comfortable visiting Elizabeth House. There were no restrictions on visiting and people were made to feel welcome. Visitors we spoke to informed us, and we saw, that staff knew who they were, addressed them by name and were always welcoming.

Good

# Is the service responsive?

## Our findings

When we asked, a relative told us that Elizabeth House was, "Marvellous. Staff know the people here intimately, and all their little foibles".

Prior to their admission, the registered manager completed a comprehensive pre-admission assessment which provided useful information about their needs and personality. The registered a manger told us that when weighing up whether the service could support the person, they considered how they would fit in with the other people living at Elizabeth House. An initial care plan was drawn up and as the staff got to know the person and how best to meet their needs a more comprehensive plan was produced.

We looked at six care plans. They gave a good idea of the person, their needs and wishes and how they liked their support to be provided. These were reviewed monthly, and any changes were placed at the front of care files to alert staff to any changes required in the provision of care. There was also a section entitled 'All about me' which gave details of the person's background, life history and people important in their lives. This was a useful document to encourage and stimulate conversation or for staff who may have been unfamiliar with the person, to learn a little about their likes and dislikes, background and culture.

Care plans were divided into sections around issues such as mental capacity, skin integrity, mobility, moving and handling nutritional needs, falls risk and managing medicines. Details around meeting need were instructive, and reminded staff to check specific issues, for example, under 'oral care' instructions on supporting or prompting people to brush teeth or how to care for dentures.

Where a risk had been identified action to reduce or eliminate the identified risk was recorded in detail. Charts were completed to record any staff intervention with a person, such as recording food and fluid intake, and when staff turned a person in bed where there was an identified risk regarding pressure areas. If necessary, a body map indicated any bruising or signs of redness. This ensured any emerging risk was identified and allowed prompt attention to prevent the risk augmenting

Care plans were reviewed and signed by the person, showing that they had been involved in considering their care. Where they were unable to sign there was evidence that their relatives had read and signed the plans. Daily records recorded all interventions with the person and provided a chronology of their stay at Elizabeth House.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our review of records and discussion with the managers, staff and people who used the service demonstrated that discrimination was not a feature of the service. We saw that staff received training in equality, diversity and human rights. This gave staff information on the risks to people's human rights in health and social care provision.

During our inspection staff organised some activities for the people who lived at Elizabeth House. For

example, people participated in a singing and dancing session in the main lounge, and told us afterwards that they enjoyed either joining in or watching the activity. Some resources were available including fiddle mitts, musical instruments, empathy dolls and colouring books, but these were kept in a corner of the dining room where they were not readily accessible.

Events were advertised on a notice board in the conservatory and included an entertainer and singer, Christmas parties, Christmas craft and a carol concert. An activity file showed some activities including arts and crafts, birthday parties, quizzes, bingo and singalongs. However, there was little variety in the types of activities offered. Staff recognised this, and when we asked what could be improved they told us that more stimulation could be provided. One care worker told us, "We would like more time for activities, or an activity coordinator to bring in fresh ideas. As carers we have so much to do. We would like more activities and more new ideas to stimulate people. However, people told us they were content. One person told us, "The entertainment suits me well. I like to sit quietly; I don't have the energy for much more. I like listening to the music".

We saw that the service had a complaints policy and people who used the service told us that they were aware of how to complain if they needed to. None of the people we spoke with had raised a formal complaint, and one told us, "Any issues I raise they are on to it straight away, so I never need to complain". When we looked at the complaints log we saw that there had been very few, but when they did arise there was evidence of a full enquiry and where the service was at fault apologies were given. The complaints policy was displayed on noticeboards throughout the home areas with contacts of where and who to make a complaint or any concerns, whether this be in writing or verbally to the home manager. One relative told us "I complained once, they sorted out the problem and were fine with me after. I know I will get a good response if I need to complain".

When we looked at the complaints and compliments log we saw the number of complaints was outweighed by the compliments received. One read: "I've been round a few care homes this is the best I've seen. Highly impressed", and a comment from a hospital ward stated, "Never seen someone from a care home so well looked after, nighties and underwear immaculate!"

At the time of our inspection nobody who used the service was at the end of their life, but staff at Elizabeth House supported people to consider their final needs and wishes and consulted them about how they wanted to be supported at this time. Each person had a 'looking ahead' plan noting any specific wishes the person might have regarding their death and funeral. This included any concerns they might have and noted any religious beliefs the person may want to be observed. Some people did not wish or were unable to discuss this, but a further section in care plans showed discussion with family members or other interested parties.

Where appropriate a 'do not attempt resuscitation' form (DNAR) signed by the person's GP was kept at the front of the person's file. A DNAR form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR).

We saw a number of thank-you messages from relatives of people who had passed away at Elizabeth House. Written comments included, "Thank you for making my [relative's] last few months brilliant"; "Thank you for the care and friendship during [my relative's] last few months at Elizabeth House", and "You have always treated [our relative] with kindness and dignity… there was no better place".

Good

# Is the service well-led?

## Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Elizabeth House is registered with the Care Quality Commission. When we visited, the home had a registered manager who had been registered since the service passed to new owners having previously worked at the service in a senior role. The registered manager was present throughout the inspection.

Everyone we spoke to held the registered manager in high regard. A person who lived at Elizabeth House said, "She is very good, easy to talk to and good company," and staff told us the registered manager was, "Genuinely nice, always encouraging and trusts us to do a good job" and "Always listens to people". When we spoke with the registered manager she told us that they hoped to achieve a family atmosphere at Elizabeth House and promoted a homely environment. She recognised the hard work of staff and applauded their creativity. She pointed out how mutual cooperation between staff had helped to create the home environment, stating, "The staff really do care and care about each other. They share the difficult tasks and help one another out".

We saw that the registered manager was visible around the home every day when on duty. She showed a clear understanding of her role and was aware of her responsibility to pass on any concerns about the care being provided, including notifications to the Care Quality Commission (CQC) and local authority commissioners.

Staff at Elizabeth House understood their role and function. They had access to a range of policies and procedures to enable them to carry out their roles safely. They supported people in a person-centred way and promoted their independence. They worked well together, taking mutual responsibility to ensure all tasks were carried out in a timely manner. The positive culture of the service was reflected in the interactions we observed to encourage people who used the service to maintain their independence and listen to them, as well as providing support.

To improve the quality of the service the registered manager sought the views of staff, visitors and people who lived at Elizabeth House. At the time of our inspection a staff survey was being undertaken. We saw feedback for the last survey in October 2017 was positive.

Surveys had also been completed by visiting professionals and families. They included comments such as, "Staff are always approachable and helpful", "Staff are calm and always show respect"; "They [staff] recognise people's need in advance and act promptly". A relative commented, "The staff really do care for [my relative] and not just in the physical sense but in terms of mental wellbeing", and another commented, "I want to come here when I get old!"

No meetings for families and people who used the service were arranged, but we saw they were consulted on specific issues. For example, we found evidence to show their views had been canvassed on activities and on meal choices, and that these had helped to shape service delivery. Staff meetings were held every four months. We looked at the minutes of the previous meeting and saw that this was well attended, with

evidence of discussion and involvement. Issues such as meal times were discussed, and general instructions passed on and minuted, such as the need to check bedding on a daily basis.

The relatives of residents we spoke to told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service. We saw any communication with relatives and any professionals, such as health care and social workers, was recorded in care files.

We saw systems were in place to monitor the quality of the service to ensure people received safe and effective care. Regular r audits and checks were undertaken on some aspects of the running of the service, leading to production of regular reports covering staffing, training, resident issues, activities, nutrition, incidents, and medicines. However, some information collected could have been used to improve service provision. For example, any accidents and incidents were recorded in an accident book, where any follow up action to the specific incident was also noted, but there was no analysis of this. We discussed with the registered manager how an audit of incidents could be used to improve quality or minimise repeat occurrences.

The registered manager told us that the new owners had been supportive; "Anything I need within reason will be provided." At the time of our inspection the owners were planning to set up a 'group chat' with other registered managers in the company to support managers to keep up to date with any changes in guidelines and changes in the care field. The registered manager told us they attended local residential care forums organised by the local authority which kept them informed of best practice. She felt supported by commissioners and the local authority quality assurance team, and told us that there was a good working relationship with the commissioners, who were supportive and helpful; "I can pick up the phone and ask them, they will always help". In addition, she had worked with the local clinical commissioning group (CCG), for example, using the 'red bag' scheme to assist people going into hospital. This is a scheme where all vital information is kept up to date and ready for any emergencies which may arise.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.