HC-One Oval Limited

Elstree Court Care Home

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

We inspected Elstree Court Care Home on 19 and 26 April 2018 and our visit was unannounced. Elstree Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elstree Court Care Home accommodates up to 41older people in an extended and adapted building. It provides accommodation and facilities over three floors and most areas have level access with chair lifts available in areas where steps are located. Care is provided to people whose main needs relate to nursing, and related physical health needs. This includes people who have had a stroke or live with a chronic health condition like Multiple Sclerosis, Diabetes or Motor Neurone Disease. People's nursing needs varied, some had complex nursing and care needs, others also required support with dementia and memory loss. Elstree Court Care Home also provides end of life care and used community specialist to support them in this care.

The service had a registered manager in place. 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 the time of this inspection 33 people were living in the service. Elstree Court Care Home was taken over by a new provider at the end of December 2017 and this is the first inspection under new ownership.

The provider had not ensured everyone had an opportunity to engage in meaningful activity. There was an activities co-ordinator who had developed an activities programme. This provided some group activity but did not ensure people's individual needs were responded to effectively. We have made a recommendation that the provider seeks advice, guidance and training from a reputable source, to support staff in providing suitable activities and entertainment to meet people's individual assessed needs.

People were happy with the care and support they received and they felt safe. Family members were complimentary about the care and support provided to people. Visiting professionals provided very positive feedback on the staff and the delivery of care. Medicines were handled safely and risks to people's health and support were identified and responded to appropriately.

People were looked after by staff who knew and understood their individual needs well. Staff were kind and treated people with respect, and promoted their individuality. One relative complimented the staff and said, "It is wonderful here, I thought they had kindness lessons, they are so wonderful and kind." Staff spoke to people in an appropriate way, promoted communication and took a genuine interest in what they had to say. There were enough staff to respond to people's care needs on a daily basis.

Staff had a good understanding of safeguarding procedures and knew what actions to take if they believed

people were at risk of abuse or discrimination. Recruitment records showed there were systems which ensured as far as possible staff were suitable and safe to work with people living in the service. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Senior staff had an understanding of DoLS and what may constitute a deprivation of liberty and followed correct procedures to protect people's rights.

People were supported to receive regular drinks and the meals that reflected their choices and needs. Visitors told us they were welcomed and people were supported to maintain important relationships and friendships. The environment was clean and well maintained. The provider had ensured safety checks had been maintained and equipment and facilities in the service.

Feedback was regularly sought from people, relatives and staff. People were encouraged to share their views on a daily basis. People were given information on how to make a complaint and said they were comfortable to raise a concern or complaint if need be.

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.

Medicines were stored, administered and disposed of safely. The environment and equipment was suitably maintained.

There were enough staff on duty to meet the needs of people. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service

Staff had received training on how to safeguard people and understood how to respond to any allegation or suspicion of abuse. People told us they felt safe. Lessons were learnt when things went wrong.

People had individual assessments of potential risks to their health and welfare and these were responded to.

Is the service effective?

Good

The service was effective.

Staff had an understanding of the Mental Capacity Act 2005 and DoLS and the need to involve appropriate people, such as relatives and professionals, in the decision making process when necessary

Staff were trained and supported to deliver care in a way that responded to people's needs.

Staff ensured people had access to external healthcare professionals, such as the GP and specialist nurses to promote health and wellbeing as necessary.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences. The environment and equipment supported people appropriately.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff. People were encouraged to make their own choices and had their privacy and dignity respected.

People were supported to maintain relationships and visitors were made to feel welcome in the service.

Everyone was positive about the care provided by all staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have the opportunity to engage in a variety of person centred activity to meet people's individual needs.

People were aware of how to make a complaint and people felt that they had their views listened to and responded to.

People were supported to make individual and everyday choices and these were recorded within individualised care documentation.

Is the service well-led?

Good

The service was well-led.

Staff and people spoke positively of the management, it's approach and availability. The registered manager was supportive to staff and had a high profile in the service. Staff were aware of their roles and responsibilities and there were clear lines of accountability.

Feedback about the service provided was sought from people, relatives and staff. This information was used to review the quality of the service provided.

Quality assurance and monitoring systems were in place. This included audits and a regional manager review. These were used to improve the service.

Elstree Court Care Home

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 checked 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 19 and 26 April 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. We considered information which included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also considered the information which had been shared with us by the local authority and the Clinical Commissioning Group (CCG) before the inspection visit.

The provider was not asked to complete a Provider Information Return on this occasion. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with 14 people who used the service and five of their relatives. We spoke with ten staff members which included five care staff, a registered nurse, a chef, the maintenance manager, the activities person and a housekeeper. We also spoke with the registered and deputy manager. During the inspection visit we spoke with a visiting physiotherapist and a social worker who had completed a person's service review. Following the inspection we spoke to a specialist nurse.

We spent time observing staff providing care for people in areas throughout the home and observed people having lunch in the dining room. We used the Short Observational Framework for Inspection (SOFI) during the day. This is a way of observing care, to help us understand the experience of people who may be less able to tell us about their experiences.

We reviewed a variety of documents which included six people's care plans and associated risk and individual need assessments. This included 'pathway tracking' three people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care.

We looked at three staff recruitment files, and records of staff training and supervision. We viewed medicine records, policies and procedures, systems for recording complaints, accidents and incidents and quality assurance records.

This was the first inspection of the service since it was registered with the CQC under a new provider.

Good

Is the service safe?

Our findings

People told us they felt safe living at Elstree Court Care Home. They said there were enough staff to help them when they needed it and that call bells were usually answered quickly. People said they were treated with kindness and this made them feel safe. When unexpected things happened people said staff took appropriate action to keep them safe. One person said, "I like living here, I feel safe, I fell on the stairs and a doctor looked at me straight away." Another said, "I am safe here, there is always staff around, at least got someone watching you." A third said, "Staff encourage me to be safe and use the red bell". Relatives were confident people were safe living at Elstree Court Care Home. One said "If you said I had to come here I'd be happy , I've visited lots of other homes".

Systems followed by staff ensured the management of medicines were safe. Medicines were stored, administered, recorded and disposed of safely. Storage facilities throughout the service were appropriate and well managed. For example, medicine rooms were locked and any drug trolley was secured to the wall when not in use. People and relatives told us people received their medicines when they needed them and were satisfied that they received the correct dosages. One person said, "They give painkillers as we need it, it depends when we had them last." Another said, "I know why I'm taking all my medicines."

We observed medicines were administered safely and in an individual way. Staff explained what they were doing and asked people if they needed any 'as required' medicines. They gave people time and support to take their medicines without rushing. Medicines were only administered by the registered nurses or care staff who had received additional training. Training schedules confirmed regular training and competency assessments were being completed on all staff who gave medicines; this was also confirmed by the registered manager.

The medicine administration record (MAR) charts were well completed and recorded when people had received their medicines. Some people were prescribed 'as required' (PRN) medicines. PRN medicines are only taken if they were needed, for example if people were experiencing pain. Individual protocols and guidelines were in place to guide staff on the safe and consistent administration of these medicines. Staff also ensured time specific medicines were given at the correct times. Staff used time alarms to remind them when these were due. Records relating to topical creams documented when these were required and additional records were being introduced to clarify when they were given by care staff.

Staff recruitment records showed the required checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the service. These checks included confirmation of identity references and a disclosure and barring check (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. Records confirmed staff were interviewed and these took account of skills and competence in the areas relevant to their roles. There were systems in place to ensure staff working as registered nurses had a current registration with the Nursing and Midwifery Council (NMC). This confirmed their right to practice as a registered nurse.

Staffing arrangements were flexible and ensured there were sufficient staff to meet people's assessed needs across the home which was located on three floors. Each day shift had two registered nurses working alongside six care staff. The night shift was staffed with one registered nurse and three care staff. The registered manger worked in addition to these numbers along with catering and domestic staff. Agency staff were used occasionally to cover known shortages and regular agency staff were used to ensure people were supported by staff who were familiar to them, and understood their individual needs. Staff told us there were enough staff to meet people's needs. One staff member said, for instance, "We have enough staff but we are on the go all of the time." Another told us the staffing had improved, "Things are better now than they were. We have more care staff to cover each floor."

Staff received training on safeguarding adults and understood their individual responsibilities to safeguard people. Safeguarding training was provided to all staff. Staff were confident any abuse, discrimination or poor care practice would be quickly spotted and addressed immediately by any of the staff team. Staff understood how to report any concerns. One care staff member said, "If I saw abuse or poor care, I'd let the manager know straight away". The registered nurses and manager were familiar with the reporting procedures and had used them in the past. The registered manager discussed recent referrals that demonstrated they had worked with the local authority to promote people's safety.

The provider promoted a safe and clean environment. Staff undertook regular training and updates on infection control. Infection control procedures were followed and staff used protective clothing appropriately. Hand hygiene was promoted and hand sanitisers were available at key areas throughout the service. Laundry facilities were in place with appropriate equipment to clean soiled washing safely. Elstree Court was found to be clean and hygienic. Cleaning rotas were signed by relevant staff and subject to regular audit. Security measures were in place and all visitors entering the service signed a visitor's book at the reception area. Health and safety checks and general maintenance were established and completed routinely by the maintenance person.
The emergency procedures and contingency plans had been reviewed and updated along with the fire risk assessment. Fire procedures were used to promote fire safety in the service and the maintenance person ensured fire equipment was maintained. Emergency information was readily available, for example a 'grab bag' was visible near the front entrance and contained information on the location of people along with Personal Emergency Evacuation Plan (PEEPs). These directed staff and emergency services on the safe evacuation of people from the service in the event of an emergency

Risk assessments specific to each person's needs had been completed and reviewed as people's needs changed; with clear guidance for staff to follow to provide safe care and support. These included nutritional risk, skin integrity and risk of pressure damage, risk of falls and mobility and, if people needed assistance moving around the home. The assessments took account of people's independence and their right to make decisions. Staff understood the importance of keeping people safe whilst not restricting freedom. If people were not able to use their call bell this was take into account with more frequent checks completed by staff. One person told us, "To keep me safe I have a pressure pad. I don't feel like keep ringing bell. I can't see or hear, so rely on staff coming when needed." When people were at risk of pressure damage to skin staff ensured appropriate equipment including pressure relieving mattresses were used. Staff checked that these were working and set correctly to ensure people's safety and moved people on a regular basis to reduce pressure on areas of skin.

Accidents and incidents were recorded and staff were clear about what action they would take in the event of a person falling or an incident occurring. Records confirmed what action staff had taken immediately and considered following the incident or accident. The registered manager reviewed all records when adding them to the computer system. We found accidents and incidents had been used to improve practice. For

example, an incident involving lifting equipment had been fully investigated. Subsequently the registered manager had reviewed staff training and improved the visual checking systems completed by staff before the equipment was used.

Good

Is the service effective?

Our findings

People and their relatives were complimentary about the staff and told us they were skilled and well trained to complete their roles within Elstree Court Care Home. One person said, "Carers have a good standard of training." A relative said, "They understand Parkinson's here. I'm very impressed, he's had no problems here. It used to upset me but here carers are very knowledgeable". Visiting health professionals were also very complimentary about the staff skills and their commitment to ensuring effective care. Staff demonstrated practical skills during the inspection For example, we observed staff assisting people to move using a variety of hoists and standing aides. Staff were competent in the use of this equipment.

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 authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff had attended training in Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They had a good understanding of MCA, the importance of enabling people to make decisions. They were confident that they supported people to make choices about all aspects of their lives. People told us staff asked for permission before doing anything. One person said, "The staff are kind and say do you mind if I do it?" One relative said, "Staff explain what they are doing and ask their permission before hand."

Mental capacity assessments were completed on admission and again when decisions on care and treatment were required and a person's ability to make that decision was not clear. Records were also in place regarding who people had appointed as Lasting Power of Attorney for health and welfare. Therefore clarification was in place on who should be involved in decisions that people were not able to make for themselves. A number of people had bed rails in use. Under the MCA code of practice, bed rails can be seen as a form of restraint. The registered and deputy manager were able to explain the rationale for the use of bed rails and an appropriate risk assessment had been completed. People's capacity to consent to the use of bed rails had been assessed and a time and decision specific capacity assessment had been completed in relation to their use.

The senior staff identified when a person may be subject to an unlawful deprivation of liberty. They understood people may be deprived of their liberty for their own safety and had taken appropriate steps to do so in people's best interest. This included the use of bed rails. Some people were living with dementia and were under constant supervision. Relevant DoLS applications had been applied for and the registered manager was in contact with local DoLS assessment team about these. This ensured people were cared in the least restrictive way.

The provider and registered manager were committed to maintaining a structured learning and development schedule for the staff they employed. Staff that were new to the service attended a structured induction programme. This included formalised training and support in understanding people's care needs along with shadowing senior staff. The induction programme was based on the Skills for Care 'Care Certificate'. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. This will ensure new staff have a clear understanding of their roles and responsibilities. One new staff member told us, "The induction and supernummery time was helpful in getting to know the residents before looking after them".

Staff completed essential training throughout the year. This training was co-ordinated by the registered manager who ensured staff completed the required training. The training programme was being reviewed and updated with a change of provider. It was varied and reflected the needs of people living in the service. It included training on health and safety, infection control, food hygiene, end of life care, dementia awareness, equality and diversity, mental capacity and DOLS, safe moving and handling and safeguarding. Additional training was provided in order to meet people's specific care needs or to develop staff. This included supporting staff and developing the skills for the registered nurses. For example, staff had been booked on blood taking courses and palliative care courses. Registered nurses also received support from both their peers and managers with revalidation. This is a process where registered nurses must periodically demonstrate their competence to practice to their professional body, The Nursing and Midwifery Council. A visiting professional explained the registered manager and senior staff ensured they had the relevant skills to look after people. For example, sourcing additional training on areas of interest or in relation to specific care needs .including Parkinson's and strokes. This ensured staff followed best practice guidelines when caring for people.

Elstree Court Care Home was adapted to meet people's individual needs. Most rooms had level access to all areas in the service and baths and showers were adapted for people with a disability. When people's mobility deteriorated and this impacted on their ability to move around the service they were moved to a more suitable room. This ensured people were not marginalised by their disability. The service was light and airy and each room had plenty of natural light. The garden was accessible to people and included a wheelchair walkway around the back garden. Having the ability to get out in the fresh air was important to people.

People were supported to have enough to eat and drink. People felt the food was good, there were choices and their preferences were responded to with a daily menu to choose from. One person said, "The food is very good, there is plenty of choice. Another said, "The day before we are given the choices menu and can always ask for something else". Relatives were complimentary about the food. One told us how their relative had put on weight since living at the service. Another explained, "She eats better now that she is helped with feeding and her fluids".

People chose where to eat and there was enough staff to attend to people within the dining room and people's own rooms. Staff supported people in an individual way assisting when necessary but encouraging people to eat independently. Staff interaction included, "Shall I cut it into smaller pieces for you?" and "Let's change from a fork to a spoon, it will be easier for you. Okay?"

People's individual needs were responded to. People had their dietary needs and preferences recorded when they were admitted to the service. Staff were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's

rights to decide for themselves. The chefs and catering staff were included in the assessment process and were fully aware of people's diets and preferences. The chef was able to discuss people's individual needs. One person was a vegetarian and requested quorn which was provided. The chef told us, "If people need a soft or pureed diet we accommodate this, following guidance from the Speech and Language Therapist's (SALT) team." Staff monitored people's weights and if people lost weight or had difficulty in eating and swallowing they were referred for professional advice. Suitable support and monitoring was put in place. For example, fluids were thickened according to the Speech and Language Therapist's directions and meals were pureed to reduce the risk of choking. Food and fluid charts were completed daily, with fluid intake totals calculated at the end of each day to ensure sufficient hydration. Prescribed supplements were also provided as necessary.

Staff responded to people's mental and physical health care needs. Staff worked in a collaborative way with community health care professionals and provided a multi-disciplinary approach supporting people to be as healthy as possible. Staff worked with a variety of health care professionals including specialist nurses, physiotherapists and dieticians. Routine and regular appointments were organised and ensured people saw a dentist, optician and chiropodist when needed. Visiting professionals told us staff were proactive in responding to people's health needs. One told us, "Staff understand how Parkinson's can affect people in very different ways with a variety of symptoms. They work to minimise and respond to these symptoms with allied health services." Staff communicated effectively with each other in order to respond to people's needs. They used the staff handover to pass on key information. Documentation and wipe boards were also used to remind and clarify any specific care or treatment. For example, when dressings were due to be changed and reviewed.

Good

Is the service caring?

Our findings

People were treated with kindness and consideration in their every day care and contact. People who used the service, relatives and visiting professionals were positive about the caring and kind approach of the staff and the home like environment. People said, "Care here is very good," "Staff are very good and show me respect," and, "Lots of nice carers." Another person reflected on the caring approach of staff and said, "I've been coming here for years, it feels like home. Staff are still here from the early days, it comes naturally to them". Relatives were confident that people were treated in a kind and caring way. One relative said, "The staff are very caring in the way they speak and treat my mother," another said, "They are absolutely lovely and I don't say that lightly."

The SOFI and general observations showed staff were patient and compassionate when interacting with people. We observed genuine warmth between staff and people, and staff took time to explain their actions to people. Staff demonstrated that they cared about how people were feeling and took action to reduce any anxiety. For example, One person was taken to sit with staff while they completed paper work. This person was more relaxed when in close contact with staff.
Staff patiently explained options to people and gave them time to answer their questions. Staff were interested in listening to people and responding to these choices.

Staff were knowledgeable about the people they were caring for and were able to explain people's individual needs and requirements. One staff member told us, "It's a lovely home I think. The residents become like your family." Another told us, "I've worked here a while so you get to know people and their families well." Individual preferences were seen as important and responded to. For example people were asked if they had preferences on the gender of staff providing personal care. Any preference was recorded and responded to. Each person was called by their preferred name and this included a nickname if this was what people preferred. Staff supported people's equality and diversity. People's individual beliefs were recorded as part of the assessment process and responded to appropriately. Staff understood that people's beliefs were important to them. One person had a strong spiritual belief that reduced the use of medication. Staff respected this and gave private time for them to practice and follow this belief. Another person had a strong religious belief that was recognised and supported in the service. Staff told us they were proud of the care provided and inclusive atmosphere in the service. This impacted on people and staff. Staff felt there was a good team 'that pulled together and looked after each other.' They were confident that they provided a good standard of care and said, "I definitely think it's a very caring place. I couldn't work here if it wasn't." Another said, "I think it's caring. The residents are really well looked after."

People were able and supported to maintain relationships with people who were important to them. This reflected people's choices and included friends, relatives and partners. Visiting arrangements were flexible and encouraged visitors to spend different parts of the day with people maintaining meaningful relationships and friendships. For example, one relative liked to be available around lunch time they told us, "They eat so much better when I am around." Visitors were able to spend private time with people and staff respected private time was important. Visitors told us they were warmly welcomed offered a drink and could stay for something to eat if they wished. Staff engaged positively with visitors, knew regular visitors by name

and spoke to them in a friendly and polite way. People were also able to maintain a contact with loved pets which was very important to some people. One person told us, "They let us bring the dog in and take him for a walk in the garden."

Staff respected people and took account of their privacy and dignity. One person told us, "Staff are very good and show me respect". Staff were courteous in their approach and ensured they did not embarrass people. When staff approached people to ask if they wanted the toilet. They did this in a discreet way and talked quietly to people. People's bedrooms were individual and recognised as private accommodation. Staff did not enter rooms without permission. Bedroom doors were kept closed when people received any support and staff took account of how people felt. One person told us, "I get embarrassed having a shower but can ask for female carer, they give me a towel to ensure I am covered up." People were supported and encouraged to personalise their own rooms. People had pictures, photographs some furniture and other memorabilia. This gave them a sense of identity and gave rooms a homely feeling.

People were involved in planning their care and support and they made decisions about the care they received. One person said, "I can go pretty much where I want." Another said, "I like to do things for myself but I need help as my eyesight is poor." Information in the care plans detailed the support people needed and reflected on how to encourage people to be independent. One visiting professional told us, "The staff promote people's mobility and this ensures their independence for as long as possible." People were encouraged to take an interest in their appearance and dressed according to their choice. A hairdresser visited on a regular basis and staff supported people with nail painting if they wanted this. People were able to spend their day as they chose. People spent time in the communal areas or in their bedrooms we saw staff checked on them regularly ensuring they were safe and did not need anything.

Requires Improvement

Is the service responsive?

Our findings

People told us staff understood their needs and supported them appropriately and responded to any changes in what they needed. People and their representatives were involved in deciding how people's care was provided. Discussions were recorded and individual care plans were written. Staff had regular access to these care plans and told us they had time to read them. A verbal handover was conducted by the registered nurse at the changeover of staff and communication was maintained between all staff throughout the day. In this way staff were up to date on people's changing needs. Relatives told us staff knew people well and 'the best way to care for them.' Visiting professionals were confident that staff were meeting people's needs and told us staff sought advice and guidance whenever people's needs changed.

Despite positive feedback on people's involvement in the provision of care we found care was not responsive in all areas.

The service had an activities co-ordinator who had developed an activities programme. However this did not ensure everyone had an opportunity to engage in meaningful activity. The programme included some group activity and individual one to one time for people in their own rooms and occasional outside entertainment. The activities observed included a jigsaw completion, a ball game and some nail painting. We found the activity provision did not engage with many people. The group activity during the inspection days included five people one day and six people the next day. One person said they did not join in the activities because they were 'childish. 'Feedback through the quality monitoring systems in the service indicated that people were not satisfied with the activities and entertainment provided. They requested more and varied entertainment. During the inspection people told us they wanted more outings and that the activities did not meet their needs. Comments included, "I'd like more variation," "The activities are not our interest, so we don't go," "I would go on trips if they were organised." Relative's comments included, "The activities are not good for her, she can't see," and, "She could do with a bit more stimulation. It's too childish and gets her a bit rattled." Records confirmed one to one contact with people who did not leave their rooms was maintained normally on a weekly basis. However these did not record any meaningful interaction for people. This lack of meaningful activities was identified to the registered manager as an area for improvement.

We recommend that the provider seeks advice, guidance and training from a reputable source, to support staff in providing suitable activities and entertainment to meet people's individual assessed needs.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Staff had not received training on this area, but they had a good understanding of each person's communication abilities and needs. People's communication needs were fully assessed and recorded. Care plans reflected how people communicated and what support they needed to promote effective communication. Staff ensured people had suitable equipment to support their communication. For example, people able to use their call bells had these close to them. When people used hearing aids or spectacles these were maintained

and available. Staff used touch and eye contact when talking to people. They spoke clearly and took time to explain things to people to ensure they understood what was being said.

Before moving into the service people's needs were assessed ensuring these could be met by the staff and service. Following admission a full individual assessment was completed along with relevant risk assessments. Care plans were developed in consultation with people and their representatives. People told us, "I've had an assessment meeting and I discussed my care with carers and management we came to a mutual agreement and what was needed," and "I was asked and we negotiated my care." Staff recorded people's healthcare needs and the support required to meet those needs. Care plans were person centred and took account of people's family history, individual personality, preferences and lifestyle. Reviews took place regularly and identified when people's needs were changing. For example, when people's mobility decreased the extra support required was recorded. One person told us, "There is a monthly review to look at care and medication." Staff knew people well and were able to tell us about each person, their care and support needs, choices and interests. Staff responded to these needs, for example one person had individual instructions on how they should be positioned in bed with the support of pillows in key positions. Staff recorded what position they had moved them to and how often on the care documentation retained in their room.

When people required end of life care and staff supported them to maintain a comfortable, dignified and pain free death. Staff had received training on end of life care and put their knowledge into practice. For example, staff provided regular mouth care to people who had dry mouths and were not drinking well. The registered nurses had received additional training and received updates to ensure they had relevant skills to provide effective care. This included the management of pain and symptom control with a syringe driver. Care plans were in place which considered what the person's wishes were at the end of their lives. They outlined what the person wanted to happen both at and beyond the point of death. These were completed as far as possible with people, and with the support of their representatives when appropriate. Staff discussed people's spiritual and cultural needs and any specific requests following death were respected.

The registered manager and provider encouraged feedback through complaints and comments about the service. There was a clear complaints procedure that was available to people and their representatives and available in the front entrance of the service. Leaflets on making complaints and providing feedback were also displayed along with a suggestions box. Records confirmed that complaints received were documented investigated and responded to in a positive way.
People said they could complain and that they would be listened to. When they had raised concerns in the past they had been responded to and any issue raised had been dealt with and improved. For example one relative said, "She was upset, I phoned up the manager and it was solved immediately." Records confirmed complaints that had been raised in the past had been documented and responded to appropriately.

Good

Is the service well-led?

Our findings

The new provider took over the management arrangements for Elstree Court Care Home in December 2017. However the management arrangements within the service has remained the same. Elstree Court Care Home had a registered manager and deputy manager in post. People and their relatives were positive about the management of the service and knew who the registered manager and deputy were. They felt listened to, consulted and involved in the care and the running of the service. People said, "The management team are really nice." A relative told us, "It is heaven, I'm so happy he is treated with kindness and dignity. I used to be a nurse, I'm very happy with his care and how management are." Visiting professionals were confident that the management arrangements ensured people's health and welfare needs were responded to and promoted good outcomes for people. One professional said, "There is a good manager and deputy at this home. They pick up and deal with any issues quickly." The registered manager promoted a multi-disciplinary approach to care and consulted with a variety of health and social care professionals on a regular basis.

There was a clear management structure in place at Elstree Court Care Home that staff understood. This structure included head of departments that communicated through regular daily team meeting catch ups. The registered manager was a registered nurse and maintained a clinical overview of people living in the service. Staff were aware of the line of accountability and who to contact in the event of any emergency. There was on call arrangement and a quality and regional manager were also available for advice and guidance to staff.

There was a positive culture in the service where staff felt they were an important member of a team. Staff told us they were happy in their work. They spoke highly of the registered manager who they said was approachable and listened and maintained a supportive environment to work in. One staff member said, "The manager is always on the floor and I can go to them whenever I need to." Another explained how the registered manager had listened to concerns around staffing levels and had reviewed how many staff were required. Staff were informed and kept up to date on changes to the service. One said, "Obviously there are new owners now and that can cause upset but it's been fine." Staff had clear job descriptions and they received regular supervision and an annual appraisal. Supervision and appraisals were staff focussed and gave the opportunity for staff development. The registered nurses confirmed clinical supervision was supported and facilitated by the registered nurse. Group supervision and staff handovers were used to discuss team practice and organisational issues. This approach supported a positive culture that was open and empowering. Staff told us they understood their roles and what was expected of them and were motivated to provide and maintain a good standard of care. Comments included; "I Love working here, everybody gets on and we work well together." Another staff member told us they were listened to at all levels and could approach any team member to raise issues directly. Compliments were shared with the team and displayed in a communal area. Staff knew about the whistleblowing procedure and how to use it.

The registered manager sought feedback from people and those who mattered to them to gain information on the quality of the service. This was completed through regular meetings, satisfaction surveys and regular contact with people and their relatives. A notice board was used to communicate feedback from

information gained. For example, they documented that further outings were to be provided in response to people's comments within satisfaction surveys. Staff views were also sourced through satisfaction surveys. These were followed up within staff meetings.

There were a number of quality systems in place and these included a variety of audits. The registered manager was in the process of transferring these over to the new provider's specific quality systems. These were comprehensive and were being implemented slowly to ensure quality monitoring was continuous. A regional manager for the organisation had recently completed a quality review that had been shared with the registered manager. Areas needing improvement had been highlighted and were being addressed to improve the service. For example, the need to improve end of life care planning had been progressed.

There was an extensive provision of clear policies and procedures that reflected current legislation and best practice guidelines. Staff had access to these and the registered manager used them to establish the standards of care expected to be maintained.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. There was a procedure in place to respond appropriately to notifiable safety incidents that may occur in the service.