MMCG (2) Limited

Eltandia Hall Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection which took place on 17 and 18 July.

People living at Eltandia Hall Care Centre receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The care home can accommodate up to 83 people across four self-contained units located over two floors, each with their own separate adapted facilities. Three of the units known as Irving, Ivy and Scott support older people. Most people staying on these units are living with dementia. Irving and Ivy units also specialise in providing nursing care, whilst the Scott unit is residential and specifically for older people with personal care needs. The Farish unit supports both younger and older adults who have physical disabilities. Some of the people living on this unit also have a learning disability or autistic spectrum disorder or mental ill health problems. Some people living in the home have a sensory impairment. At the time of our inspection 73 people resided at the Eltandia Hall Care Centre.

The service has had two new registered managers in the last 12 months. The latest manager was registered by CQC in March 2018. A registered manager is a person who has registered with the CQC. Registered managers like registered providers 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.

In August 2017 the home was re-registered by the CQC after the service was taken over as a going concern by a new provider. At the last comprehensive inspection of this home in April 2017 when they were managed by the provider Lifestyle Care Management, we rated them 'Requires Improvement' overall. This was because we found poor management of medicines, risks, complaints and governance, and lack of staff support and understanding of the Mental Capacity Act (2005). We undertook a focused inspection in April 2017 and judged the service had made improvements to address the issues, but continued to rate them 'Requires Improvement' overall because we wanted to be sure they could maintain what they had achieved over a more sustained period.

At this comprehensive inspection we found after 12 months in charge the new provider had improved the service people living in the home received. However, the new providers acknowledged there is a lot more work they need to do to make the home better and ensure it continued to move forward in the right direction of travel. We have therefore rated Eltandia Hall Care Centre 'Requires Improvement' overall and for the two key questions 'Is the service effective and caring?' For the three key questions, 'Is the service safe, responsive and well-led? we rated them 'Good'.

We rated them 'Requires Improvement' for effective because staff did not have all the right knowledge and skills to carry out their roles and responsibilities. Although the new provider had a well-established training

programme in place, it did not cover the needs of everyone who lived at the home. For example, most care staff had not received any training in learning disability or mental ill health awareness, preventing and appropriately managing behaviours that might challenge the service and understanding equality and diversity. This meant staff might not have the right competencies to effectively carry out all their roles and responsibilities.

We also rated the home 'Requires Improvement' for 'caring' because some people did not always feel they were well-cared for or supported by some of the staff who worked at the home. Although we observed positive interactions between people living in the home throughout our two-day inspection, several people and their relatives and community health and social care professionals expressed concerns about the caring attitude of a few staff and the way this minority sometimes treated people living at Eltandia Hall. The new managers had identified a shortfall in the caring attitude displayed by a minority of staff at times. They told us they had begun to address this problem through a combination of additional staff training and supervision and the use of staff disciplinary procedures, where appropriate, which staff we spoke with confirmed.

These shortfalls represent breaches of the Health and Social Care (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We also found important information people living in the home might find useful was not always accessible to people with a learning disability or a sensory impairment. This was because no easy to understand pictorial, plain English or audio versions of the 'Service users' guide, the providers complaints procedure or care plans were available in other formats other than the standardised written one. This meant some people might not have sufficient opportunities to be actively involved in making decisions about the care they received at the home.

The negative comments described above notwithstanding, most people living in the home, relatives and community health and social care professionals felt the standard of care provided at Eltandia Hall had begun to steadily improve since the new providers and managers had been in charge.

There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse and neglect. The provider assessed and managed risks to people's safety in a way that considered their individual needs. Appropriate recruitment checks took place before staff were permitted to commence working at the home. There were enough staff to keep people safe. The premises and equipment were safe for people to use because managers and staff routinely carried out health and safety checks. Managers ensured the environment continued to be hygienically clean for people and staff demonstrated good awareness of their role and responsibilities in relation to infection control and food hygiene. Medicines were managed safely and people received them as prescribed.

People were supported to eat and drink enough to meet their dietary needs and preferences. Managers and staff were aware of their duties under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent before providing any care and support and followed legal requirements when people did not have the capacity to do so. They also received the support they needed to stay healthy and to access health care services. People said the home was a comfortable place to live.

Staff communicated with people using their preferred methods of communication. This helped them to develop good awareness and understanding of people's needs, preferences and wishes. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. When people were nearing the end of their life, they received compassionate and

supportive care.

People received person centred care and support that was tailored to their individual needs. Each person had an up to date and personalised care plan, which set out how their care and support needs should be met by staff. These were reviewed regularly. The opportunities people had to participate in meaningful activities that reflected their social interests had improved in the last 12 months. People were encouraged to maintain relationships with people that mattered to them.

The newly registered manager and her deputy manager were well-regarded by people living in the home, their relatives, community professionals and staff. The provider operated effective governance systems which ensured all aspects of the home were routinely monitored. Any shortfalls or gaps identified through these checks were addressed promptly. The provider had suitable arrangements in place to appropriately deal with people's concerns and complaints. The provider also gathered feedback from people living in the home, their relatives and staff.

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. Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

The provider had assessments and management plans in place to minimise possible risks to people, this included infection control and food handling measures. The home was clean, free from odours and was appropriately maintained.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

Medicines were managed safely and people received them as prescribed.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. This was because staff did not have all the right knowledge and skills to effectively carry out their roles and responsibilities.

People received support from a skilled, experienced and committed staff team.

People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access health care services.

The registered manager and staff were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. Although we observed positive interactions between people living in the home, some people, their relatives and community health and social care professionals expressed concerns about the lack of care and support shown by a minority of staff who worked at

Eltandia Hall.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

Is the service responsive?

Good

The service was responsive. People were involved in discussions and decisions about their care and support needs, although people with a learning disability or sensory impairment could not always access information they might find useful because it was not always to available in alternative easy to read or audio formats.

People had an up to date, personalised care plan, which set out how staff should meet their care and support needs. This meant people were supported by staff who knew them well and understood their individual needs, preferences and interests.

The opportunities people had to participate in meaningful social activities that interested them, both in the home and the wider community, had improved in the last 12 months. People could maintain relationships with people that mattered to them.

The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

Is the service well-led?

Good

The service was well-led. The home had a new suitably qualified registered manager in post.

The relatively new provider had effective systems in place to regularly assess and monitor the quality of service that people received.

The provider routinely gathered feedback from people living in the care home, their relatives and professional representatives. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided.

Eltandia Hall Care Centre

Detailed findings

Background to this inspection

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

This inspection was conducted over two days on 17 and 18 July. The first day of our inspection was unannounced and we told the provider we would be returning on the second day. The inspection team on the first day consisted of two inspectors, a specialist advisor who was a registered nurse and an expert-by-experience. The expert-by-experience had personal experience of caring for someone who lived with dementia. Only the lead inspector returned to the service on the second day.

Before the inspection, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During this two day inspection we spoke with ten people who lived at the home, and six visiting relatives or friends and two community health and social care professionals including, a social worker and a pharmacist. We also talked with various managers and staff who worked for the provider including, the deputy manager, a regional quality and compliance manager, a regional clinical standards manager, four registered nurses, eight health care workers, three activities coordinators, the head chef and a laundry assistant.

Throughout our inspection we observed the way staff interacted with people living in the home and performed their roles and responsibilities. We also used the Short Observational Framework for Inspection (SOFI) to observe lunchtime meals being served on the units on both days of the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included ten people's care plans from across all four units, six staff files and a range of

other documents that related to the overall management of the service including, quality assurance audits, medicines administration sheets, complaints records, and accidents and incident reports.

In addition, we received written feedback about the service from two external care managers representing a local authority's safeguarding and commissioning teams. We also received a 'Dignity' report from Merton Seniors Forum who visited the home in March 2018. Merton Seniors Forum is an organisation who champion the 'dignity' of older people living in the Borough.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "Yes, I do feel safe here", while another person remarked, "I feel very safe in this place." The provider had robust systems in place to identify report and act on signs or allegations of abuse or neglect. Staff had received up to date safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. Staff told us the new managers continually encouraged and supported them to speak out if they were ever concerned about staffs poor working practices or behaviour toward people living in the home. One member of staff said, "I know we've had a few problems here with some staff, so we've been told to keep an eye on each other and work together as a team."

We looked at documentation where safeguarding alerts had been raised in respect of people living in the home and saw the new provider had taken appropriate steps, which they followed up to ensure similar incidents were prevented from reoccurring. The provider had alerted the local authority's safeguarding adults' team and the CQC without delay about these safeguarding incidents and continued to work closely with the relevant safeguarding authorities to manage them.

After we had carried out our inspection we were made aware of two serious incidents involving people who lived at the home. The provider immediately notified the local authority and the CQC about the occurrence of these incidents. We contacted the provider after our inspection and we have been assured they took appropriate action to mitigate the likelihood of these risks reoccurring.

Measures were in place to reduce identified risks to people's health, safety and welfare. People's care plans included detailed risk management plans for staff to follow, which were routinely reviewed and updated. Risks that were assessed included falls, malnutrition and dehydration, choking and pressure sores. It was clear from discussions we had with staff and working practices we observed staff understood the risks specific individuals might face and what action they needed to take to prevent or mitigate them. For example, throughout our inspection we saw several instances of two staff correctly using mobile hoists to transfer people safely from one place to another. Staff confirmed they had completed their practical and theoretical lifting and manual handling training, which was refreshed annually.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency and business plans to help staff deal with such events quickly. We saw fire exit signage conspicuously displayed on doors and walls throughout the premises and fire evacuation ski-pads were available in stairwells to help people with physical disabilities navigate the stairs. People's care plans contained a personal emergency evacuation plan (PEEP), which explained the help people would need to safely evacuate the building in an emergency. Records showed staff routinely participated in fire evacuation drills at the home and received on-going fire safety training. Staff demonstrated a good understanding of their fire safety roles and responsibilities.

The environment was well-maintained, which contributed to people's safety. Maintenance records showed environmental health and safety, and equipment checks were routinely undertaken by suitably qualified

external contractors in accordance with the manufacturers' guidelines. This included checks in relation to the service's gas safety and electrical installations, portable electrical appliances; fire equipment, including fire extinguishers, fire alarms and sprinklers; heating and ventilation systems; water hygiene and monitoring of water temperatures; passenger lifts; and, the routine servicing of mobility aids, bed rails, call bells, and window restrictors. We also saw radiators were suitably covered throughout the home.

The provider's recruitment processes were robust. The provider's human resources department obtained at least two employment references from new staff's previous employers and carried out checks on their criminal records, proof of identify, eligibility to work in the UK, full employment history and explanations for any breaks in employment and health.

The home was adequately staffed. Most people living in the home and visiting relatives and health and social care professionals felt there was usually enough staff working at Eltandia Hall. Throughout our two-day inspection we saw care staff were always visible in communal areas, which meant people could alert staff whenever they needed them. We also saw numerous examples of staff responding quickly when people used their call bells or verbally requested assistance to stand or have a drink.

The provider used a dependency tool to calculate the amount of care each person living at the home needed to receive. Managers routinely reviewed staff rotas in response to people's changing needs and additional staff were arranged as required. The deputy manager gave us a good example of how they had responded to a person's changing needs by arranging for them to have one-to-one staff support during the day to keep this individual safe.

People continued to be protected by the prevention and control of infection. People told us the home always looked clean and tidy. A visiting professional said, "The home always looks and smells clean." The service was free from any unpleasant odours. We observed staff using appropriate personal protective equipment. For example, we saw staff always wore disposable gloves and aprons when providing personal care to people and there was always soap and paper towels in the toilets. Records indicated all staff had received up to date infection control training and there were clear policies and procedures in place. Staff were knowledgeable about what practices to follow to prevent and control the spread of infection. Appropriate systems were in place to minimise any risks to people's health during food preparation. We saw the kitchen was kept hygienically clean, and catering staff used colour coded chopping boards when preparing different food groups and checked fridge and freezer temperatures daily. The home had been awarded the top food hygiene rating of 5 stars by the food standards agency. Records indicated all staff had completed basic food hygiene training.

Medicines were managed safely. People told us they had confidence in the staff who supported them to take their prescribed medicines on time. One person said, "The staff make sure I get my medicines on time." We saw medicines were securely stored in locked medicines trolleys or cupboards in each unit's locked clinical room. People's care plans contained detailed information about their prescribed medicines and how they needed and preferred them to be administered. We saw medicines administration records (MARs) were appropriately maintained by staff authorised to handle medicines in the home. There were no gaps or omissions on MAR charts. Checks of medicines stocks and balances, indicated people received their medicines as prescribed. Protocols for managing 'as required' medicines were in place and clear instructions were printed on MAR charts so staff knew when and how to administer these types of medicines. A community pharmacist told us, "The service has significantly improved the way they manage medicines in the past six months and staff's medicines handling practices are much safer now."

Requires Improvement

Is the service effective?

Our findings

Staff did not have all the right knowledge and skills to effectively carry out their roles and responsibilities. Although the new provider had introduced a comprehensive rolling programme of training for staff, which most staff had completed, the programme had clearly not been designed around the specific care and support needs of everyone who lived at Eltandia Hall. Although the service employed three nurses with specialist learning disability or mental health qualifications, most care staff had not received the right levels of learning disability, mental ill-health problems or sensory impairment awareness training. This meant staff might not have the right competencies to effectively perform their roles and responsibilities. Several staff told us although their training was generally good they felt they would benefit from receiving additional learning disability, mental ill-health and sensory impairment awareness training.

This training shortfall represents a breach of regulation 18 of the HSCA (Regulated Activities) Regulations 2014.

Gaps in staff's knowledge and skills described above notwithstanding, all new staff were required to complete a thorough induction and shadow experienced members of staff before being approved to support people unsupervised. To complete their induction staff had to achieve all the competencies required by the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Nursing staff also completed additional training in the use of specialist medical equipment to meet people's more complex health care needs. For example, nurses completed training in how to use percutaneous endoscopic gastrostomy (PEG) feeding tubes and catheters safely. PEG feeding is an endoscopic medical procedure in which a tube is passed into a person's stomach.

Staff had sufficient opportunities to review and develop their working practices. The new provider had introduced a rolling programme of regular supervision (one-to-one meetings), competency assessments and annual appraisals where staff were encouraged to reflect on their work practices and identify their training needs. Records indicated staff at all levels had attended at least one formal individual meeting with their line manager in the last three months. Staff told us they were encouraged to talk about any issues or concerns they had about their work. One member of staff said, "I understand the new owners want us to have quarterly supervisions with our line managers, the last one being our big annual appraisal at the end of the year to see how we've been doing."

People continued to be supported to maintain their health and well-being. People were positive about the healthcare support they received at the home. One relative told us, "Staff are very good at changing my [family member's] dressings regularly." People's care plans set out how staff should be meeting their specific health care needs. Staff carried out regular health checks and maintained daily records of the support people received, including their observations about people's general health. The provider ensured people attended regular health care check-ups with a range of community health care professionals, which included weekly GP visits, psychiatrist and tissue viability nurses, speech and language, occupational and physio-therapists, dieticians, dentists, opticians and chiropodists. Staff maintained appropriate records of these health care appointments.

The premises were kept free of obstacles and hazards which enabled people to move safely and freely around their home and garden. We saw the environment was decorated and furnished to a reasonably good standard. People and their visiting relative and community professionals consistently told us the interior décor of the home had improved in the last 12 months. Typical comments we received included, "The place looks a lot better since the recent paint job", "My [family member] likes how her bedroom is decorated which we helped personalise with a few pictures and photographs from home. New curtains and furniture in the lounge have made the place feel homelier as well" and "A considerable amount of money seems to have been spent by the new provider on refurbishing the place, which I understand is still ongoing. The communal rooms are certainly brighter than they have been." We saw lots of easy to understand pictorial signage was used throughout the home to help people orientate themselves and identify important rooms, such as their bedroom, the lounge, dining area and toilets.

People were supported to have enough to eat and drink. We received a few negative comments from people about the standard and choice of food offered at the home, although most people said they enjoyed the meals and typically described their quality and appearance as 'good'. Feedback included, "The food is ok, but can get a bit monotonous at times…I wouldn't mind a nice pork chop every now and then", "They [staff] usually ask you what you want to eat and it normally tastes pretty good" and "We can have as much to drink as we like and we can choose what we eat. If I don't like the meal I'm given I can order something else. "The meals served at lunchtime on both days of the inspection looked and smelt appetising. Lunchtimes were not rushed and there were enough staff available on both days to provide personal support to people who required assistance to eat their meal. We saw staff routinely offered people drinks during and outside of mealtimes.

The service protected people, especially those with complex needs, from the risk of poor nutrition, dehydration and swallowing difficulties. People's care plans included detailed nutritional assessments which informed staff about people's food and drink preferences and any risks associated with them eating and drinking. We observed staff at mealtimes ensure people who were at risk of choking had their food appropriately cut up or pureed in accordance with their nutritional risk assessments. Staff monitored the food and drink intake of people who had been assessed as being at risk of malnutrition or dehydration to ensure these individuals continued to eat and drink adequate amounts. The head cook was aware of people's individual dietary needs and able to cater for people with food allergies or special diets due to their health care needs. We saw catering staff prepare a range of soft, pureed and fortified (high calorie) meals for people with specific nutritional needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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. We saw appropriate arrangements were in place to ensure people consented to their care and support before this was provided. Care plans showed people's capacity to make decisions about specific aspects of their care was assessed. This gave staff the information they needed to understand people's ability to consent to the care and support they received. We saw staff always offered people a choice and respected the decisions they made. For example, during lunch we observed staff ask people to choose what they wanted to eat from the daily menu. We saw if

people had capacity they were encouraged to sign their care plan to indicate they agreed to its content and the care and support they received. Staff we spoke with demonstrated a good understanding and awareness of people's capacity to consent and to make decisions about their care and support. Several staff told us they always asked people for their consent before delivering care and respected their decision to refuse support. Managers had identified that some people required their liberty to be deprived to keep them safe and free from harm. We saw the service had applied to the local authority for authorisation to deprive people of their liberty and maintained records about the restrictions in place and when the authorisations were due to be reviewed.

Requires Improvement

Is the service caring?

Our findings

Comments we received from people living in the home and their relatives were very mixed about the caring attitude of staff who worked at the home. People and relatives told us they did not feel they or their family members were always well-cared for or supported by a minority of staff who worked at Eltandia Hall. Typical feedback included, "Some staff are caring and very nice, but others are not…I can speak up for myself, but I'm worried about how they [staff] treat others who live here", "The first staff member I spoke with when I first arrived at the home had a very poor attitude and was quite dismissive of me, but other staff I've talked with since have been extremely helpful and kind" and "Most staff who work at Eltandia are very kind and can't do enough for you, but there's a minority here who aren't that nice. There is one member of staff my [family member] really doesn't get along with at all."

Comments we received from community health and social care professionals were equally mixed about the caring attitude and approach of some staff. Typical feedback included, "Staff interaction can be inconsistent. To be fair the way most staff engage with the residents is very warm and caring, but in my professional opinion I think some of the staff don't know how to treat people with the respect they deserve", "Most staff do sit and talk with people and seem quite caring, but some staff aren't that good at engaging with my clients, their relatives or me" and "Two staff had both spoken about my client during their annual care plan review in a way that was rather patronising. It was as if my client wasn't there."

Throughout are two-day inspection we observed staff interact with people living in the home in a mainly kind and compassionate way. For example, staff always greeted people warmly and responded quickly to people's questions and requests for assistance. We also observed most staff assist people to eat their meals in a dignified manner, which they achieved by sitting down next to people they were supporting and continually engaging with them.

However, on the second day of our inspection we saw two staff spent most of the time talking to each another and not engaging with the people they were assisting to eat their lunch. The new managers told us they had inherited a culture at the home where the caring attitude of a minority of the staff was sometimes lacking. They told us they were in the process of addressing this issue through a combination of staff training and supervision, and where appropriate staff disciplinary procedures, which staff we spoke with confirmed.

This shortfall in the caring attitude and approach of a few staff represents a breach of regulation 10 of the HSCA (Regulated Activities) Regulations 2014.

Staff communicated with people in appropriate and accessible ways. People's care plans contained information about their personal communication styles and preferences and how individuals made choices and decisions about the care and support they received. People's communication needs and preferences were well known by staff. This was evidenced through our conversations with staff who could explain how each person communicated and made choices about what they wanted. Several staff described how they knew from people's facial expressions that they might be thirsty and needed drink. Managers told us the staff team could speak 20 different languages between them, which meant people whose first language was

not English, would be able to communicate their needs and wishes to a few staff who spoke their mother tongue, such as Tamal (Asian language) or Polish for example.

Relatives and friends could visit without being unnecessarily restricted. Visitors told us they were not aware of any restrictions on times they could visit their family member, friend or client. Managers and staff told us people's guests were encouraged to have a sit-down meal with their family member or friend, as well as celebrate special days, such as birthdays and anniversaries.

Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. People told us religious leaders representing various denominations of the Christian faith regularly visited the home. Information about people's spiritual needs and ethnicity was included in their care plan. We saw Halal meat was available in the kitchen, which the catering staff cooked and stored separately. Halal refers to what is permissible in Islamic dietary law. The head cook also demonstrated a good understanding of the wide range of cultural, ethical and religious dietary needs and wishes of people living in the home, which was reflected in the weekly menus and the meals served each day. For example, the head cook knew who did not eat beef and/or pork on religious grounds, who had a meat free diet and which people liked to eat Caribbean or Asian style cuisine.

The provider had up to date equality and diversity policies and procedures in place which made it clear how they expected staff to uphold people's rights and ensure their diverse needs were respected. Records indicated staff received equality and diversity awareness training as part of their induction.

Staff encouraged people to be as independent as they wanted and could be, although most people living in the home were dependent on the care and support they received from staff with day-to-day activities and tasks. For example, during lunch people who were unable to use traditional cups and plates had been given specially adapted crockery which enabled them to eat and drink with minimal assistance from staff. Staff could also explain to us what aspects of their care people needed support with, such as moving and transferring or assistance at mealtimes, and what people were able to do independently. Throughout the home we saw handrails and a passenger lift that enabled people to move freely around their bedroom, the communal areas and the rear garden.

Good

Is the service responsive?

Our findings

People received care and support which was tailored to their individual needs and wishes. A relative told us, "Staff have gotten to know my [family member's] habits, routines and what she likes to do." People's care plans were written in a person-centred way that focussed on their individual care needs, abilities and choices. They also included detailed information about how people preferred staff to deliver their personal care and who was important to them, such as close family members and friends. Staff were knowledgeable about the people they were supporting, knew what was important to them and provided support in line with people's needs and expressed wishes.

Care plans were reviewed at least monthly and updated as and when required if there had been changes to a person's needs and/or circumstances. Where changes were identified, people's care plans were updated quickly and information about this was shared with staff through shift handovers and meetings.

People were given choices about various aspects of their daily lives. A community professional told us, "I believe my client can choose when they get up, what they wear and what they eat every day." Throughout our inspection we observed staff offered people choices. For example, we saw staff actively encourage people sitting in a dining area to choose the food they ate for their lunch, which they achieved by showing people what the two main lunchtime meal options that day looked like when they were served up on a plate. This enabled people to make informed decisions about the food they ate at the times meals were served.

People were given essential information about the service. People and their relatives told us they had been given a 'Service Users' guide which set out the providers philosophy of care and the facilities and services provided at Eltandia Hall. We also saw a range of easy to understand pictorial signage and photographs conspicuously displayed throughout the home to help people identify rooms and areas that would be important to them, up and coming social events and activities, and profiles of staff who worked on each unit.

However, important information people might find useful was not always accessible to everyone who lived at the home. For example, there was no easy to understand pictorial, plain English or audio versions of the 'Service users' guide, the provider's complaints procedure or care plans available in different formats other than the standardised written ones. This meant people with a learning disability or visual impairment would not be able to access the information contained in these documents which might limit their opportunities to be actively involved in making decisions about the care and support they received at the home. We discussed this with the managers who agreed where appropriate easy to understand pictorial, plain English, large print and audio versions of the 'Service Users' guide, the providers complaints procedure and people's care plans would be developed and made accessible to people living in the home. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

The opportunities people had to participate in meaningful social activities at the home and in the wider community had steadily improved in the last 12 months. Feedback we received from people, their relatives

and community professionals was rather mixed on the subject, although most agreed the services relatively new activities coordinators had significantly improved the range of social activities on offer at Eltandia Hall in a short period of time. Typical comments included, "There wasn't much I wanted to join in with when I first moved here, but after I told them I liked to play cards staff often sit down with me to play a hand or two," "I think it used to be very boring for my [family member] here. In the past people weren't encouraged to go out or try anything new here, but now my [family member] does so much more…They're off to a local pub tomorrow for lunch, which never used to happen. I put it down to the new owners" and "In the past 6 months I've seen a marked improvement in the range and quality of social activities my client can now choose to join in with at the home, including trips out."

During our two-day inspection we saw most people from one unit went out with staff for a pub lunch and another person go clothes shopping with their key-worker. In-house activities initiated by the activities coordinators during our inspection included, a group quiz and a gentle exercise class, a discussion group in the garden and an individual playing cards with a member of staff.

We saw each unit had its own designated activities coordinator. An activities coordinator told us, "I think we've done a pretty good job in a relatively short space of time to improve the standard of social activities people can engage with, especially the community based ones, such as the coffee mornings at a local church and lunches out at the pub. We know we can do better, but I think we're definitely getting there." Records indicated the relatively new activities coordinators had introduced a wide range of interesting in-house and community based activities in the past year which included, gentle exercise classes, ball games, baking, bingo, sing-a-longs, quizzes, gardening, reminiscence groups, pampering sessions, visits by local school children, a summer barbeque and fayre in the garden and trips out to local coffee mornings, pubs and the coast.

We saw staff had begun the process of finding out people's life histories, which once competed would be included in people's care plans. Managers told us these life histories would give care staff and activities coordinators essential information about people's interests so activity programmes could be individually tailored to meet people's expressed social needs and wishes. Progress made by the service to achieve this stated aim will be assessed at their next inspection.

Managers told us the new provider had recently introduced the Namaste programme at the home. The Namaste programme is an evidence-based programme designed to improve the quality of life for people living with dementia. The activities coordinators had received specialist Namaste training from a community dementia nurse to implement the programme. The deputy manager told us the new providers had already agreed plans to convert an unused communal room into a specially designed Namaste sensory room. This space would include soft lighting, comfortable chairs, oil burners and light music to create a calming and relaxing environment for people living with dementia. Progress made by the provider to implement the Namaste programme and create a new sensory room will be assessed at the services next inspection.

The provider had suitable arrangements in place to respond to people's concerns and formal complaints. Most people living in the home and their visiting relatives or friends said they knew how to make a complaint if they were unhappy with the service provided at Eltandia Hall and confirmed they had been given or seen a copy of the 'Service Users' guide, which contained the new providers complaints procedure. However, two relatives we spoke with said they did not know how to make a complaint and had never seen any information about how they might go about raising their concerns. On the first day of our inspection we found only one copy of the providers' complaints procedure in the reception area which was not written in plain or simple language, or an easy to understand pictorial format or conspicuously displayed in a place where people could easily read it. We discussed this accessibility issue with the managers during our

inspection who resolved it by ensuring easy to read pictorial versions of the providers complaints procedure were created and clearly displayed throughout the home by the second day of our visit.

The provider used complaints and concerns to improve the quality of the service. Complaints were dealt with by the provider's management team. The complaints records showed that complaints lodged at the service had been taken seriously, investigated and where required action taken and lessons learnt.

When people were nearing the end of their life, they received compassionate and supportive care at the home. People's preferences and choices for their end of life care were clearly recorded in their care plan and acted upon. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms in care plans for people who had made this decision. Records showed staff had completed up to date end of life care training. Staff demonstrated a good understanding of how to support people who were nearing the end of their life and their families. The service also had a designated palliative care champion who was a suitably experienced and qualified nurse responsible for advising and training staff on end of life care matters. We saw accommodation was available on-site for relatives and close friends to stay overnight when someone was receiving palliative care. Managers told us they worked closely with GPs and palliative care professionals from a local hospice.

Good

Is the service well-led?

Our findings

The service was well-managed. The service has had two new registered managers in the last 12 months. The most recent registered manager who was a qualified nurse had been in post for four months. People living in the home, relatives and community professionals all spoke positively about the way the home was now being run by the new registered manager and the deputy manager. One person told us, "I like the new managers. They seem to know what's they're doing and are both very approachable and easy to get along with," "The new managers are good at ensuring everything is well organised and paperwork is easy to follow and find" and "I'm confident the new managers can continue improving Eltandia Hall and make it a better place for people to live."

The registered manager was supported in the day-to-day operation of the home by a deputy manager, a clinical lead nurse and a range of senior nurses and care coordinators who all worked in the home. At provider level, support came from a regional quality and compliance manager and clinical standards manager. The deputy manager told us, "I feel we get all the support we need from the new providers senior management team who regularly visit us here at Eltandia Hall." The managers demonstrated good awareness of their role and responsibilities about meeting CQC registration requirements and for submitting statutory notifications of incidents to us.

The service had an open and inclusive culture. People and their relatives said they had opportunities to share their views about the home with the managers. People also said managers and senior staff were accessible. The provider used a range of methods to gather views from people and their relative's including, bi-monthly meetings and annual care plan reviews. Managers told us the new provider was in the process of arranging for stakeholder satisfaction surveys to be sent out to people living in the home and their relatives, which they planned to do annually. Progress made by the provider to achieve this aim will be assessed at their next inspection.

The provider valued and listened to the views of staff working in the home. Most staff said they had a high regard for the leadership style of the new registered manager and her deputy. Most staff felt the managers were supportive and listened to what they had to say. Several staff frequently described the newly registered manager as "professional" and "friendly". One member of staff said, "I think the new manager has done a fantastic job to improve the home in a very short period. Staff who weren't interested in making Eltandia Hall better are beginning to leave or buck their ideas up." Staff attended bi-monthly team meetings where they could contribute their ideas to improve the home. Records of these meetings indicated discussions regularly took place which kept staff up to date about people's changing care and support needs. Staff were also rewarded for demonstrating 'excellence' in the work place. The new provider had recently introduced an 'Employee Care Award' which recognised staff who performed 'outstanding' work.

There were appropriate arrangements in place to monitor the quality and safety of the service people received. Senior managers were responsible for undertaking regular audits and spot checks at the home. For example, the regional quality and compliance manager regularly visited the home and carried out themed audits that focused on a different aspect of service delivery each month, while a human resources manager

routinely checked staff were recruited safely and in line with the provider's staff employment procedures. An independent contractor was responsible for monitoring the homes health and safety arrangements. In addition, the managers and senior staff team based in the home were responsible for carrying out their routine checks which included, care plans and risk assessments, medicines management, infection control and food hygiene, fire safety, complaints and safeguarding incidents and accidents. Several staff felt the new managers spent more of their time on the units assessing staffs working practices than the previous managers. For example, the new managers had introduced unannounced out of hours spot visits to monitor if the home was run properly outside of normal working hours.

The range of governance systems described above were also used to review any accidents, incidents or near misses involving people and develop improvement plans when recurring themes and issues had been found. The deputy manager told us they regularly discussed the improvement plans at meetings with the regional manager. They gave a good example of action they had taken to improve the homes medicines handling practices after the audits described above had identified a higher than expected number of significant medicines handling errors that had occurred in the second half of 2017. Records indicated staff had been retrained in the safe management of medicines and there had been a significant decrease in the number of medicine recording errors that had occurred in the home in the last six months.

The provider worked closely with various local authorities and community health and social care professionals. A community social care professional gave us a good example of how a local authority's safeguarding and contracts teams had worked in close partnership with the homes new managers during the last six months to develop and agree an action plan to improve staff training and support. Another social care professional told us, "The homes managers liaise well with us." The deputy manager told us they frequently discussed peoples changing needs, reviewed joint working arrangements and shared best practice ideas with a range of community health and social care professionals who frequently visited the home. This included local GPs, district nurses, community psychiatric teams, tissue viability and palliative care nurses, social workers, dieticians and occupational and speech and language therapists.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure all staff always treated people using the service with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff they employed had received all the appropriate training and professional development they needed to enable them to effectively carry out the duties they were employed to perform. Regulation 18(2) (a)