Encompass (Dorset)

Elsadene

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 30 July 2018 and was unannounced. The inspection continued on 31 July 2018 and was announced.

Elsadene is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the previous inspection in February 2016 Elsadene was registered as a hospital. On 4 January 2018 Elsadene changed its registration to a care home. For that reason, Elsadene was inspected as a care home under the Adult Social Care assessment framework.

Elsadene is a large, detached property in Weymouth. The home is set out over three floors and provides long term accommodation and care for up to 13 adults living with enduring and complex mental health needs. At the time of our inspection 11 people were living at the home.

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

People felt safe. They were supported by staff with a good understanding of how to safeguard them and how to raise concerns either internally or externally if they suspected harm or abuse. People's individual risks were assessed and reviewed. People were encouraged to take positive risks with restrictions minimised as far as possible.

There were enough staff to meet people's needs and respond flexibly to unforeseen changes. People received their medicines on time and as prescribed. The home was clean and free from malodours. Staff understood their responsibilities to prevent and control the risk of infection.

The home carried out regular accident, incident and near miss audits. This included a description of what had happened, the result of the investigation, and follow up action taken. Learning was shared with people and staff. This helped reduce the risk of things happening again.

People had their needs comprehensively assessed to support their move to the home. This included their care needs and how they preferred to live their lives. People were supported by staff who had received an induction and shadow shifts with more experienced staff. People were supported to eat a balanced and healthy diet. They were given choice of what to eat and drink and could eat as much or as little as they wanted. People spoke highly about the food.

People were supported to attend appointments to maintain their health and well-being. Where people's

health needs changed there was timely contact with relevant health and social care professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Where people lacked capacity to make particular decisions they were supported by staff who were trained and worked in line with the principles of the Mental Capacity Act 2005.

Staff consistently demonstrated a kind and caring approach towards people. Interactions were warm, natural and positive. When people were feeling upset or worried staff supported them emotionally.

People's privacy and dignity was supported at all times. They were given time and space to spend time alone relaxing or with friends and relatives. People were encouraged to maintain their independence.

People had thorough pre-assessments which had supported their move to the home. These included people's needs, preferences, network of support, and their abilities. There was a wide range of activities available at the home. These supported and motivated people to maintain their interests and develop new skills.

People were supported to maintain contact with family and friends whether via visits, phone or social media. Relatives told us that they felt involved and included. They spoke positively of the difference the staff had made to their family members' lives.

The home managed complaints in line with their policy. People expressed confidence that when issues were raised they were resolved in a timely way and to their satisfaction.

There was a positive and open culture at the home where everybody's views were listened to and considered important. Staff understood and supported the vision of creating a low-key, low-stress environment where people could recover from episodes of feeling mentally and/or physically unwell.

Staff told us they enjoyed working at the home and felt supported by the management. Staff said they felt valued and motivated from having their efforts recognised and opportunities provided for personal development.

Regular team meetings were held to share information and learning. Annual away days were also held as opportunities to learn more about complex issues with input from invited speakers from health and social care. Feedback was sought from people living at the home with their thoughts then used to develop a plan of action.

The home had established and maintained good working relationships with health and social care professionals and a local college and university. This had resulted in pro-active in-reach services that helped to keep people mentally and physically well for longer and prevent unnecessary transfers to inpatient facilities. Student nurses were positive about their experiences on placement at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff demonstrated a good understanding of how to safeguard people from harm or abuse.

People were supported to take positive risks.

There were enough staff to keep people safe and meet their needs.

Medicines were managed safely, stored securely and correctly recorded.

Staff were trained in infection control measures and were aware of how to reduce risks to people in this area.

The home logged and reviewed accidents, incidents and near misses to identify the cause and prevent them happening again.

Is the service effective?

Good

The service was effective.

Records were clear, up-to-date and available to all staff providing care.

People were supported by staff who had received an induction and training relevant to their role.

People were supported to have a well-balanced diet.

People were supported to stay well through staff arranging and facilitating visits to and from health and social care professionals.

Staff understood and supported people in line with the principles of the Mental Capacity Act 2005 (MCA 2005).

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness by staff.

People could express their views and make decisions about the care and support they received. Families, carers and advocates were involved when this was appropriate.

People's need for privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care plans, and the care they received, was personalised to meet their specific needs.

The home had a well-publicised complaints policy and systems in place to manage and resolve complaints.

Each person at the home had been given the opportunity of making an advance decision. This is a decision people can make to refuse a specific type of treatment at some time in the future.

Is the service well-led?

Good

The service was well-led.

The managers were well respected, had a visible presence around the home, and were approachable.

Regular, well attended team meetings included discussion about areas for improvement and how these would be achieved.

People were given the opportunity to feedback on their experience and this information was used to improve the service that they received.

Annual team away days were used to improve staff understanding of how best to support people with complex needs.

The home had established and maintained partnerships with other agencies to help stabilise, maintain and improve people's mental and physical well-being.

Elsadene

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.

The inspection took place on 30 July 2018 and was unannounced. The inspection continued on 31 July 2018 and was announced. The inspection was carried out by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is how providers tell us important information that affects the running of the service and the care people receive. Prior to the inspection we contacted the local authority safeguarding and quality improvement teams for their views on the home.

We did not ask the provider to send us a Provider Information Return. This is information we require providers to supply at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We collected this information during the inspection.

We spoke with five people who used the service, two relatives and two health and social care professionals. We also spoke with the registered manager, deputy manager and seven staff.

We reviewed three people's care files, policies, risk assessments, health and safety records, consent to care and treatment and quality audits. We looked at three staff files, the recruitment process, complaints, training and supervision records.

We observed care practice and interactions between staff and people who live there. We used the Short Observational Framework for Inspection (SOFI) during a lunch time. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As requested the registered manager sent us copies of the staff training record and home development plan after the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I can tell staff if I don't feel safe and they will help me. They will always help." Staff demonstrated a good understanding of how to safeguard people from harm or abuse in the home and when out in the community. They understood what signs to look out for and were confident in what they would do if they had a concern. Training included safeguarding of vulnerable adults and children.

People were supported to take positive risks. The home looked to minimise restrictions and give people as much freedom as possible. Some people who came to live at the home had periods of overnight leave. If people remained well and self-caring during the period of leave this could then be extended. This increase in freedom helped people, and those supporting them, to recognise that they were on a path to recovery. One person had variable mobility meaning at times they were more at risk of falls in and out of the home. This person had mental capacity and understood the risks therefore staff only accompanied this person in the community when they requested it.

Regular, well attended team meetings included an opportunity to review and act on patient safety alerts, for example from NHS and Public Health England. These alerts are important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care. A recent alert shared with staff had helped them and people reduce the risk of getting seasonal influenza.

Equipment was routinely checked and serviced and environmental safety audits were completed. This lowered environmental and equipment-related risks to people and staff. The risk to people from fire was reduced through regular checks and maintenance of fire equipment, systems and procedures. This included fire escapes, the fire alarm and fire extinguishers. People had Personal Emergency Evacuation Plans (PEEPS) in place which guided staff on the most appropriate way to support people to get out of the home safely in the event of an emergency such as a fire or flooding. These were reviewed monthly.

There were enough staff to keep people safe and meet their needs. Although the home did not use a dependency tool the stability of the staffing team and the years of experience they had helped with matching the number of staff and skill mix required to the current and changing requirements of the people living there. When a person had become agitated in the community the home was able to respond flexibly by providing two staff to ensure their safety. Staff were encouraged to write people's appointments and key activities in a request book so that the management could ensure that there was an appropriate staffing and skills mix. People told us that staff had time for them and did not rush around. Staff said that the rota supported them to have meaningful interactions with people. Our observations confirmed this.

The home had robust recruitment practices. Checks were done to ensure staff were suitable to support people at the home. Pre-employment and criminal records checks were undertaken. Records included photo identification, application forms with details of work history and qualifications, interview records and references.

People received their medicines on time and as prescribed. Medicines were managed safely, stored securely and correctly recorded. Medicines ordering was done by staff with the required nursing qualification. They were also only administered by staff that had been trained and assessed as competent to give medicines. The temperature of the room where medicines were stored was monitored and records showed this was within the acceptable range. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way. We observed people being supported in a timely way with relevant medicine when they felt in pain or discomfort. The home conducted medicines competency checks and records audits to maintain standards and keep people safe. People were supported to be as independent as possible with their medicines. Where people had the ability to manage their own medicines the home was in the process of making this more person-centred by installing lockable cabinets in their rooms. Risk assessments had been completed to support this approach. People with limited capacity to understand their medicines and the benefits of taking them were given extra support.

Staff were trained in infection control measures and were aware of their responsibilities for maintaining high standards of cleanliness in the home. The home was visibly clean and there were no malodours. Cleaning schedules for communal areas were up to date. With people's consent staff carried out deep cleaning of their rooms to help them stay safe and well. There were hand sanitisers and supplies of personal protective equipment around the home and staff made appropriate use of these. Colour coded mops, cloths and chopping boards reduced the risk to people and staff of cross contamination.

The home logged accidents/incidents/near misses and reviewed this information to determine the cause and to reduce the chance of it happening again. One person's glasses had been fixed as it was noted that they became agitated when they could not use them. This demonstrated the staff had learned the triggers to this person's wellbeing and knew what to do to prevent circumstances that could cause an adverse change in their behaviour. After a person had experienced a trip on some steps staff encouraged them to use the handrail available. Quarterly reports allowed the tracking of incident types and trends to be identified.

Good

Is the service effective?

Our findings

Care and support was planned and delivered comprehensively and in line with an approach that focused on recovery from periods of being mentally and/or physically unwell. Records were clear, up-to-date and available to all staff providing care. The home was in the process of moving care records from a paper based system to an electronic system accessed by hand held devices. Staff had received training in how to use these and could confidently navigate the information they held to help them support people in a timely and efficient way.

Visiting health professional notes were readily available to staff which ensured that people received a continuity of care. All relevant parties were included in reviews of people's needs including the person concerned, relatives, staff familiar to the person, and health and social care professionals. The reviews were used to consider if expected outcomes were being achieved, for example increased engagement and enjoyment from community activities or less frequent behaviours of concern. One relative said "I go to all the reviews. They always let me know when they're coming up."

People were supported by staff who had received an induction and training relevant to their role. Staff members told us, "We get the training we need and options to do other courses", "They are very, very good with training and always let you know when courses are coming up", "My induction included intense training on [behaviours of concern], safeguarding and care plans" and, "The trainers know what they are talking about." One staff member said fire training had taught them how to evacuate the house. The home's induction programme also covered infection control and equality and diversity. One person's probationary review following induction noted, 'I would just like to say how much I love the job and all the staff I work with have been so helpful.'

Nursing staff at the home were aware of their responsibilities to re-validate with their professional body. Nurse re-validation is a requirement for all qualified nurses. This process ensures they provide evidence of how they meet their professional responsibilities to practice safely and remain up to date. Staff received regular supervision which gave them an opportunity to raise issues, reflect on their practice, and discuss learning opportunities. One staff member told us, "My supervisions are good. You can air anything." Another staff member said, "We get time to reflect quite a lot in supervision." A visiting health professional expressed, "I take my hat off to the staff. They are very skilled and the leadership here maintains that."

People had choice of what they ate and drank. Food was plentiful, well-presented and all home-made. Some of the meals included fruit and vegetables grown in the garden. We heard one person telling staff how tasty they had found the courgettes provided for lunch. This person told us, "The food is brilliant." The cook regularly met with people to find out what they preferred to eat and drink and demonstrated a good knowledge of people's likes and dislikes. People were encouraged and supported to make healthy food choices. The home was planning to purchase a laptop to enable people to order their own shopping. People told us that they could have as much or as little food and drink as they wanted. People had the choice to either have their meals in their rooms or join other people in the dining room. Staff and people sat together and engaged in friendly, easy conversation. Meal times were calm and unrushed. At tea time people could

help themselves to buffet food. This was being trialled to encourage people to be creative and develop independent living skills.

People were supported to stay well through staff arranging and facilitating visits from health and social care professionals including psychologists, GPs, diabetic nurses and social workers. One health professional said, "The staff go out of their way to provide care that is tailored to meet people's individual needs." The home recognised the benefits of working collaboratively with health and social care professionals to keep the people living at the home mentally and physically well. A staff member expressed, "If I had a relative with mental health problems I wouldn't think twice about them coming here."

Where required, staff supported people to attend appointments for example with a GP, continence nurse or optician. On these occasions the staff helped to reassure people and/or provide people with clear explanations of proposed treatment options. People had regular visits from healthcare professionals and annual health checks. Depending on people's preferences these could be held at the home or local surgery. Care plans noted previous health and social care professionals' visits and people were reminded of upcoming appointments.

The home was laid out over three floors with the second and third floors accessible using a lift. There were 13 bedrooms, a spacious lounge, dining room and small locked room where people's medicines were stored. People could meet visitors in a private room or use their bedrooms. Grab rails had been fitted in some people's rooms to help them if they experienced problems with their mobility. There was a large conservatory that looked out on to the enclosed garden. People had free access to the garden which had a BBQ and covered seating area. People used this space at their leisure to spend time alone or with staff and other people living there.

Staff understood and supported people in line with the principles of the Mental Capacity Act 2005 (MCA 2005). The MCA 2005 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 were assumed to have capacity to understand an issue unless there was evidence indicating otherwise. Staff acknowledged that mental capacity was something that could fluctuate rather than being fixed. For example, they told us that people's mental capacity "may be affected when a person becomes less well." The home conducted monthly audits of people's mental capacity and consent to care and support.

Staff consistently sought people's consent prior to helping them meet their needs. For example, we heard one staff member helping a person with their medicines ask. "Do you mind if I give you your tablet?" Where people had been assessed as lacking capacity to give informed consent meetings were held to see what should happen in their best interests, for example in cases where people required complex dental work or a course of treatment for life limiting conditions. Staff knew who to consider involving on these occasions. Where people had others with the legal authority to make decisions on their behalf, such as a power of attorney or a solicitor, the home had liaised with them appropriately depending on the type of issue needing a decision, for example finance or health and welfare.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). For

two people that required DoLS we saw that it had been applied for and authorised by the local authority. There were no conditions attached to the DoLS being granted. A review date had been set for each.

Good

Is the service caring?

Our findings

People were treated with respect and kindness by staff. One person said, "The staff treat [us] decently here." One relative told us, "We were quite impressed with how the staff support [name]. They have [name]'s well-being at heart. They were very caring. I was very impressed with their attitude. It was very comforting to know that [name] was there." Another relative said, "They all seem very caring." One person's plan guided staff in helping to improve a person's self-esteem by 'telling [them] they look nice.' This person confirmed that staff treat them to pampering sessions which helped them feel good.

People were supported by staff who respected their right to live their lives how they wished to. This included their preferred name, gender identity, the clothes they chose to wear, and how they spent their time. When people's preferences changed staff recognised this and met their needs. We observed one person being supported to spend some time for themselves. This was also noted in their care plan which noted, 'likes peace and quiet before breakfast.'

Staff demonstrated the ability to support people at times they felt anxious or upset. For example, one person became worried when they had lost something we observed staff supporting the person emotionally with reassuring words and helping them to find it. One person's care plan reminded staff to reflect on a person's achievements and current capabilities if they were feeling emotionally low. We observed positive interactions between staff and this person.

People could express their views and make decisions about the care and support they received. One person's care plan noted that they preferred to see certain doctors and nurses at the hospital and wherever possible this had been supported. This helped the person feel more settled and accepting of treatment and reduced the possibility of behaviours of concern. Another person's care plan advised staff that the person could 'recognise symptoms in [them]self.' This was evidence of a person-centred approach.

The home worked closely with a local advocacy service which helped ensure that, if required, people had the support required to convey their needs. We observed an advocate had attended the home for a person's review during day two of our inspection.

People's need for privacy and dignity was respected. We observed staff using people's preferred names and always knocking and asking for consent to enter before going into people's rooms. Where there was a need to convey or discuss sensitive information staff gave people the opportunity to go somewhere more private or spoke in a hushed tone so that they would not be overheard.

Although none of the people at the home were known to be in an intimate relationship the management said they would support this to happen should people wish to explore this as part of their lives. There was evidence that people were being supported to maintain and enjoy long-standing close friendships.

People were encouraged to live their lives as independently as possible. One person said, "I can come and go as I like. You can have what you want in your room. I can go to bed anytime I like."

Good

Is the service responsive?

Our findings

People's care plans, and the care they received, was personalised to meet their specific needs. People had pre-assessments before moving to the home to help ensure the staff could meet their holistic needs. On moving in people had a named key worker which helped deliver a consistency of approach and build familiarity and trust. Care staff had access to people's care plans and health professionals' notes. We observed staff giving and receiving updates about people's care needs during a handover meeting. The information we heard matched what we had read in people's care plans and what people, relatives and staff had told us. There was clear evidence that staff were aware of people's changing needs and the action/s required to support them.

Care plans were comprehensive, person-centred and included evidence of regular reviews of people's care and support needs with involvement from the person and/or people important to them. People were encouraged to attend their review meetings. One relative said that the care [their] family member had received was "excellent" adding, "[Name] has had no relapses since being there. They keep [name] to [name]'s routine which is everything to [name]. [Name] couldn't do much better than Elsadene. We're really pleased [name] is there." A staff member told us, "There is a relaxed atmosphere and that is what works well for the people who live here." The registered manager mirrored this opinion when telling us, "It's a low-key, low-stress environment where people can thrive."

From 1st August 2016 onwards, all organisations that provided NHS care and / or publicly-funded adult social care were legally required to follow the Accessible Information Standard (AIS). The AIS sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

People's communication needs were identified to support their move to the home and was an ongoing consideration. Information and interactions were provided in a format, level, pace and frequency that each person could understand. For example, one person had 1-1 sessions with staff to help them improve their capacity to understand issues affecting their life. Two people had photos of their medicines on cards so that they knew what they were being offered and the reason it was prescribed. Another person we spoke with had a sight impairment. They confirmed that staff supported them with this by introducing themselves and standing close to them when speaking.

People were supported and encouraged to maintain contact with family and friends and make new ones through visits to and from the home and participation in community activities. We saw people receiving visitors and going out with family members and other people they had made friends with at the home. People were heard making arrangements with each other to attend upcoming activities. People were given access to the home's wi-fi so they could use the internet and stay in touch via social media.

The home had two activities coordinators who consulted with people to develop a programme of activities that met each person's diverse needs. Meetings were held with people each month to see what activities

they would like to do. One person confirmed this when telling us, "We have meetings to say what you want to do or don't want to do." Suggestions and ideas were then added to the following month's activities programme. The activities coordinators worked closely with care staff to help ensure activities were coordinated and well supported. Staff had received training from a visiting occupational therapist so that they better understood the importance of activity for people looking to recover from feeling mentally unwell. One health professional described the activities coordinators as "amazing."

Activities included well-being walks, a community disco, and an arts group. We observed an armchair aerobics session run by one of the activities coordinators and supported by other staff. Five people joined in and were heard laughing and joking with the staff. People had the choice to join in, to observe or to do their own thing. One person said, "I go out on my own and with the groups. I enjoy going out on the outings." Staff had shown creativity on an occasion where a person who had enjoyed stone masonry could no longer do it at a local quarry. They supported the person to purchase masonry tools so that they could continue doing the activity at the home.

People's choice to spend some time quietly on their own, whether in their room or elsewhere in the home, was respected. People were given the time and space to be themselves and spend their day how they wished. A staff member said, "I think it's important that the [people] feel it's their home." One person's relative told us the staff had encouraged their family member to go on holiday which they had "thoroughly enjoyed." The home evaluated each person's experience of an activity to ensure that it met their needs. Meaningful activity was seen as a way of supporting people to enjoy their lives and stay well. Two people were decorating jars for an upcoming garden party. When one of the people expressed a wish to have some background music of their choice playing to aid the activity the staff present made it happen. People and staff were then observed singing along together to the music with one person teaching the staff the words.

The home had a well-publicised complaints policy and systems in place to manage and resolve complaints. Records showed the home had received no complaints since being registered as a care home. People and relatives told us they would know how to complain and all said they felt assured that any concerns they had would be investigated and resolved to their satisfaction. The home kept a file of compliments it had received. One comment stated: 'With many thanks for all you have done for our family.'

At the time of the inspection no people at the home required end of life care. The registered manager said that if that changed they would immediately liaise with primary care, GP and relevant specialist nurses. Each person at the home had been given the opportunity of making an advance decision. This is a decision people can make to refuse a specific type of treatment at some time in the future. Some people had a Do Not Resuscitate (DNR) in place. A DNR is a written legal order confirming a person's wishes to not be resuscitated in the event their heart was to stop or they were to stop breathing. Staff had recently worked with a person, their relative, and health professionals to put one in place. Those people that did have a DNR had this recorded in their care plan.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager started in that role in January 2018. Prior to that the registered manager was the deputy manager for 19 years. The registered manager told us they got their support from the deputy manager (formerly the registered manager), a network of registered managers and supervision with the provider's service and development lead.

All staff spoke highly of the registered manager and deputy manager. Both were well respected, had a visible presence around the home, and provided clear leadership. They were considered as approachable by people, relatives and staff. Staff said they felt able to raise anything to management including suggestions of how the service could improve. The registered manager said, "All the staff here can, at any time, add to the vision and help shape the service." The vision was to provide a low- stress environment for people with complex needs; some of whom had been unsettled in previous places they had lived. The registered manager said, "We mainly instil self-confidence and self-worth. When we combine these people can grow." The registered manager then added, "I want staff to show foresight and leadership in a determined but settled manner. I want it to be a therapeutic environment." The deputy manager reiterated this when saying, "We understand the benefits of a positive emotional climate on a person's health. We constantly take the temperature of the team."

People were supported by a cohesive staff team that got on well. There was an open and inclusive culture where team building helped staff to feel comfortable and able to raise concerns or put forward ideas. One relative said, "It's a nice home. It's a good team." Staff members' comments included: "Its lovely here. Everybody is helpful and mucks in. It is a pleasant working environment", "I love it here! It's a good team to work with. Everybody is approachable", "I love working here. Every day is different. All the staff are very nice and helpful" and, "This is the best job I've ever had. I like the residents, my colleagues and the atmosphere. Everyone is friendly and supportive."

Staff told us that they felt valued and were motivated by being praised for their practice, for example during supervision and appraisals. Two staff member's notes stated, '[Name] should be commended for how well [they] have integrated into the team and [their] hard work so far' and, '[Name] has excellent skills and is very supportive to the team.' One staff member said that the first thing they had noticed on starting work at the home was their "opinion is very valued." Staff appraisals also included feedback from their colleagues. Staff said they found it useful to know how they were perceived by colleagues and that this had helped them understand the contribution they brought to the team. One person's appraisal summary said that colleagues viewed them as 'kind, compassionate, clever, with good ideas.' The registered manager told us, "I couldn't wish for better staff. Nothing is too much trouble."

Staff were also made aware if there were areas of concern with their practice and/or they had any development needs. For example, where a staff member had expressed a wish to become a mentor action

was taken to find a suitable course. If there were concerns about a staff member's practice an action plan was put in place with agreed timescales and a date for review.

In a planned December 2018 survey people will be asked to provide feedback on areas including: privacy and dignity, involvement, and their rights. Feedback from monthly meetings with people had contributed to an action plan. Relatives could attend these meetings if they wished. The home told us they do not currently seek feedback from relatives and health professionals but were going to do this as part of their annual survey. The home produced a quarterly newsletter which people and their relatives contributed to.

Staff took part in annual team away days. Staff told us these were used as learning opportunities where they could improve their understanding of how best to support people with complex and enduring needs to recover and stay well. The away days often included sessions facilitated by health and social care professionals. At one away day staff had reflected on choice and control and ways to avoid de-skilling people. Another had focused on what staff could learn from observing people during activities. This had helped staff recognise how people could benefit from activity for example with their mood, motor skills or sequencing. The notes from this session had been shared with staff and advised 'it is important to note that not one activity fits all – not to force people to do things that they don't want to as it can be counter therapeutic.

The home was keen to share the work it did and had written to Prince Harry to provide a personal insight into mental health challenges and support a national campaign. The registered manager said that they were getting more complex referrals and in response planned to arrange specialist training including inviting speakers from the community mental health team. With regards improving staff skills the registered manager told us, "Staff will grow if given the chance to grow through training and being supported to take on new responsibilities."

The management had recently put together a home development action plan with issues identified from audits and meetings with people and staff. The issues had been aligned with CQC's five key lines of enquiry. There were clear descriptions of the issues identified and corresponding actions with expected completion dates. Auditing was leading to continuous improvements. The plan included a positive review of medicines management by a local hospital pharmacist. It also identified a need for management and activity coordinators to keep up to date with best practice with a monthly review of NICE guidelines. In addition, management staff had joined a local learning hub and the activity coordinators were contributing to an activity hub. Ideas were then brought back into the home.

The home had established and maintained partnerships with other agencies such as local surgeries, community mental health teams, and a local college and university. These partnerships helped stabilise, maintain and improve people's physical and mental well-being while making Elsadene a good place to live and work. One health professional said, "I would be happy for my family members to move there and if I needed help I'd want to go there. I can't sing their praises enough. We could do with other homes like [Elsadene]."

The home had supported student nurse placements with two recent students noting, 'I have really enjoyed this placement and wish I could stay longer' and, 'The care here was very good. The service users were listened to…everyone was treated equally but also specific to their needs. The staff were all lovely.' The home had encouraged students with them to critique practices and offer suggestions for improvement. Staff told us that having students at the home had helped to re-invigorate their practice.

The home understood and had met its responsibility to share safeguarding information with relevant

agencies and submit notifications to CQC to advise us of any issues that affected the running of the service and the care people received.