CareQuality Commission

Lotus Care (Ellerslie Court) Limited

Ellerslie Court

Inspection report

38 Westcliffe Road
Southport
Merseyside
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Tel: 01704568545

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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

This inspection took place on 30 August 2017 and was unannounced.

Ellerslie Court is a Victorian House that has been converted into a Care Home providing accommodation and personal care for up to fourteen adults with a physical disability. At the time of our inspection there were 14 people living at the home. The registered provider of the service was Lotus Care Limited. This was the service's first inspection under the new registered provider.

The service provides accommodation over four floors with the use of a passenger lift. Communal areas are on the ground floor and consist of a dining room, two sitting rooms and a conservatory. There are a range of aids and adaptations to aid people with a range of physical disabilities.

A registered manager was 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.

As part of our inspection, we checked that the service had sent is all statutory notifications that the provider is required to send us by law. We saw that we had received most notifications as required, however the registered manager had not sent in one notification to update us of the outcome of an incident. We discussed this at the time of our inspection and saw it was an error on the provider's behalf. The provider took action straight away and we were sent this notification.

The people we spoke with told us that they liked living at the home and they felt safe. We saw there was enough staff on duty to be able to meet the needs of people who lived at the home. Staffing levels were accessed using a dependency tool to ensure sufficient numbers of staff were on shift.

Staff we spoke with were able to describe the course of action they would take if they felt someone was being harmed or abused in any way. This involved reporting concerns to the manager in charge and whistleblowing to external organisations such as, CQC and the Local Authority.

Medication procedures were safe, and medication was only administered by staff who had received the correct training to do so. Medication was stored in line with best practice guidelines. Specialist techniques for administering medication were clearly recorded in people's care plans.

Staff recruitment was safe. Staff were only offered positions at the home once all checks had been completed which included references and a police check.

Risk assessments contained key details with regards to how staff should offer appropriate support and reassurance for people to help mitigate risks. Accident and incident recording was thorough, and people

had been appropriately referred to other clinical teams when needed.

People received support in line the Mental Capacity Act 2005 (MCA) where appropriate. Where authorisations were required to lawfully deprive a person of their liberty, we saw these were requested without delay and reviewed regularly. DoLS applications were in place for people, and these were reviewed regularly.

Staff had recently undergone a new training programme, all staff training was updated according to the provider's own mandatory training subjects. Certificates stored in a separate file confirmed that the staff had attended this training. In addition, all staff had received a supervision at least every eight weeks, and all staff had had an annual appraisal.

There was a wide range of menu choices available for people. Different diets were catered for, and there was a choice offered if people did not like the main course. We also saw fresh fruit was available in the dining room.

People told us and our observations showed that staff treated people with kindness, respect and consideration. Most of the staff had been in post for over three years, and knew the people who lived at the home well.

People were involved in the reviewing and development of their care plans were able. Family members were also involved. Where people did not have the capacity to consent to their care plans we saw that a best interest process was followed which involved the person, their key worker, and their family. This involved meeting with people who knew the person best with the person present and making complex decisions in their best interests.

Staff were able to describe how they treated people with respect and dignity. We saw various examples throughout the duration of our inspection of staff treating people with dignity, and respecting their choices and wishes.

There was a complaints process in place. This had been made available in easy read and pictorial format to help people understand the content easily. There had been no recent complaints regarding the service.

Information in care plans was person centred. Care plans also contained information about people's backgrounds, preferences, likes and dislikes in all aspects of everyday life. As some people who lived at the home were unable to verbally communicate their views or opinions, information contained examples of how people used other ways to communicate, such as picture cards, signs and facial expressions.

There were various quality assurance procedures (checks) taking place at the home both by the registered manager and the area manager. Some audits would have benefited from being undertaken more regularly, which we raised with the registered manager at the time of inspection. However, we saw that audits were robust and information was shared with the staff around their findings.

Feedback form and the process for gathering feedback had been changed and adapted to suit the needs of the people living at the home. Feedback forms had recently been sent out, so there was no report for us to view at the time of our inspection.

Team meetings and resident meetings took place regularly. We viewed the minutes of these and people had made valuable contributions which the service had responded to.

There was a positive, homely culture at the home. Staff told us they enjoyed working there.

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.

Risk assessments contained a sufficient level of information to help staff mitigate risks.

Medication was managed safely and stored securely.

Staff were recruited safely and were only offered positions in the home once all checks had been completed.

Staff were able to describe the process they would follow to help keep people safe from abuse.

Is the service effective?

Good

The service was effective.

People were support by staff who had the correct skills and knowledge to do so. Staff had access to regular supervision and had an annual appraisal.

The principles of the Mental Capacity Act 2005 were adhered to and staff were knowledgeable regarding this Act and associated legislation.

Menus offered a range of choice. People liked the choice of food.

Is the service caring?

Good

The service was caring.

We observed kind and caring interactions between staff and people who lived at the home.

People told us they liked the staff, and staff were able to provide examples of how they offer respectful and diverse support.

There was advocacy information displayed if people required this.

Is the service responsive?

Good

The service was responsive.

Care was highly personalised, and each person's choices and personalities were taken into account when support plans were drawn up and care was delivered.

There was a complaints procedure in place which was available in a range of formats for people who required this. There had been no recent complaints for us to view.

Is the service well-led?

Good

The service was well-led.

We had not received all statutory notifications as required. This was discussed at the time of inspection and we saw it was a mistake on the part of the provider and steps were taken to rectify this. We had received all other notifications as required.

Everyone we spoke with was complimentary about the registered manager and the new provider.

There was a process in place for gathering the views of the people who lived at the home. This had recently been completed.

Team meetings and resident meeting regularly took place so that people were able to share their views about the service.

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Ellerslie Court

Detailed findings

Background to this inspection

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

This inspection took place on 30 August 2017 and was unannounced.

The inspection was conducted by an adult social care inspector.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spent time with three people who were living at the home, one visiting healthcare professional and one relative. We spoke to four staff members including the registered manager and the chef.

We looked at the care records for three people living at the home, three staff personnel files and records relevant to the quality monitoring of the service. We looked around the home, including people's bedrooms, the kitchen, bathrooms and the lounge areas.

Good

Is the service safe?

Our findings

Everyone we spoke with told us that they felt the home was safe and secure. One person said, "Oh I definitely feel safe here. I know everyone is here." Someone else said, "Yes, I feel safe and looked after." A visiting family member said, "[Person] has not been at the home for very long. But in that short time we have noticed an improvement in them. I feel [person] is safe." Most of the people who lived at the home were unable to verbally communicate with us, so we observed people in the communal areas, and interactions with staff to enable us to understand people's experiences of care at the home. We looked at people's body language, facial expressions and any other means of communication they used to inform our observations. Our observations indicated positive interaction between staff and people who lived at the home.

Staff records we saw demonstrated that the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to them commencing work at the home.

The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the registered manager to assess their suitability for working with vulnerable adults.

We saw that all firefighting equipment had been checked, and new equipment was in place in various parts of the home to help people evacuate safely. PEEP's (personal emergency evacuation plans) explained each person's level of dependency and what support they would require to ensure they were evacuated safely. We spot checked some of the certificates for PAT (portable appliance testing), electric, gas, and checks on the other equipment such as the hoists. These were all in date and helped to ensure the safety of the service.

We looked at the provider's PIR under the heading 'Is the Service Safe?' and saw they stated, (quote from PIR) 'Person centred care planning and risk assessments for each resident are in place to ensure they are empowered to live their lives in the way they choose. These are reviewed monthly or sooner if there is a change.'

We checked risk assessments and saw that they had been produced for people and contained information about their clinical diagnosis, their emotional well-being and their physical needs; this information, centred around their choice and preferences. For example, we saw that one person had a pressure ulcer, and there was comprehensive documentation in place including a wound care plan, and a description of how the ulcer was healing. We saw that another person needed specific support when being transferred, as they were at risk of involuntary movements when being hoisted. The risk assessment for this person clearly described the steps the staff should take to take minimise the risks to this person. We saw that people who could present with challenging behaviours had their needs risk assessed to ensure that harm to themselves

and others was minimised, including any behaviour triggers, and words or phrases that people did not like that may upset them.

We saw that other risk assessments such as falls, diet and nutrition, bedrails and mobility were also in place and these were being reviewed every month.

The senior carer provided us with an overview of how medicines were managed within the home. Processes were established for receiving and monitoring stock, and the disposal of medicines. Medicines were held in a locked trolley. Medicines were administered individually from the trolley to people living at the home. Medication requiring cold storage was kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily to ensure the temperatures were within the correct range for the safe storage of medicines.

The medication administration records (MAR) included a picture that was sufficiently large enough to identify the person. We noted that the MAR charts had been completed correctly and in full. There were no missing signatures or spaces on people's MAR.

Arrangements were in place for the safe storage and management of controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs Legislation. There was no person living at the home receiving controlled drugs at the time of our inspection. Some people were prescribed topical medicines (creams). These were stored safely and body maps were routinely used to show where topical creams should be applied.

Some people were prescribed medicines only to be taken when they needed it (often referred to as PRN medicine) and had a plan in place to guide staff about when this medication should be given. PRN medicine was mostly prescribed for pain or if people became upset or anxious.

We saw that one person was being given medication covertly. This is when medication is hidden in food or drink. We saw that there were detailed arrangements for this procedure which included the GP, the pharmacists, and the person's family member. The registered manager had also followed underpinning Mental Capacity Act legislation to ensure this decision was in the person's best interests.

We looked at the adult safeguarding policy for the home and asked the staff about their understanding of their roles in relation to safeguarding. Staff were clearly able to describe the procedures they would be expected to follow to keep people safe from abuse. One staff member said, "I go to the registered manager and tell them. I would not hesitate." We also asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use this policy if they felt they needed to. We spent time discussing a recent safeguarding outcome which involved the police, and saw that they provider had taken appropriate action to support the person involved and keep them safe. We also saw management plans had been put into place to help minimise the incident occurring again.

We checked rotas and saw that shifts were filled by staff who worked at the home to provide consistency for people who lived there. Rotas and our observations evidenced that there was enough staff on duty to be able to meet people's needs.

There was a process in place to record and monitor incidents and accidents. We looked at the process for analysing falls. We saw that falls were well documented. This was accompanied by an written explanation from the registered manager which took into account any patterns or trends. One person in particular was prone to falls, and we saw that their footwear had been identified as possible cause on some of the

occasions they fell. We saw that steps had been taken to support the person to purchase appropriate footwear with their consent. There was currently no auditable documentation for falls, so we discussed this at the time with the registered manager and saw they were in the process of developing a document which would show that falls were being looked at separately from other incidents, as a way to check that appropriate action was being taken for people who were at risk of falls.

Good

Is the service effective?

Our findings

People and relatives told us they felt the staff were trained and skilled. One relative said, "They know what they are doing." A healthcare professional also said that the staff appeared well trained and skilled. We saw that the provider had a new training process in place which included accredited training modules; these were completed by staff and then sent away for external assessment. We saw that the training matrix had been recently updated, and staff certificates were stored in a 'certificates file.' We checked the certificates against the dates recorded on the training matrix to ensure the training had taken place as documented. We found this to be the case.

We saw that staff completed specialist training on a ventilator and cough assist machine to be able to support people safely with these needs. This training involved medical professionals attending the home, completing observations with staff and signing to say they were competent at completing this task. We saw that all new staff completed an induction which was aligned to the principles of the Care Certificate. The Care Certificate is a set of standards health and social care workers can adhere to as part of their role. All staff engaged with regular supervision which took place every eight weeks and all staff had had an annual appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

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 that applications had been submitted to the local authority to deprive people of their liberty in their best interests and these were being monitored by the registered manager.

We spent time with the registered on the day of the inspection discussing the MCA. It was evident that there was a good amount of knowledge in relation to the MCA, and staff had received training around the MCA. Decisions that people could make themselves were well documented as part of their capacity assessments. We saw that any other communication needs were taken into account, such as visual aids or signs people may have needed to support them to communicate their decision.This shows that the registered manager and the staff team were exploring various methods to support people to be as involved in their care as possible and to ensure effective communication.

People were supported to access medical care when they required it. Each person had a health record in their care plans detailing their last appointments with GP's, district nurses, opticians and chiropodists. We received information from a medical professional during our inspection who was complimentary regarding the running of the home and responsiveness of the staff, they said "I am confident staff will go over any exercise plans with people as needed."

The building was adequately adapted to meet people's needs. There was a new lift in place, and some of areas of the home had been re-decorated. The registered manager informed us that plans were ongoing to further improve the building and environment for people, as some areas did require this. For example, one of the carpets was quite badly stained and needed to be replaced we saw that the new wooden flooring had been chosen by people who lived at the home and there was a date agreed for when this would be fitted.

We saw that people were given choice over what they would like to eat and food was well presented. We saw that a dietary sheet had been completed for each of the people living in the home who had specialised diets, which contained the nutritional value of the foods and how the foods should be presented, for example, fork mashed, soft diet and cut up. The chef was knowledgeable regarding people's likes and dislikes. Vegetables were fresh and there were bowls of fresh fruit around communal areas in the home for people to help themselves.

Good

Is the service caring?

Our findings

People we spoke with and our observations evidenced that staff were caring. One person said, "I couldn't ask for better," also "Marvellous." Another person said "Yes" when we asked them if they liked the staff. The visitor we spoke with told us that the staff were kind and caring.

We observed care being delivered in a caring and compassionate way. Our observation showed that people clearly knew the staff very well by the way they were responding to them. Staff spoke with people in a way which was meaningful for them, often using objects of reference or physical signs and prompts.

Staff were aware of the importance of confidentiality and how this needed to be maintained. Personnel records and care files were securely stored away and it was clear data protection was being effectively managed.

It was evident that staff were aware of the importance of maintaining and preserving people's privacy and dignity; we saw staff discreetly asking people if they wished to use the toilet, or when offering people help to go to their rooms.

Staff we spoke with were able to give us examples of how they protected people's dignity and respected their wishes. One staff member said, "I always make sure I knock and get invited in before I go in someone's room." Another staff member said, "I don't just assume people want me to do things for them, I will always ask first."

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so. We saw that no one was accessing this service during our inspection.

Care plans had been reviewed and signed by the person (if they were able to) themselves or their relative, if legally allowed to do so; people told us they had been involved in their care plan. Family members said they had been involved with care planning and felt that their family member's independence was encouraged as much as possible. People we spoke with agreed that there was a good understanding of peoples' likes and dislikes.

The registered manager had changed different types of documentation to ensure that it was accessible for people. For example, we saw that some of the policies had been converted to easy read to help support peoples understanding; there was also large print documentation which had been available for someone at their request.

Good

Is the service responsive?

Our findings

We saw that people were provided with personalised care which was responsive to their needs. One family member told us, "They [person who lives at the home] hasn't been here that long and we can already see the change in them."

Care plans were person centred. This means developed with the needs of the person at the centre of the care plan and not the needs of the organisation. We saw that care plans were individualised and contained information about the person, such as their backgrounds, likes, dislikes as well as other areas of interest. Everyone had a document, which contained photographs of the person, explaining their life history and personal journey. We saw this had been completed with the person by their keyworker. This was important, because as well as containing background information, this document also contained information around people's behaviours such as any triggers or situations which may cause them to display behaviours that challenge. For example, key words or phrases that the person did not like.

We saw that support plans were written in a way which took the choices of people into consideration. For example, we saw how someone liked to be offered a choice of clothes, and why it was important to them that this happened. Another person had regular support from staff to enable them to keep in contact with their family using an iPad. This was important to them, because they wanted to maintain a close relationship with their family.

We saw that people regularly engaged in activities which were important to them. Staff arranged parties and celebrations for people, and we saw a famous local group often came to the home to sing for people. There was a trip organised to Blackpool for people to see the lights, and a person living at the home told us they were really looking forward to this. We saw that people took part in games and film nights at the home, however most people chose to take part in separate activities. We saw that rotas had been adapted to accommodate people's individual choices with regards to activities. Some staff would work longer hours at certain times to ensure people were supported to engage in outings and trips.

Our review of documentation showed the service worked with other agencies to ensure care plan reviews and best interest meetings took place when needed. We saw that people were involved and included in these meetings.

We looked at complaints and how the complaints procedure was managed in the home. The complaints procedure was displayed in the hallway of the home and was accessible for people to view. The procedure clearly explained what people had a right to expect when they raised a complaint and the timescales as to when they should expect their complaint to be responded to. The complaint's procedure was available in different formats to support people's understanding. People and the relative we spoke with told us they were aware of the complaints procedure and knew who they would go to if they wanted to complain. Most people said they had never had a cause to complain. One person told us, "I would tell staff."

Good

Is the service well-led?

Our findings

There was registered manager in post who had worked at the home for 10 years.

People told us they liked the registered manager. Staff said the registered manager was supportive. One staff member said, "Most of us have worked together for a long time, so we can just talk to each other." We asked about provider oversight at the home and if staff felt supported by the new registered provider. All of the staff we spoke with said they did.

The culture of the service was familiar and friendly. Everyone had worked together for a long time, and people were treated with respect and compassion. The registered manager displayed weekly quotes in the staff office which encouraged teamwork and empathy.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, dignity, independence, respect, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

We saw that most notifications with the exception of one had been reported to the Care Quality Commission. We highlighted this at the time of our inspection and found it was an oversight on the registered manager's behalf. Our later discussions with the registered manager assured us they fully understood what they needed to report to us by law and were apologetic concerning the omission. This was sent without further delay during our inspection.

There were audits for the safety of the building, finances, care plans, medication and more regular checks like the water temperatures. We saw any recommendations were being followed up with a plan of action by the registered manager. For example, we saw that one audit of the environment had identified the need for some modernisation, such as a replacement carpet. This had been shared with the registered provider and an action was being taken for replacement of some items, this was ongoing. We saw that all of the monthly information from the audits were sent to the area manager who made visits to the service to check the actions identified were being carried out. The dates on some audits were quite sporadic. For example, some were completed in May, others in April, then more recently in July 2017. We spoke with the registered manager who confirmed that they were planning to ensure all audits took place around the same time every month to make sure actions plans were easier to check and provide a robust audit trail.

The service had also developed good systems for getting feedback from people living at the home and their relatives. We saw a series of surveys and meetings aimed at seeking feedback about the home. We saw that feedback was regularly acted upon, for example, people had raised they would like new décor. The provider had therefore recently refurbished some parts of the home and ordered a new wooden floor. Survey's had been reformatted so there was now an easy read form available for people to use if they wished.

Team meetings and resident meetings took place every month, we were able to view minutes of these.

We asked people and staff of there was anything they would do to improve the home, and everyone either said 'No' or 'I don't think so.'