The Hampshire Isle Of Wight And Channel Islands Association For Deaf People Limited

Easthill Home for Deaf People

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

Overall summary

The inspection took place on 5 and 6 November 2015 and was unannounced. The home is registered to provide accommodation for up to 15 older people and specialises in caring for deaf people. There were nine people living at the home when we visited, some of whom were living with dementia or had a learning disability.

At the time of our inspection the manager had applied to be registered with CQC and their application was being processed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our previous inspection on 5 and 7 May 2015, we identified breaches of five regulations. We issued two warning notices in relation to the safety of the care provided and the lack of quality assurance processes. We also issued requirement notices in relation to the need

Summary of findings

for consent; safeguarding people from abuse; and the suitability of the premises. The provider sent us an action plan on 12 August 2015 stating they had taken action and were meeting the requirements of all regulations.

At this inspection we found all areas of concern had been addressed. This was confirmed by comments made by people, relatives and staff, who reported significant improvements had been made in the quality and safety of the service.

People said the most important aspect of living at the home was the opportunity to mix with other deaf people and to be able to communicate with staff effectively. A mix of deaf and hearing staff were employed, who were skilled in communicating with people using British Sign Language (BSL). They understood how to adapt BSL to people's individual needs and used this effectively.

Staff acted as advocates for people when they became ill and supported them to access healthcare services. BSL interpreters were arranged for all medical appointments to help people communicate effectively with doctors and specialists.

People were treated with kindness and compassion. Staff spoke fondly about the people they supported and knew them well. People were encouraged to remain as independent as possible, their privacy was protected and they were treated with respect.

People told us they felt safe. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. Individual risks to people, such as developing pressure injuries or falling, were assessed and managed effectively. Arrangements were in place to deal with emergencies, including suitable fire safety measures.

Care and support were provided in a personalised way by staff who understood and met people's needs well. Care plans were comprehensive and were regularly reviewed. A range of activities was provided and the home had set up a deaf club to encourage deaf people living in the community to visit.

The home was clean and staff followed guidance to reduce the risk of infection. Medicines were managed safely and people received their medicines when they needed them.

There were enough staff to support people at all times and recruitment processes helped make sure only suitable staff were employed. Staff received appropriate training, support and supervision in their work and felt valued.

Staff followed legislation designed to protect the rights and freedom of people living at the home and sought consent from people before providing care or support.

The dining room and some people's bedrooms had been decorated and people had been involved in choosing the colour schemes. Plans were in place to improve the building further.

People were satisfied with the quality of the food and received a choice of suitably nutritious meals. If people started to lose weight, they were referred to specialists and given appropriate support.

People were involved in discussing and planning the care and support they received and were consulted about all aspects of the service. The provider acted on feedback from people, for example by changing the menu and introducing new foods. The provider's complaints policy had been translated into BSL and people knew how to complain.

There was a clear management and staffing structure in place and people and their relatives said they considered the service was well run. Staff and management had a shared vision to provide high quality care. Staff were happy in their work and well-motivated.

There was an open and transparent culture. Community links were being developed, visitors were welcomed and staff enjoyed good working relationships with external professionals. Audits of key aspects of the service were conducted. The results showed the service was making continual improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to identify, prevent and report abuse. Risks to people's health and safety were managed effectively.

Medicines were managed safely. The home was clean and infection control guidance was followed.

There were enough staff deployed to meet people's needs. The process used to recruit staff was safe. Staff were aware of action to take in an emergency.

Good

Is the service effective?
The service was effective.

Areas of the home had been redecorated in consultation with people and further improvements were planned.

People's rights and freedom were protected. Staff sought consent from people before providing care and support.

Staff were suitably skilled, including in the use of BSL. They received appropriate training and support in their roles.

People were given appropriate support to eat and drink enough. They were able to access healthcare service when needed.

Good

Is the service caring?
The service was caring.

Staff were kind, caring and compassionate. People were encouraged to remain as independent as possible and treated with dignity and respect.

People's privacy was protected and confidential information was kept securely.

People were involved in discussing and planning the care and support they received and were involved in all aspects of the service.

Good

Is the service responsive?
The service was responsive.

People received personalised care. Staff were skilled at communicating with people and understanding their individual needs. Care plans were comprehensive and were reviewed regularly.

People were encouraged to engage in a range of activities. The provider sought and acted on feedback from people, relatives and professionals.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

Management and staff had a shared vision to provide high quality care. There were good working relationships between the management and staff. Staff understood their roles, were happy in their work and well-motivated.

There was an open and transparent culture in the service. Staff worked well with external professionals and visitors were welcomed.

Appropriate quality assurance systems were in place.

Easthill Home for Deaf People

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 5 & 6 November 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience in the care of deaf people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. We were assisted to communicate with people and staff through the use of a British Sign Language interpreter.

Before the inspection we reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with six people living at the home. We also spoke with the manager, the deputy manager, six care staff, a cook, a cleaner and a volunteer. We looked at care plans and associated records for six people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

Following the inspection we obtained feedback from two family members and a social services care manager.

Good

Is the service safe?

Our findings

At our previous inspection, on 5 and 7 May 2015, we identified concerns relating to infection control, the management of medicines and fire safety arrangements. At this inspection we found action had been taken and all concerns had been addressed.

All parts of the home were clean and hygienic. The provider had assessed infection control risks and taken action to reduce the risks; they had also completed an annual statement of infection control. Steps had been taken to manage the risks of cross infection between people, for example by encouraging staff to be vaccinated, where appropriate.

Staff had received training in infection control. Personal protective equipment (PPE) was readily available at key points throughout the home and we saw staff using this appropriately. Cleaning schedules were in place for each area of the home, together with a colour coded system to help reduce the likelihood of cross contamination between areas being cleaned. Staff completed check sheets to show they had completed the cleaning in accordance with the schedules, which we saw were up to date. A cleaner told us "They've done a lot of decorating, which makes it a lot easier to clean. I can ask for anything I need and I usually get it. The foot pedal bins weren't working, so we got new ones; we're getting shelving put up in the bathroom and more hand soap dispensers on the walls. It's very good."

Staff were clear about how to handle soiled or infectious linen safely. They used soluble red bags which could be placed directly into the washing machine without having to be opened first. Guidance in the laundry room informed staff of the relevant programmes to use for each item of laundry, to help make sure they were cleaned effectively. The kitchen had been re-assessed by the local authority and had been awarded a rating of five stars (the maximum) for its food safety arrangements. Regular audits of infection control arrangements were conducted to check that best practice guidance was being followed. The latest audit had identified no concerns.

Medicines were managed safely. Systems were in place that ensured medicines were ordered, stored, administered and disposed of in a way that protected people from the risks associated with them. Only staff who had received the appropriate training, and had their competency assessed, were able to administer medicines. The recording of medicines was accurate and confirmed people had received their medicines as prescribed. Information about when staff should administer 'as required' (PRN) medicines, such as sedatives and pain relief, had been developed to help make sure people received these consistently. Staff administering medicines were supportive and unhurried. They explained to people what the medicines were for and allowed people to take their medicines in their own time. Where people wished to manage and administer some of their own medicines, the risks associated with this were assessed and people were supported to do this safely. For example, two people kept inhalers with them and measures were in place for staff to monitor how often they used them.

When medicines required cold storage, a refrigerator was available and the temperature was checked and recorded daily to check that medicines were being stored according to the manufacturer's instructions. Staff were unsure how to re-set the thermometer after taking a recording, but agreed to research this to make sure their recordings were accurate. Suitable arrangements were in place to record the application of topical creams and ointments. Staff dated the containers when they opened them, so they could monitor their use and ensure they were not used beyond their safe 'use by' date once opened.

Suitable arrangements were in place to deal with foreseeable emergencies. All staff had undertaken fire awareness training and knew what action to take in emergency situations. Vibrating alarms and flashing lights were in place for people and were used to wake people if the fire alarm activated. Personal evacuation plans were available for all people. These included details of the support each person would need if they had to be evacuated and were kept in an accessible place. Staffing arrangements ensured there was always a hearing member of staff on duty, so they could use the telephone to call emergency services and communicate with attending professionals, such as doctors or paramedics. Staff had also received training in first aid.

People told us they felt safe at the home. One person said, "I feel safe being around staff who can use BSL." A family member told us the home provided a "stimulating and secure environment for residents". Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. Staff were encouraged to raise

Good

Is the service safe?

concerns with the registered manager, or senior representatives of the provider, and were confident appropriate action would be taken. One staff member told us "It's about thinking and looking at how residents are treated. If I did see anything concerning, I'd go straight to [the manager] and I know she would get on the case straight away."

Risks were managed effectively. Equipment, such as bath hoists, lifts and wheelchairs, were checked and serviced regularly. Windows of upper floor rooms had restrictors fitted so people could not fall through them and fire exits were alarmed. Other environmental risks had also been assessed and action taken to monitor and manage these appropriately. For example, temperature controls had been installed on hot water outlets to prevent people from being scalded.

Staff understood people's individual risks; they assessed, monitored and reviewed these regularly and people were supported in accordance with their risk management plans. For example, clear guidance was available to staff about how to protect people who were at risk of skin breakdown, including the use of special cushions and mattresses, which we saw being used. The manager explained how one person was at risk of pressure injury due to the way they chose to lay in bed. They spent time with the person, showed them pictures of the harm that could result and helped them to understand the risk. Subsequently, the person had chosen to position themselves differently in bed, which had prevented pressure injuries from developing. They had also taken the person shopping to choose foods to eat; this had helped them gain weight, which had reduced the risks further.

Staff were using two different tools to assess people's risk of pressure injuries which could have caused confusion. We discussed this with the manager and they chose to adopt one particular tool for all people. They implemented this and by the end of the inspection had reassessed people's risks using one scale that was consistent with that used by visiting community nurses.

Suitable plans were in place to protect people from risk of falling. People had been assessed for fall-saving equipment, such as walking aids; these were accessible to people at all times and we heard staff reminding people to use them. Where people might be at risk if they got out of bed during the night, pressure mats had been installed, with the person's consent, to alert staff that the person may need support.

Risk assessments were in place for people who smoked. However, these were limited and only stated that people were aware they could not smoke in the building; they did not specify an alternative place where people could smoke safely. One person told us they knew they had to smoke outside, but that this was a problem when it rained as there was no shelter available. We discussed this with the manager who agreed to identify a suitable place for people to smoke in bad weather. This would reduce the likelihood of people being tempted to smoke in their rooms.

There were enough staff to meet people's needs at all times. People told us staff responded quickly when they asked for help. A family member told us "Staff ratios are more appropriate to meet residents' needs now." Three staff were available throughout the day and two during the night. Staffing levels were determined on the basis of people's needs and taking account of feedback from people and staff. Staff absence was covered by existing staff working additional hours, or by two 'bank staff', who had previously worked at the home on a permanent basis and knew the people living there well.

The process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

Good

Is the service effective?

Our findings

At our previous inspection, on 5 and 7 May 2015, we identified concerns relating to the protection of people's rights and the suitability of the premises. At this inspection we found action had been taken and most concerns had been addressed.

Some areas of the home had been redecorated since our last inspection, including the dining room and some bedrooms. People had been involved in choosing the colour schemes and some had moved to newly decorated rooms. Other people told us they were happy with the decoration of their rooms. People had chosen a new colour for the walls of the dining room by being shown colour swatches. The work was completed while most people were away on holiday, so it would not disturb them. People told us they were very happy with the results as this was the room they spent most time in and said it created a "beautiful" and "more peaceful" environment. The manager told us that people needed good levels of light in the dining room to aid communication. We saw they had installed daylight spectrum light bulbs and changed the curtains to allow more natural light into the room.

One person, who had particular needs because of an eye condition, had moved to a ground floor room. The room had been decorated in a way that was recommended by a specialist, in colours chosen by the person, and suitable lighting had been installed to meet their needs. Staff told us the changes had had a real impact on the person; they were able to access their room more easily, had become less agitated and were more relaxed. Our own observations confirmed this.

Plans were in place to further enhance the environment by installing a more robust stair lift that could accommodate wheelchairs, swapping the dining room and lounge around so people would be more comfortable and replacing carpets that were badly worn. However, these plans had been delayed due to additional work that was required to reinforce the stairs, so had not yet been completed. In the meantime people continued to spend most of their time in the dining room on chairs that were not comfortable or relaxing.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. Assessments had shown that all of the people living at the home had capacity to make decisions about the care and support they received. Staff showed a good understanding of the legislation. Before providing care, they sought consent from people using suitable forms of communication and gave them time to make decisions. On some occasions this took longer and staff repeated questions or choices several times in different ways, to make sure the person had understood. Where people had declined care or treatment, such as opportunities to visit the dentist, these were respected and recorded. Most people had signed their agreement to their care plans, while others, whose care plans were being developed, were waiting to do this.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Whilst no-one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and had made an application for one person. After a comprehensive assessment by the local authority DoLS assessor, it was concluded that the person was able to make decisions when supported by staff who were able to communicate with them effectively. One person told us "I'm free to come and go as I please; there's no restrictions and I know the keypad code for the front door."

People told us they were supported by staff who had the right skills to look after them. They said the most important aspect of living at the home was the opportunity to mix with other deaf people and to be able to communicate with staff effectively. In this respect, people described the home as "unique". The provider employed a mix of deaf and hearing staff who were skilled in communicating with people using BSL. Hearing staff attended weekly training in BSL and were able to obtain nationally recognised qualifications. They were supported in their learning on a day to day basis by the deaf staff, who had a greater vocabulary and knowledge of BSL. This allowed them to understand particular signs that were unique to each person.

In addition to BSL, staff completed other training relevant to their roles and responsibilities. The provider had a clear policy on the type and frequency of training that staff were

Good

Is the service effective?

required to undertake. Records showed staff had completed all essential training and dates for refresher training had been set. A high proportion of staff had also completed, or were undertaking, vocational qualifications in health and social care. A family member told us it was clear that "training is being implemented to improve overall standards."

Newly recruited staff worked with experienced staff until they had been assessed as competent to work unsupervised. They undertook an appropriate induction programme to prepare them for their role. Arrangements were also in place for staff new to care to gain the Care Certificate, which two staff members had enrolled on. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Staff were supported appropriately in their role, felt valued and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The manager told us that supervisions included an element of observation, during which staff practices were observed and discussed. They added, "We try to make it a positive experience for [staff]." Staff confirmed this; one said, "[Supervisions] are really useful; if I needed any more training I could ask for it and I'd get it." Another told us "If I have any concerns I can share them during supervisions and am fully supported." Staff who had worked at the home for more than a year also received an annual appraisal which assessed their performance. A family member told us "There seems to be a better working atmosphere discernible by a much more positive attitude from staff."

People were satisfied with the quality of the food and told us one of the cooks in particular was "very good". One person said "We like all the food and always clear our plates." Another person told us "They know my preferred choice for breakfast and always do it right." People were offered varied and nutritious meals appropriate to the seasons and were satisfied with their meals. Alternatives were offered if people did not like the menu options of the day, as well as suitable alternatives for people with special dietary needs. People were encouraged to eat and staff provided support where needed. For example, one person was prompted to eat and a plate guard was put in place to help them to eat independently. Drinks were available and in reach throughout the day and staff prompted people to drink often. One person would only drink out of a particular type of glass and staff made sure the person always used this.

Two people had been identified as at risk of losing weight. Appropriate plans were put in place to monitor this and encourage the people to eat well. These included purchasing favourite foods, fortifying food with additional calories and referring people to GPs and dieticians. A staff member told us "[One person's] favourite at the moment is tomato soup, so we're adding cream and cheese to it, which they love." The person told us they also received snacks, although these were limited to biscuits and crisps. Staff monitored the food and fluid intake of people at risk using food and fluid charts, which we saw were up to date.

People were able to access healthcare services. Relatives told us their family members always saw a doctor when needed. Care records showed people were referred to GPs, community nurses and other specialists when changes in their health were identified. People were supported to attend appointments and BSL interpreters were arranged to aid communication. One person had had a recent psychotic episode and staff arranged an urgent visit to the home by a psychiatrist, together with a BSL interpreter.

Staff acted as advocates for people when they became ill. Two people had had a succession of illnesses and staff felt medical staff were not responding effectively. Therefore they plotted a timeline on a piece of paper to enable medical staff to see the full extent of the concerns over a period of time. This helped identify the nature and extent of the person's illness and showed the length of time they had been unwell. The manager told us "We weren't getting anywhere and just wanted [medical staff] to see the full extent of the problems."

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate manner. One person said, "The staff are good and caring." Another person said of the staff, "They're nice and will come over and chat with me. They tease me and it cheers me up" A family member told us staff had "always been caring." We observed positive interactions that were warm, friendly and respectful. Staff smiled as they went about their work and used touch appropriately. Staff knew about people's lives and backgrounds. These were recorded in detail in people's care plans and staff used this knowledge to help build positive relationships.

Staff spoke fondly of the people they supported and clearly knew them well. One staff member said, "Things are back to the way they were. It's lovely to see [people] happy again." Another told us "We're looking after residents in a better way now and making their lives more fulfilling."

A person who had lived at the home for many years died recently while other people were away on holiday. Staff recognised the impact this would have on people and broke the news to them when they were together as a group, so they could grieve and support one another together. Staff supported people who wished to attend the funeral by arranging a minibus so they could travel together; and the minister who conducted the service used BSL, so they could understand it. It was clear from talking to people and staff that this event, and the way it was managed, had brought people closer together. It had also provided an opportunity for people to develop links with the wider deaf community who had attended the funeral, which people told us had been a positive experience.

Staff were skilled at communicating and engaging with people. They understood how to adapt BSL to people's individual needs and used this effectively. For example, one person preferred staff to finger-spell words while holding their hand. If hearing staff needed support to communicate with a person, then deaf staff acted as relay interpreters to help facilitate the communication. The manager told us staff also used this technique when people were admitted to hospital, had important appointments or needed to discuss complex issues. For example, a deaf staff member had come in to the home on their day off to assist the DoLS assessor to communicate with a person, who used a particular form of BSL. This resulted in a positive outcome for the person and demonstrated the commitment of staff.

One person had limited knowledge of BSL, so staff had created a range of pictures to help the person communicate. The home's newsletters, menus and activity planners were also produced in pictorial form so people could understand them more easily.

Hearing staff were aware that by communicating with one another verbally could exclude people and deaf staff and lead to misunderstandings. One staff member said, "If we're laughing, then people could think we were laughing about them; so we always try to remember to sign as well, and then people can join in."

Care plans contained information entitled "What I do and what it means". This helped staff to understand and interpret people's body language, particularly when they were distressed or in pain. For example, one person's care plan stated, "If I tap the left side of my chest it means my chest or shoulder hurt. Offer me gentle massage." Another person's care plans stated, "If I stand in the kitchen and put gloves on, give me small tasks as this makes me happy."

Staff were aware of deaf culture, which was an important feature of people's lives. They were also aware that deaf people who had lived in homes for much of their lives had a tendency to give answers which they thought would please staff. For example, one person had told one member of staff that they preferred to go out to the hairdressers, but had told another member of staff they preferred the hairdresser to come to the home. To resolve the matter, staff asked a family member of the person to discuss it with them, so their true wishes could be established.

People were encouraged to remain as independent as possible in line with their abilities. For example, one person wished to visit family on the mainland. They only needed support to purchase their ticket and order a taxi, which a staff member did for them. They were then able to travel on their own, which they did. A family member told us "The atmosphere within Easthill is relaxed, supportive and caring without impacting on residents' independence."

Staff ensured people's privacy and dignity were protected by closing doors when personal care was being delivered. They explained how they took time to ask what help the person wanted and made sure the person was at least partially covered at all times, for example by using towels. One staff member said, "When I'm helping someone in the shower I avert my eyes or turn my back until they're ready." People had locks on their bedroom doors, which some

Good

Is the service caring?

chose to use. There was a quiet area on the ground floor where visitors and family members could talk to people in private. Confidential information, such as care records, was kept securely and could only be accessed by people authorised to see it.

People were given a choice of receiving support from male or female staff and their choices were respected. Before entering people's rooms, staff used a flashing light system to alert the person; they waited for a response and then sought permission from the person before entering.

People were involved in discussing and planning the care and support they received. One person said, "I've seen my care plan and know what's in it. Staff sometimes come and talk to me about it." Family members (where appropriate) were also consulted and kept informed of any concerns. One family member told us there were "open and transparent conversations with families, ensuring all are fully aware of any underlining changes in residents' health and well-being".

People were also consulted about other aspects of the service. For example, staff had recently been supplied with uniform polo shirts and people had chosen the colour of them for each of the staff roles. One person said, "It helps me to know who to approach." A family member told us "Staff now wear designated colour polo shirts giving all, including families and visitors, clear guidance on staff's roles and responsibilities."

Good

Is the service responsive?

Our findings

People received personalised care from staff who understood and met their needs well. One person said, "I always get all the help I need."

Care plans provided comprehensive information about how people wished to receive care and support. They included the usual morning, evening and night time routines for people, but stressed the need for staff to be led by the person and their wishes at the time. One person told us "I decide when I have a shower; it's my decision." Two people told us they chose to have baths in the evenings and one of them said "The night staff are always happy to help give me a bath." A staff member told us "People all have their own needs; we help them communicate but we're led by them." Where people needed support with personal care, detailed guidance was provided for staff about the way in which the person preferred to receive such support. Records of the daily care and support people received showed they had been supported in accordance with their care plans.

Reviews of care were conducted regularly by nominated key workers. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. As people's needs changed, the key workers developed the care plans to ensure they remained up to date and reflected people's current needs. People were consulted as part of the review process and their views were recorded.

Four people had diabetes and appropriate arrangements were in place to manage this effectively. Staff had created visual aids to show people how much sugar was in each food product to encourage them to make informed choices. Staff monitored people's blood sugar levels where needed and knew what action to take if the levels were outside of the expected range. People were supported to attend regular diabetic health checks. Staff had developed information to help identify when people were in pain and used pictures of happy and sad faces to help people communicate their level of pain. Records showed people had received pain relief when needed.

One person had a 'do not attempt resuscitate' (DNAR) form in place and was at risk of choking on their food. Guidance in the person's care plan specified that the DNAR form only related to cardiac arrest and not to other life-threatening situations, such as if the person started choking. When we discussed this with staff, they showed a clear understanding of the purpose of the DNAR form and the action they were expected to take if other emergencies occurred.

People were encouraged to take part in activities. The personal histories, interests and hobbies of people were recorded in care plans and these were used to tailor activities to meet their individual preferences. People were also consulted regularly about activities they would like to take part in. For example, several people had recently requested to attend 'horse therapy' and this was being arranged.

An activities coordinator had been appointed who showed a real passion for the role and was highly respected by people living at the home. A family member told us "The activities coordinator has even encouraged [our relative] to use a [hand-held computer]; something we never thought he would do. This has improved communication between us." Another family member said, "We are delighted that an activity programme has been reintroduced and a coordinator appointed. This has resulted in a much more varied programme of activities."

Organised activities included exercise, crafts, board games, bingo and watching films. We observed an exercise class and a week's holiday had also been arranged, which most people had attended and enjoyed. They had been given a range of options and chose the holiday themselves. One person described it as "Brilliant" and a family member told us "The recent residents' holiday at Bognor Regis appears to have been a success."

Following the closure of a local deaf club, staff had recently established a new club at the home. Deaf people who lived in the community were invited to the club, which provided social contact and helped prevent people from becoming insular or socially isolated. A staff member told us "We involved the residents from the start and they are trying to decide whether to hold the meetings every week or every two weeks.

Minutes of 'residents' meetings' showed people were encouraged to influence, and provide feedback about, the way the home was run. These were recorded in written and pictorial format to make them easier for people to read. A family member told us "We think it is a sign of

Good

Is the service responsive?

improvement at the home that these meetings are being held again on a regular basis. We know that both staff and residents appreciate this." Another family member said there was a "clear indication that Easthill are seeking residents' opinions. Discussion points are openly available on the noticeboard for all to see".

Following feedback from people about the menus, we saw these had changed and new foods, such as omelettes, faggots and curries were being introduced. A curry with poppadum and naan bread was provided on one of days of our inspection. Some people were keen to try this and it provoked a lot of interest and positive comments.

There was an appropriate complaints procedure in place, which people and relatives were aware of. This had been translated into BSL on a DVD, which staff had shown to people to encourage them to raise any concerns. No complaints had been recorded since our last inspection, but we viewed several letters of appreciation from family members expressing their gratitude for the care given to their relatives. The provider had previously conducted surveys or people, families and professionals and was considering new ways of doing this given the small number of people currently living at the home.

Good

Is the service well-led?

Our findings

At our previous inspection, on 5 and 7 May 2015, we identified that effective quality assurance systems were not in place. At this inspection we found action had been taken and this had been addressed. One family member told us "There are visible improvements since the CQC report was written." Another said, "There is a noticeable improvement in the atmosphere at Easthill as soon as you arrive. We now feel reassured that [our relative] is in a home which has been put back on a firm footing again."

Audits of key aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly to assess, monitor and improve the quality of service. Where remedial work was needed, we saw action was taken promptly. Audits were monitored through the use of a scoring system, which showed the quality of the service was steadily improving each month. The manager conducted unannounced spot checks at varying times of day and night to monitor performance of the service out of hours, and an 'on call manager' was available at all times to support staff.

People and their relatives said they considered the service was well managed and their views were sought about how the service should be run. A family member told us "We found staff were organised and understood their roles."

There was a clear management and staffing structure in place. The manager was supported by a head of care and a newly appointed deputy manager. Senior staff, who acted as key workers for people and administered medicines, and care staff provided care and support to people on a daily basis. The manager was supported by head office staff, including the provider's Chief Executive Officer (CEO) who visited the home regularly and who they described as "really supportive".

There was a close working relationship between management and staff who had the best interests of people at heart and had a shared vision to provide high quality care. Staff told us they enjoyed working at the home and were well-motivated. Comments included: "I'm happy working here and get on well with the residents as we share the deaf identity"; "The manager is supportive and approachable; we're all working together now"; "The manager is open minded and willing to learn about deaf culture. She always puts residents first"; and "The team work is fantastic".

The provider had a range of methods to seek feedback from staff. One of these was a suggestions box. The manager showed us suggestions that had been put in the box and the action they had taken in response, which was feedback to staff. These included creating a 'residents information pack' to provide key information about each person in the event of the person being admitted to hospital at short notice; and the introduction of laundry baskets in people's rooms. Where suggestions could not be implemented, the reasons for this were also fed back to staff so they were kept informed. Monthly staff meetings were also held and included a BSL interpreter to facilitate communication between hearing staff and deaf staff.

There was transparent and outward-looking culture at the home. A family member told us "There is a much more open style of management now." The home was developing external links by opening its doors to deaf people living in the community and encouraged people to go out more. Staff welcomed visits from family members and people who had previously lived at the home, and enjoyed good working relationships with external professionals." The provider had a whistle-blowing policy which gave details of external organisations where staff could raise concerns if they felt unable to raise them internally. There was also a duty of candour policy in place to encourage staff to be open if things went wrong and people were hurt.

The provider notified CQC of all significant events. The rating from the previous CQC inspection was prominently displayed in the reception area. However, the provider had not displayed this on their website as required. The manager told us this was due to technical difficulties with the webpage, which were being addressed.