Eastfield Care Homes Limited

Eastfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 May 2018. It was unannounced.

At our last inspection on 27 and 28 February 2017, we found a breach of regulation relating to how the provider carried out assessments for people who lacked capacity or were at risk of being deprived of their liberty. We found improvements were needed in a total of three key areas. Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question effective to at least good.

At this inspection we found improvements had been made in all key areas, and the provider was meeting the fundamental standards required by regulation.

Eastfield Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Eastfield Nursing Home is registered to provide residential and nursing care for up to 52 older people who have a range of needs, including older people, people living with dementia, and people living with a physical disability. The home is situated in the village of Liss and includes a secure garden for people to enjoy at the rear of the home. Facilities include a dining room, a conservatory seating area and three shared lounges. At the time of the inspection 42 people were living at the home.

There was a registered manager in post. A registered manager is a person who has registered with CQC 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 provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to protect people from risks associated with the management of medicines and the spread of infection.

Care and support were based on thorough assessments and care plans, which reflected professional standards and were kept up to date. Staff received appropriate training and supervision to maintain and develop their skills and knowledge to support people according to their needs. People were supported to eat and drink enough to maintain their health and welfare. People were supported to access healthcare services, such as GPs and specialist nurses. 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.

Care workers had developed caring relationships with people they supported. People were supported to take part in decisions about their care and treatment, and their views were listened to. Staff respected people's independence, privacy, and dignity.

People's care and support took into account people's abilities, needs and preferences, and reflected their physical, emotional and social needs. People were able to take part in a range of leisure activities and entertainment. People were kept aware of the provider's complaints procedure, and complaints were managed in a professional manner.

The provider had a clear vision and strategy, which was shared with staff. Systems were in place to make sure the service was managed efficiently and to monitor, assess, sustain and improve the quality of service provided.

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.

People were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure workers were suitable for work in a care setting.

Processes were in place to make sure medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

People's care plans and assessments were comprehensive and reflected professional standards.

Staff were supported by training and supervision to care for people according to their needs.

Staff were guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions or were at risk of being deprived of their liberty.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

Is the service caring?

Good

The service was caring.

People had developed caring relationships with their care workers.

People were able to participate in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care and support met their physical, mental, emotional and social needs and took account of their preferences and wishes.

There was a complaints procedure in place, and complaints were dealt with professionally.

Is the service well-led?

Good

The service was well led.

People's care records were complete and up to date.

A management system and processes to monitor and assess the quality of service provided were in place. There was an action plan to sustain and improve the quality of service.

There was a friendly, empowering culture in which people were treated as individuals and could speak up about their care and support.

Eastfield Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 and 31 May 2018 and was unannounced.

The inspection team comprised two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we had about the service before the inspection. This included previous inspection reports, notifications and information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Notifications are information about certain events providers are required to tell us about by law.

We spoke with seven people living at the home and six visiting family members. We observed people's care and support in the shared areas of the home, and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, a visiting healthcare professional, and four members of staff.

We looked at the care plans and associated records of six people, including their medicines administration records. We reviewed other records, including the provider's policies and procedures, meeting minutes, internal checks and audits, the provider's improvement action plan, quality assurance survey returns and reports, training and supervision records, mental capacity assessments, Deprivation of Liberty applications and authorisations, staff rotas, and recruitment records for three staff members.

The registered manager sent us copies of infection control audits after the inspection visit.

Good

Is the service safe?

Our findings

When we inspected Eastfield Nursing Home in February 2017, we found the provider was meeting the fundamental standards in this area. However, we had concerns that staff were not always deployed in sufficient numbers to keep people safe and respond promptly to requests for assistance. At this inspection we found improvements had been made.

People and their family members told us they were satisfied people were kept safe. One person said, "Yes, safe as I can be anywhere. I am surrounded by company, carers and people who live here." A visiting family member told us, "Yes, I just feel that [people are safe] because of the people [staff]."

There were no complaints about long waits for assistance, although people gave us mixed views about the suitability of some staff. One person said, "They do come and go. I don't like strange faces, but someone is better than no-one." Another person said, "Some are brilliant and some are not so brilliant". The registered manager told us there was a range of experience amongst the staff employed, but less experienced staff always had a senior staff member or the manager himself to call on if needed. They had recently increased staffing levels at certain times in response to people's changing needs.

We saw that staff were able to go about their duties in a calm, professional manner, and respond in a reasonable period of time if people asked for help. Staff we spoke with considered their workload was manageable and they had time to chat and interact with people. At 3pm every afternoon, all staff on duty took time out from other duties to engage with people and have a conversation with them.

There continued to be a robust recruitment process for new staff. Records were kept to show that the necessary checks were made before new staff started work. These included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working in a care setting. The registered manager interviewed all candidates personally. The provider had recently recruited staff who had previously worked at the home via an agency. This meant they had the chance to observe these care workers in practice, and assess their suitability to work in the service.

The provider had in place appropriate systems and processes to protect people from harm and the risk of abuse or unsafe care. Staff were aware of the types of abuse and the signs they should look out for. They were aware of how to report concerns and that the provider had a whistle blowing policy which protected their rights if they had to raise concerns. One staff member told us they were confident they would be able to "do the right thing" if circumstances required it.

Where concerns were raised about people's safety, the registered manager cooperated with the local authority to carry out the necessary internal investigations. They notified us when concerns were raised and kept us informed about the outcome of safeguarding investigations.

The provider took steps to assess and manage risks to people's safety and welfare. People's individual care plans contained assessments and guidance in relation to risks including falls, skin health, oxygen therapy,

diabetes and behaviour staff might find challenging. Risk assessments took into account people's individual circumstances and other conditions and needs which might affect how the risk was managed. For instance, one person's skin health risk assessment included relevant information about their tube feed, and included guidance on how to maintain their skin health around the tube site. The format of the computer based care planning system meant that it was not always possible to cross reference guidance for staff in the care plan with the individual risk assessment. However, there was a risk assessment summary which gave staff an overview of all risk assessments in place for each person. Staff were satisfied they had the information needed to support people safely.

There were risk assessments and audits in place to manage the safety of the premises and equipment used to support people. These included a fire risk assessment which had not identified any concerns, and an asbestos survey which had concluded there was no asbestos risk in the building. Quarterly and annual health and safety audits were in place which covered areas such as fire safety equipment, electrical appliances, lifting equipment, the nurse call system, and gas appliances. Maintenance and service records were in place for equipment used to support people. The provider had taken appropriate steps to make sure the environment people lived in was safe for them.

People and their family members were satisfied they received their medicines at the right time and according to their preferences. If they needed pain relief this was administered without delay. One person said, "They bring it pretty quickly. I don't normally need any." Another person when asked about pain relief said, "Yes I have taken it this afternoon."

A visiting family member described how staff had raised concerns their relation was "over-medicated". The registered manager had discussed this with the community mental health team, who agreed to change the prescription which had a positive outcome for the person's behaviours. The family member said, "Now that his medication has been changed, he is able to cope with the staff more."

Records relating to the administration of routine medicines were accurate and up to date. Where a person was prescribed a skin patch, the records showed the position of the patch was rotated in line with good practice. Another person received a medicine covertly. Records showed this had been checked for safety and that a correct mental capacity and best interests process had been followed.

Where people were prescribed medicines "as required" instructions for staff were not always detailed in terms of when to administer them. One person was prescribed a medicine "for agitation", and the instructions referred to a trained nurse using their judgement to decide when to administer. This relied on the trained nurse having knowledge about the person that was not recorded for the benefit of a nurse who might be less familiar with the person. When the medicine was administered records showed the date, time and dose administered, but not the reason for administering or whether the dose had been effective. Records showed other people were receiving "as required" medicines every day.

The registered manager was confident people were receiving "as required" medicines safely. They had communicated with other healthcare professionals involved with people's medicines to confirm this, but there had not been time for a formal review of people's medicines to change the "as required" prescriptions.

The provider had processes in place to protect people from the risk of the spread of infection. These included the use of appropriate personal protective clothing and equipment. There was a monthly infection control audit which checked for maintenance, cleanliness and other infection control concerns. Any actions identified in these audits were followed up. People and their relatives found the standard of maintenance and cleanliness in the home to be good. A visiting family member said, "Yes. Her room is always clean. You

never see an unmade bed. I asked about [Name's] radiator and it was done the same afternoon."

Staff we spoke with were aware of their responsibility to raise concerns which might affect people's safety. They were confident concerns raised would be taken seriously by the registered manager, and any lessons learned communicated to others. One staff member said, "[Registered manager] is always there for us." We saw examples of memos and notices in the staff room which communicated lessons learned to all staff.

Good

Is the service effective?

Our findings

When we inspected Eastfield Nursing Home in February 2017, we found the provider was not always meeting the fundamental standards required by the regulations in terms of supporting people's human rights when they lacked capacity to make decisions. Following that inspection, the provider sent us an action plan showing how they intended to become compliant with the relevant regulation. At this inspection we found improvements had been made and sustained.

The Mental Capacity Act 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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Act. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the Mental Capacity Act 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people were considered to be at risk of lacking capacity, the provider used a local authority toolkit to carry out the necessary capacity assessment and record the subsequent best interests decisions made on behalf of people. The toolkit guided staff to follow the correct process and ask the questions required by the Act and its associated code of practice. Assessment records showed how the process was followed, and if other interested parties, such as people's families, were involved. Where a person had a deputy appointed by the Court of Protection, the deputy was informed and invited to take part in the person's capacity assessment and best interests decision.

Where people were at risk of being deprived of their liberty in order to keep them safe and provide the necessary care and support, the provider applied for authorisation under the Deprivation of Liberty Safeguards and notified us appropriately. Where people lacked capacity, their rights were respected and decisions made in their best interests.

Staff were aware of their responsibilities under the Mental Capacity Act 20015, and of the need to only deliver care and support with the person's consent. The provider had recently updated their consent form, and where they could, people had signed to indicate their consent.

Since our last inspection, the provider had implemented a computer based system for care planning and assessment. People's consent records were cross referenced on the computer system, which meant staff could see readily where people's consent to their care and support was recorded.

Care plans were based on people's initial assessments and were comprehensive in covering how people's needs should be met. The initial assessment carried out by a senior staff member was followed by a second assessment by the deputy manager, who was a trained mental health nurse. This meant there was a check that assessments were in line with current professional standards. Trained nurses were responsible for clinical care plans with a senior care staff member responsible for other areas of people's care and support. The system prompted staff to review and update people's care plans every six weeks. Staff could access people's care plans using hand-held devices, which meant they always had the most up to date version available.

The care planning system led to positive outcomes for people. If monthly checks identified a person was at risk of poor nutrition, the system prompted staff to keep records of their food and fluid intake. Where people had wound care plans in place, written records and photographs showed how the wound healed and improved.

Care plan summaries were in place which gave a good picture of people's primary needs and care priorities. They were individual to the person and covered detail such as adapted cups, preferred routines, choice of continence products, and ability to use the call bell. These summaries were made available in print to new and agency staff. There were also laminated summary plans in all rooms to highlight essential needs.

People's initial assessments were also used to identify any additional training needs to enable staff to support people according to their needs. Staff were satisfied they received appropriate and timely training and had regular supervision meetings with a senior staff member. They felt prepared to support people according to their needs. There was regular refresher training in subjects the provider considered mandatory, and the provider had an effective system in place to track completed and planned training. The provider supported staff to achieve relevant qualifications and meet their continuing professional development requirements.

New staff received a thorough induction which was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

The provider supported people to eat and drink enough and to maintain a balanced diet. People's breakfasts were prepared on site, and for other meals the provider used an external specialist supplier which delivered prepared menus twice a week. These took into account nutritional guidance and people's individual needs, such coeliac disease in which people cannot tolerate gluten.

People were satisfied with the quality of the food, although one person found insufficient choice in sandwiches offered. They said, "There's sandwiches at tea time. There's a choice of three. It's always the same three. It gets very boring." Other comments ranged from, "I don't mind it" to, "It's excellent. That's the strong point here." People all said they had enough to drink. They pointed out jugs of water, juice and hot drinks, such as coffee.

Records showed the provider worked in partnership with other organisations to deliver effective care, treatment and support. Staff had worked with a nurse specialising in Parkinson's disease to develop one person's care plan. Advice and guidance from a speech and language therapist had been included in another person's care plan so that they received the correct consistency of diet, and their fluids were thickened to make them easier to swallow. Where a person had a tube feed, the provider worked together with their GP and a nutrition nurse to ensure their needs were met. When a best interests decision was made

about administering medicines covertly, the person's GP and a pharmacist had been involved in the decision.

People were satisfied they could have GP and other appointments when needed. One person said, "They are in touch with the doctor." Another person described how staff supported them to have a confidential discussion with their GP when they visited the home. A visiting healthcare professional told us they found the provider made appropriate referrals when people's needs changed, and that staff listened to advice and guidance on how to support people with specific conditions.

At our previous inspection in February 2017, we recommended the provider took advice on how to develop the environment of the home to make it more suitable for people living with dementia. The provider had made some progress with respect to the use of contrasting colours for hand rails, and appropriate signs around the home. People had photographs and other pictures on their bedroom doors to help them orientate themselves. The provider had a longer-term plan to replace patterned carpets, which might disorientate people, with plain ones. There was an outdoor seating area in the enclosed garden with shade so that people could take advantage of the open air in comfort and be protected from the risk of sunburn. One of the shared lounges had an attached kitchen which people could use if they wanted to bake cakes. This allowed people to practice skills they might have used all their lives.

Good

Is the service caring?

Our findings

People told us they were able to get to know staff and got on well with them. One person said, "There's no reason not to [get on with staff]. If you want something extra they will let you have it. I like extra cups of tea, so I have them." People acknowledged it was easier to get to know staff who had been working at the home for a longer period. One person told us, "I try to know their names, but hanging on to their names is a different matter." Another person said, "There is quite a lot of staff… Most are caring." Other comments included, "They seem to be all right" and, "Some are better than others."

We saw positive interactions between staff and people. One staff member noticed a person appeared to be cold, so they went to get them a jumper. Another staff member sat next to a person to explain to them that they would soon be having lunch if they stayed where they were. Conversations between staff and people were natural and lively. Staff used appropriate physical contact to reassure people, such as holding their hand. On another occasion staff use a "high five" to engage with a person.

Staff took time to explain what was happening. For instance, when a priest came in to administer communion to people, one person asked, "What does that do?" and "What are they drinking?", and a member of staff explained things quietly to them. When lunch was served, we saw a care worker explaining what was on a person's plate, after which they said, "That sounds lovely."

At other times staff were more reserved and respectful which meant they occasionally missed a chance for friendly interaction, for instance when serving meals and supporting people to eat. However, when a group of people who had been out on a trip returned and had their meal later than others, staff engaged with them positively to find out how the trip had gone.

A visiting family member told us about one of the registered manager's initiatives, "[Manager] introduced something. All staff have to talk to someone at 3pm for half an hour to get to know them and know about their lives. It's easy to see just what's there and forget who they were."

Visitors told us they were always made welcome, "They give me a coffee," and had the opportunity to engage with staff about their relation's care and support. One visitor said, "I make sure I get to know the carers. They are kind and helpful, but there are areas that need tightening up."

Records showed people and their families were involved in their care reviews. The computer care planning system prompted staff to record these contacts which were by telephone, direct involvement in meetings, and on one occasion by video computer link. Where appropriate people's communication care plans included guidance on how to make sure people were able to take part in decisions about their care. Examples of these included speaking slowly and clearly, and using simple words. Staff were aware of people who needed hearing aids or glasses in order to access information about their care. Records of care reviews included comments about how the person had responded during the review. Examples included, "[Name] has no concerns about being in a care home and is happy her needs are met," and, "[Name] is very involved her care planning."

Staff we spoke with were aware of how to respect people's independence and dignity. They gave us examples of how they achieved this when supporting people with their personal care by making sure doors and curtains were closed, and using towels to preserve people's modesty.

People's care plans gave guidance on maintaining people's independence and dignity. One person's plans put stress on asking for permission and explaining staff intentions and benefits to her. There was particular emphasis on making sure the person felt they were being treated as an adult. Another person's plans stated, "If I require reassurance, come and chat to me. Tell me everything I need to know before something is done for me and be aware if I don't understand it may be shown as aggressive behaviour. Offer reassurance and prompts as required." Care plans were written so that people were treated and respected as individuals, taking into account their feelings.

Good

Is the service responsive?

Our findings

People's care and support was based on assessments and plans that took into account a range of physical, mental, emotional and social needs. Assessments included people's sight, hearing and mobility, and care plans included how to support people with activities of daily living if they had disabilities or impairments in these areas. For instance, one person was supported to move about the home using their electric wheelchair. Staff were aware another person had hearing difficulties and they could write things down to make sure they understood.

The provider supported people to practice their chosen religion, both by ministers visiting the home and by supporting people to visit their chosen place of worship. Other activities were available which could improve people's sense of wellbeing such as aromatherapy and head and neck massage.

There was a range of activities and leisure pursuits available to people. The service had a minibus which meant up to seven people could go on trips together. On the first day of our inspection there had been a trip to a nearby town. People also went shopping, to cafes and to community centres, and could take part in events nearby such as a film festival, music group and tea dance.

Activities in the home included quizzes, cooking, arts and crafts, gardening and individual wellbeing sessions for people who could not or chose not to leave their room. The provider invited musical performers into the home to entertain people. The registered manager's own dog came to work with him, and had been "adopted" by one of the people using the service.

Staff kept records when they learned things about people's life history from people themselves or their families. For instance, one person had served in the Royal Navy and enjoyed all sports, but particularly golf. This allowed staff to engage with people in a meaningful way and support their emotional needs through reminiscence and conversation.

Another person who was no longer able to communicate verbally with staff had a care plan which took into account their need for social inclusion. It recorded which radio stations they preferred and if their television was on, guided staff to make sure they were in a position so that they could see it. It stated, "Care staff can always talk to me about the weather and what is in the news. I can't return the conversation …, but it is important." People's care plans took account of their needs as a whole person. An unsolicited compliment from another person's family member reflected this, "Generally all round my aunt has been much better cared for in much nicer surroundings than previously."

The provider had a complaints policy and procedure in place. This was included in a welcome pack received by all new people moving into the home. The registered manager logged and kept records of complaints. There had been one complaint logged since our last inspection. The registered manager had addressed the substance of the complaint and replied to the complainant by email.

People we spoke with felt they did not need to raise an official complaint because they could raise any

concerns with the registered manager. One person said, "If I had any real complaint, I would talk to [registered manager]." Another person said, "I have moaned to [registered manager] and things were resolved very quickly."

At the time of our inspection, there was nobody being supported in the final stages of their life. Care plans showed that appropriate conversations had taken place with people about their wishes around their end of life care. Where people preferred not to discuss this, their wishes were respected. Where people had made advance decisions, for instance if they did not wish to be resuscitated in the event of heart failure, records showed this had been discussed with them and, where appropriate, their families.

Good

Is the service well-led?

Our findings

When we inspected Eastfield Nursing Home in February 2017, we found the provider was meeting the fundamental standards in the key area of well led. However, we had concerns that actions taken to improve the quality of care records were still in progress and yet to be embedded in staff practice. At this inspection we found the improvements had been completed and sustained. All care records had now been transferred to the computer based care planning system, and staff and people using the service were experiencing the benefits.

The owner of the home was also the registered manager, and their vision and strategy for the service was therefore very influential. They saw their role as enabling a homely, friendly service where it was enjoyable to both work and live. They were proud that the home had provided continuity of care for people, some with very complex needs. They believed they were seen as a good employer and that senior staff felt empowered to do what was right for people. Staff we spoke with supported this view. One member of staff told us they had "free rein" with respect to organising activities for people and they were "lucky with the budget". Another member of staff said the registered manager "always listened". Staff told us the registered manager had their respect, and the home was a "relaxed and comfortable place".

People told us they saw the registered manager "every day" and that he was approachable. One person said, "[Registered manager] always says 'Hello', and the staff all do." Another person said, "One day he sat down and we had a talk for about an hour and then he got called away." A visiting family member told us, "He is an owner-manager, not just a manager. I think that is why he cares so much."

The registered manager was available by mobile phone when off duty, but had made arrangements with a family member who managed a nearby home to cover occasions when he was not contactable. He had started delegating more tasks to his deputy manager and other senior staff.

A visiting relative said, "It's well managed. Very much so, he's on the ball. I went up to [relation's] room and [registered manager] was up there washing him and so on. You don't often get that from a manager." A staff member described the registered manager as "involved and hands on". We saw this during our inspection visit. The registered manager told us he took opportunities to get involved with people's care as it gave him the opportunity to hear people's views about the service directly, and to observe that care and support met his required standard.

There were more formal processes in place to monitor and assess the quality of the service. The registered manager had invited the manager of an unconnected care home to undertake a quality audit, which meant they had an independent perspective on the service. The registered manager sought "constant" feedback from senior staff, and from health and social care professionals. They engaged with people's families by means of a service evaluation report, which showed 94% of respondents considered the service good or very good. Comments included "staff excellent", "excellent selection of activities", "food is good and well presented", and "very caring". One family member had written, "I don't have to worry about Dad."

The registered manager engaged with people and their families at formal meetings and less formally at coffee mornings. Points raised at these were included in their annual development plan, which included 15 actions to improve and sustain the quality of service they provided. Some of the actions were completed, such as changes to handrails recommended following our last inspection, and the siting of a suggestions box near the entrance to the home. Other actions in the plan included improvements to the garden, and to the laundry service, the provision of new equipment and changes to how the available space in the home could be used.

It is important that people who use services can get information about the quality of individual services. For this reason, providers are required by regulation to display the ratings from our inspections both in the home and on any website used to promote and advertise the home. The ratings for Eastfield Nursing Home were on display near the entrance to the home, but were not on the provider's website. We pointed this out to the registered manager, and they arranged for the ratings to be displayed on the website within 48 hours of our visit.

The provider worked with other agencies such as the local authority safeguarding team in a professional manner, providing information when required, and carrying out provider led investigations where concerns were raised.