Mrs Christine Lyte

Eastwood House

Inspection report

Eastwood Care Home
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Grimsby
Lincolnshire
DN34 5BE

Tel: 01472278073

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Eastwood House is a care home for 19 elderly people, some of whom may be living with dementia. The home is situated in a central area of Grimsby, close to local amenities. The building is a converted domestic house that has been extended. Bedrooms are provided on both the ground and first floors with access via a passenger lift. There is a lounge and conservatory area which is used as a dining room. At the time of this inspection,13 people were using the service.

The service was owned by an individual person and they were the registered manager. They also managed the organisation's other service in Lincolnshire. We have referred to this person as the provider throughout the report. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

We found the quality monitoring programme was limited. This had resulted in shortfalls being missed when audits and checks were completed and when some issues were identified, these had not been addressed in a timely way. Areas included care records, incident recording, safety checks, equipment, training and the environment. Accidents and incidents had not been analysed to help find ways to reduce them.

There was some inconsistency with the application of mental capacity legislation. Some people had assessments of capacity and records of best interest meetings when restrictions were in place, but this was not consistent throughout the service.

People had assessments of their needs completed and care plans developed but these were not always thorough and information was missing from them. This meant important care could be missed or care delivered which wasn't in line with people's preferences.

You can see what action we told the provider to take regarding consent, care planning and quality monitoring at the back of the report.

The staffing levels were reviewed and increased on the second day of the inspection to ensure there were sufficient staff on duty in the evenings. The provider confirmed they would review and increase the number of hours allocated to the deputy manager to complete the management and administration duties. People were cared for by a stable staff team who knew them well.

Staff were recruited safely which ensured employment checks were in place prior to new staff starting work. Staff understood how to protect people from harm and abuse and were clear about reporting procedures. Generally, there were safe systems in place to manage risks to people's health and safety although there were gaps in some safety checks and assessments.

People who used the service and their relatives were complimentary about staff approach. They said staff were kind and caring and respected people's privacy and dignity. The atmosphere was relaxed and we saw staff knew people well. People's views were sought during care reviews, resident meetings and surveys.

Staff had access to training, supervision and support. Gaps in training had been identified, plans made and courses booked to address shortfalls. An appraisal system was scheduled to start the following month. Staff told us they felt very supported by the deputy manager and were able to raise concerns. There were staff meetings which enabled them to receive information and express their views.

Overall medicines were managed safely; we found some minor shortfalls with recording and stock control which the provider was addressing.

People had access to community health professionals for advice and treatment. Staff generally knew when to consult these professionals, we found there had been a delay in requesting an assessment from an occupational therapist for a person's whose needs around mobility support had changed. This was followed up during the inspection.

People who used the service were provided with nutritious and well balanced meals and had access to drinks and snacks at any time during the day.

A varied programme of entertainment and activities was available and we saw people enjoying group activities. Relatives told us the staff were always welcoming and we saw staff supported people who used the service to maintain relationships with their family.

There were systems in place to manage complaints and people who used the service and their relatives told us they felt able to raise concerns and complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements were made during the inspection to ensure sufficient numbers of staff were on duty to meet the needs of people who used the service. Staff recruitment processes were safe.

Staff knew how to protect people from the risk of harm and abuse, they understood reporting procedures. Aspects of the risk management of people's health and safety were inconsistent.

Generally, there were effective systems in place for managing medicines; aspects of stock control management needed strengthening and improvements with hand written medication administration records.

Is the service effective?

Requires Improvement

The service was not always effective.

There had been inconsistent application of mental capacity legislation and deprivation of liberty safeguards. This meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions, and important documents had not been completed.

Staff had access to relevant training and gaps in training had been identified and planned. A staff appraisal system was scheduled to commence the following month.

People's nutritional needs were met and they liked the meals they were provided with. People were able to see community health care professionals for treatment and advice when required.

Is the service caring?

Good

The service was caring.

We observed staff to be kind, caring and attentive during our inspection. Staff had developed good relationships with the

people who used the service and there was a happy, relaxed atmosphere.

The privacy and dignity of people was preserved. People were supported to maintain independence and staff sought their consent prior to carrying out care tasks.

People were involved in planning their care and support and told us they were well cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's care plans did not provide sufficient guidance for staff in how to meet their needs and in the way they preferred.

There were activities, outings and entertainment for people to participate in. Those people spoken with told us they enjoyed these.

People felt able to complain in the knowledge any concerns would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager/provider was not visible and few people and relatives knew who they were. The deputy manager had day-to-day responsibility to manage the service and following the inspection, improvements were made to provide dedicated time for them to complete their management and administration duties.

Systems for quality monitoring required strengthening in order to identify all shortfalls and support effective improvements.

There were regular meetings for staff, people who used the service and their relatives to raise issues, provide feedback, and share information about the home.

Eastwood House

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 registered 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 15 and 16 August 2017 and was unannounced on the first day. The inspection was led by an adult social care inspector who was accompanied on the first day by an expert by experience who had experience of supporting older people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. We also looked at notifications sent in to us by the provider, which gave us information about how incidents and accidents were managed. We spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.

We spoke with eight people who used the service and seven of their relatives who were visiting during the inspection. We looked around all areas of the service and spent time observing care. We also 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 deputy manager, two senior care workers, two care workers and the cook. We spoke with two visiting health and social care professionals. Following the inspection we spoke with the provider.

We looked at the care records of five people who used the service including assessments, risk assessments, care plans and daily recording of care. We looked at other records relating to people who used the service; these included accidents and incidents and medication records for ten people.

We also looked at a selection of records used in the management of the service. These included staff rotas, training and supervision records, quality assurance audit checks, surveys and minutes of meetings with staff and people who used the service. We had a tour of the premises.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe at Eastwood House. Their comments included, "I feel safe all the time" and "I wouldn't be here if I wasn't [safe]."

Staff received training on safeguarding adults from abuse, they were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm. Earlier in the year there had been delays with the service reporting an incident to the local safeguarding team. The provider confirmed in future they would always take responsibility for reporting concerns that had been reported internally. We found reporting procedures had been discussed at group and individual meetings with staff. At this inspection, staff told us they would pass on any concerns to the provider or the deputy manager and were confident their concerns would be dealt with immediately. Prior to the inspection we were made aware of some recent safeguarding concerns. The local authority were concerned that a person's general health had deteriorated and the person was not receiving the support they now required. This concern remains under investigation by the local authority and will be followed up at the next inspection.

People who used the service and relatives considered the numbers of staff on duty were sufficient. Their comments included, "Yes there are sufficient staff. Sometimes, if really busy, they could do with more but never had a problem getting anyone if [name of person] wants to go to the toilet" and "Yes, there seems to be enough staff around when we come; they are very attentive."

At the time of the inspection there were 13 people who used the service and levels of two care workers were provided on each shift. Rotas showed that the numbers of staff had been maintained by the use of staff working additional shifts to cover sickness and holidays. Comments about staffing levels from staff included, "We struggle in the evenings now, we need someone in the lounge to monitor and provide support" and "It's hard to manage everyone's care in the evenings with just two staff, it was better before when we had the four 'til seven shift. Some people need two carers to help them and that leaves no-one in the lounge."

We observed care and support and saw staff were visible and attentive throughout the day. Staff were available to quickly intervene if people became distressed, ensure people received assistance with their meals and to supervise communal areas appropriately. On the late shift we observed they struggled to provide the evening meal service and assist some people with their personal care. One person was anxious and continually wandered around looking for staff support. We observed staff demonstrated a very positive approach to supporting the person and helping them settle, but due to work pressures were unable to stay with the person, who then became anxious and upset. On the second day of the inspection the deputy manager acknowledged staffing levels on the evening shift needed increasing and confirmed an additional care worker was now rostered to work 4pm-7pm.

The deputy manager confirmed the staffing numbers were planned using a dependency calculation which assessed the number and needs of people who used the service. They considered the dependency assessment would benefit from review to better reflect the needs of people living with dementia. The service

also employed a cook and domestic staff. The activity co-ordinator had recently resigned and care workers were given additional hours to provide this support.

Recruitment documentation indicated application forms and references were in place and checks with the Disclosure and Barring Service (DBS) had been completed. DBS checks helped to ensure only appropriately vetted people worked in care homes. We checked two staff recruitment files for staff who had been employed since our last inspection. We found one member of staff's application form did not detail their dates of their previous employment and therefore any gaps could not be explored. We mentioned this issue to the deputy manager to follow up.

We checked the management of medicines and found there were generally safe procedures in place for the ordering, receipt, storage and administration of medicines. This included medicines which required special control measures for storage and recording. We found one person's medicine had been out of stock for a week, although there was evidence of delays by the GP and pharmacy provider, the staff at the service should have followed this up more robustly. We also found some minor recording issues where staff had not signed and obtained a witness signature for handwritten entries on the medication administration records (MARs). Any 'as required' medicines were not supported by written instructions which described the situations and presentations when these medicines could be given, which is good practice. We observed medicines being administered. The staff member was patient in their approach and checked that people had taken their medicine before moving to the next person.

Staff spoken with demonstrated a good understanding of people's needs and how to keep them safe. During the inspection, we saw staff competently transferring people between chairs and wheelchairs using a hoist. They explained the procedure to people as they guided them into the chair and made sure they remained safe. On one occasion they noted a person was at risk of slipping out of the dining room chair and supported the person to move back to their arm chair.

Care records indicated risk assessments were completed for specific areas such as mobility, falls, moving and handling, pressure damage prevention, nutrition and the use of bed rails. We found the risk management of bedrails was not consistently managed. Different record formats were used and not all assessments prompted staff to record that the decision to use the rail was safe and the least restrictive option. We also found one person did not have a risk assessment in place to support the provision of rails on their bed. We mentioned this to the deputy manager and they stated they would check all risk assessments were in place and contained appropriate information. We found one person's moving and handling risk assessment was ambiguous and did not provide staff with clear guidance about how to determine if the person required the hoist to support transfers or was able to weight bear. The deputy manager reviewed this during the inspection. People who had been assessed as being at risk of developing pressure ulcers were provided with suitable equipment to reduce the risk and we saw that this equipment was being used as specified in people's care plans. Records were in place which provided evidence care had been provided in accordance with the care plans. For example, re-positioning charts were in place for people at high risk of developing pressure ulcers and these had been completed. There was low incidence of pressure damage.

Generally we saw accidents and incidents were investigated and appropriate action was taken to prevent their re-occurrence. However, we found incidents in relation to one person's recent falls and another person's bruising had not been recorded on incident records. The deputy manager acknowledged they needed to review the management of incidents in the service to ensure each incident was reviewed and followed up to ensure appropriate care was provided and any lessons learnt.

The service was clean and there were no odours. The laundry had appropriate equipment and supplies to

ensure soiled linen was washed correctly. We discussed the storage arrangements for clean laundry and the how improvements could be made to cover the open shelves to reduce risk of cross contamination. Equipment used in the home was serviced and checked at intervals to make sure it was safe to use. We found safety latches were not in place for two windows on the first floor and the checks on bed rails were not completed in line with current guidance, which the deputy manager confirmed they would address. We found risks in relation to the building had been assessed although these did not include the current measures in place to manage and protect people's safety when using the stairs. The provider confirmed these issues would be addressed. We saw people had personal emergency evacuation plans, which provided staff with guidance in how to support people to safety quickly and efficiently when required. In addition, there was a business continuity plan in place to ensure that people had a safe place to take shelter if they could not remain at the home.

Requires Improvement

Is the service effective?

Our findings

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. We found the application of MCA was inconsistent. Whilst we found some people had capacity assessments and decisions made in their best interest recorded when they lacked capacity, others did not. Some people had restrictions in place such as bedrails however, their capacity to make these decisions had not been fully assessed and the decision to provide them had not been discussed and recorded as in their best interest and as the least restrictive option for people. In some cases we found decisions had been added to existing capacity assessment and best interest meeting records retrospectively. We also found one person had a daily limit on the cigarettes they could smoke and there were no records of any discussions with the person's relatives and relevant professionals that this practice was the least restrictive and in the person's best interests.

Not working within the principles of MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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). Applications for DoLS had been submitted to the local authority and two had been authorised.

People we spoke with told us staff always sought their consent prior to assisting them and we observed this in practice during the inspection. Staff understood people had the right to refuse care and in such situations, they would always consult with senior staff for further support and advice.

Staff confirmed they received sufficient training and support to enable them to feel confident when supporting the people who used the service. We saw staff had access to a range of appropriate training and induction. There were some gaps in training but these had been identified and planned for by the deputy manager. Records showed that 12 of the 14 staff had achieved or were working towards nationally accredited qualifications. Staff received supervision meetings with their line manager to identify training, support and future development needs. The deputy manager explained an appraisal system was due to start.

We saw people had access to health care professionals for treatment and advice and these included GPs, district nurses, dieticians, speech and language therapists, opticians and chiropodists. We found one person's needs had changed in relation to their mobility and their ability to transfer safely was now unpredictable and could vary during the day. We found there had been a delay in making a referral to the occupational therapy team for assessment and staff had been directed to complete this by a health professional following a care assessment. During the inspection we checked the referral had been

completed.

A health professional told us staff provided holistic care and always raised concerns with them. They described staff as approachable and friendly. A social care professional was also complimentary about the staff in relation to their communication and quality of care they provided.

We found people's nutritional needs were assessed and met. We found that where there were concerns about people including swallowing difficulties or weight loss for example, referrals had been made to the appropriate professionals including speech and language therapists or dieticians. The cook explained how they fortified foods for people who were at risk of losing weight and provided soft and textured diets for people with swallowing difficulties. We discussed how the range of snack options people were offered between meals could be improved. When people were at risk of dehydration their fluid intake was being monitored. Although we discussed with the deputy manager that monitoring would be more effective if there was a record of target fluid intake, that intake was checked at regular intervals and totalled at the end of each day.

We checked menus and observed mealtimes; people were offered a choice of appetising meals and hot or cold drinks. On the first day we observed people were supported to the dining room and then had to wait some time for their meal to be served, some people became agitated. The dining room let in lots of sunshine and was hot, we saw staff supported two people to move seats to try and be more comfortable. At times we considered people would have benefitted from more prompt support. However, observations of the meal service on the second day showed this was more organised and people experienced a more positive meal service. There were no delays with serving and staff had more time to spend with people providing any assistance they needed.

People commented positively about their meals and the quality of the food, their comments were, "Good, very nice, we get what they give us, I like them [meals] all", "Don't mind the food at all", "Don't like everything but mostly enjoy it, always freshly cooked, can't grumble" and "Good – to tell you the truth I've no complaints, enjoy everything." Relatives told us, "[Name of person] has a good appetite, eats everything put in front of him" and "Very good, excellent."

We found there had been some adaptations to support the needs of people who used the service. For example, there were grab rails in corridors, toilets and bathrooms and raised toilet seats. The bedrooms at Eastwood House were in various corridors on both levels and were not numbered in a logical fashion and only a few of the doors had identifying features on them, this meant some people may struggle to identify their room independently. There were a lot of pictures on the walls, including the corridors, featuring old movie stars, food packaging and old signs. A large photograph display was in the lounge. The conservatory contained a lot of memorabilia displayed on shelves which was interesting to look at and had some reminiscence value; there was also a fruit stall which displayed fresh fruit. The deputy manager acknowledged that there were a lot of items on the walls which could be confusing for some people living with dementia and they would review this. They also acknowledged the patterned carpets in some areas could cause confusion.

We noted a number of minor maintenance and decorating issues which had not been addressed. For example, light bulbs needing replacement, broken items of bedroom furniture, some walls with damaged paintwork and blinds needed in the conservatory. The deputy manager identified areas of the service which had been decorated and explained the plans for refurbishment included a new roof for the conservatory, although there was no formal renewal programme in place.

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the home and the care provided. They were very complimentary about the care staff. Comments included, "Yes, the staff look after me well", "Really surprisingly I am quite happy and I've sold my house so it's a good job. I am looked after extremely well", "[Staff] look after us ok, and they sit and chat if you want. It's better than being at home alone, can't grumble, get looked after fine, you get good days and bad days, but they look after you well", "Lovely, can't fault it, staff are marvellous, can't fault anything, you're not just a number, treated personally", "Fantastic home, staff are our family – one big happy family. We are always doing something, it's fantastic" and "The staff are kind, caring and compassionate. They seem to treat [Name of person] like she is family." One person who used the service told us that they considered some staff, 'get a bit impatient with some of them sometimes but not in a nasty way'. We mentioned this to the deputy manager to follow up.

We observed care interactions were completed in a kind and sensitive way. Staff were observant and intervened if people looked as though they may need something. Staff gave explanations to people before carrying out tasks and spoke to them in a patient and friendly way. People appeared relaxed in the company of staff.

People who used and visited the service were provided with a range of information about the home. Relatives we spoke with said they had been involved in their family member's care plan and had discussions with staff about their relative's preferences for personal care, meals, activities and daily routines.

A health care professional told us, "All the staff have a caring attitude towards patients and have good professional relationships with nurses. Privacy is provided when nurse's visit and staff inform us if patients decline their choice of recommended treatment, such as hosiery."

We saw people were able to make choices about how they spent their time and most people chose to spend time during the day in the lounge and dining room. On the days of the visit the weather was warm, the door of the conservatory was open and people could go into the garden as and when they wanted. People told us that staff supported them to make choices about their care. Comments included, "I suppose I can decide and [choose to] do what they say; they are very good to me here", "Yes, I say when I want to go to bed" and "They like to get you upstairs before the night staff come at 9pm, at 8.30'ish I go up, I have a television in my bedroom, I don't mind."

We observed staff treating people in a respectful manner and that people's dignity was upheld. We saw people looked well-cared for and well-groomed. We saw staff promoted people's privacy and dignity and knocked on bedroom doors prior to entering. In discussions, staff gave us examples of how they respected core values such as privacy, dignity, choice and independence. Comments included, "We always knock on doors and wait to be invited in. We have a couple of shared rooms and we always try and respect people's privacy." Shared rooms had privacy curtains and these were also provided around the en-suite areas in people's rooms; the toilet and bathroom doors had locks.

We found the service had a friendly and welcoming atmosphere and all of the relatives spoken with told us they could visit the home whenever they wished to. One person's relative told us, "We have walked in at any hour. Staff have been sat talking with her and holding her hand or painting her nails." Another relative told us they had chosen the home because of the welcome, they said, "It's nice and light, a happy atmosphere, clean, no smells and the size – just the right number." During the afternoon the atmosphere was lively and there was quite a 'buzz' in the lounge as visitors talked, not only to their own relatives, but also with other people who used the service.

We observed people were supported by staff to be as independent as possible. If they were able to carry out tasks themselves, staff encouraged them to do so. When one person requested their frame so they could go to the toilet this was quickly brought to them. Although we saw they were advised by a member of staff to put their hands on their frame to push themselves up, they managed to use the chair arms for support. To use the frame in this way could cause risk of falling and we mentioned this to the deputy manager to follow up.

Information was available about local advocacy services. The deputy manager told us that that one person had recently used an advocate to support them with decision making. There was information displayed in the service so that people knew how to contact an advocate if they wished to. Advocates are trained professionals who support, enable and empower people to speak up or speak on their behalf.

We noted that staff held some records in the dining room. Whilst most of the records were stored in a secure cabinet we found some needed to be stored in this cabinet or the office when not in use. The deputy manager took action during the inspection to ensure all records were stored securely and people's confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

At this inspection we found staff had not always been as responsive to people's changing needs as they should have been. Records showed one person had recently undergone an assessment of their continuing care needs by the local clinical commissioning group. They had identified that the care support and equipment provision the person needed had not always been put in place to meet their changing needs. The staff were advised to contact relevant health care professionals and request assessments for mobility and equipment to prevent pressure damage occurring. During this inspection we found a referral to the occupational therapist had been made and a new profile style bed and pressure relieving mattress had been provided. Concerns had also been identified about the person's pain management on the assessment visit and we found there was no care plan in place to direct staff on the assessment and monitoring of the person's pain control and they had not received regular pain relief medicine. This meant there was a risk the person's pain may not have been managed appropriately. The deputy manager contacted the person's GP and their pain relief medication prescription was reviewed and changed.

We found some concerns in the assessment and care planning processes within the service. Each person who used the service had an assessment, risk assessments and a care plan. However, there were areas of need which had been identified but lacked a care plan to guide staff in how to support the person, although in some cases, information was detailed in the risk assessment records. Some care plans had detailed information about how to support the person in a person-centred way but this was not consistent throughout all the care plans we looked at. Some care plans did not have sufficient information and some had not been updated when the person's needs had changed. For example, one person had a lost weight yet their care plan had not been updated and there was no clear care strategy in place detailing more regular weight monitoring, calorie intake to be achieved, the provision of a fortified diet and how to encourage food intake in order to support the person to gain or maintain weight effectively. One person had behaviours which caused them distress and anxiety but the care plan was brief in how this was to be managed in a person-centred way and some of the language used could be misinterpreted as restrictive practice. Checks of a person's records showed they had recently experienced falls yet there was no assessment completed or detailed plan of care to provide staff with clear directions around the action to take to reduce the person's risk of falling.

Not ensuring people's needs were properly assessed and failing to ensure care was thoroughly planned to ensure those needs were met was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the shortfalls in assessment and planning of care, we found staff knew people's needs well and were able to connect certain behaviour with specific needs, for example, when someone needed to use the toilet. There were detailed records of people's personal histories and from discussions it was clear staff had a good knowledge of these and the contact people had with their families.

On the first day of the inspection a care worker attended the service to provide activities for people; the activity co-ordinator had resigned and left the previous day. We observed people in the lounge participated

in games of dominoes, bingo and listened and sang along to music. From talking to people who used the service and visitors it was apparent that activities and events took place on a regular basis. A summer garden party had taken place the previous weekend and an entertainment group dressed as Disney characters had attended. A 'Summer Spectacular' was advertised for the forthcoming August Bank Holiday featuring 'Mr Music' with a dress code of 'Bermuda shorts, Hawaiian shirts and sunhats'. One person told us how much they had enjoyed the summer fete and how much fun Mickey Mouse was. A relative showed us a video of the event on their mobile phone and described how much fun everyone had.

Comments about how people spent their day and activities they enjoyed included: "I can do what I like. I enjoy a cigarette and go out now and then; I went to the park the other day", "Play dominoes and that sort of thing, I join in with what is going on", "Odd times they take us out, some days seem longer than others. I've made some great friends in here. Do different things, not just twiddling your fingers", "He likes to be in the conservatory or out in the garden, doesn't like to sit all day, they let him go out and tidy up and all that", [Name of person] loves singing and dancing. They have had the GI Girls [entertainers], they're really good. They went for fish and chips on the pier at Cleethorpes and really enjoyed that" and "There are activities most days, they go for walks and [Name of person] goes in their wheelchair."

A complaints procedure was in place. People and relatives we spoke with told us they were aware of how to complain but had not had cause to do so. There had been no recent complaints. A relative told us, "[Name of deputy manager] always listens and responds immediately."

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems were not always effective in highlighting concerns and driving improvements. We found shortfalls in the quality of the care records which had not been identified through the audit programme. These shortfalls also included records which supported consent to care. There were no audits completed on staff training which meant there were no regular checks carried out to highlight when refresher training for staff was due. We also found there were no audits of the environment and facilities to check maintenance, standards of décor, furniture and safety systems. For example, we found two windows which did not have safety latches fitted and there were no regular checks carried out on the safety of the windows in the service. We also identified shortfalls with the checks on bed rail safety and risk management of the stairs, which had not been identified through audit systems.

External audits had been completed by representatives from the local care commissioning group (CCG) in April 2017 on the systems to support pressure damage prevention and infection prevention and control at the service. The findings of the audits showed numerous shortfalls and action plans had been put in place by the CCG. They had re-visited the service and completed further audits of these areas in July 2017 when improvements were found and the findings had been more positive. However, these shortfalls had not been identified through the home's audit programme and improvements had been driven by the external auditing processes.

We had concerns about effective recording within the service. We found the recording of monitoring charts for food and fluid intake was inconsistent. There was no system in place for overseeing the recording of fluid intake at regular intervals throughout the day, to ensure those people at risk were on track to receive adequate hydration. One person had recently experienced two falls, yet staff had not completed any incident records. Another person had sustained a large bruise and an incident record had not been completed, there were no records to show the cause of the bruising had been looked into. There were no audits of accidents or incidents in the service which would allow the provider to review if appropriate action had been taken and also to analyse the incidents looking for patterns and trends.

Not having an effective quality monitoring system meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was the provider and they also managed the organisation's other service in Lincolnshire. The deputy manager explained that they had day-to-day management responsibility of Eastwood House and the provider visited the service most weeks to look round, check records and speak with staff and people who used the service. The provider was not present for the inspection and we found little evidence of their oversight. The deputy manager confirmed they had no dedicated hours for management and administrative duties and struggled to fit the work in around their care duties. Following the inspection we spoke with the provider about the inspection findings, improvements needed with the management of the service, their visibility at the service and at meetings for staff and people who used the service. The deputy manager confirmed they had met with the provider and had been allocated three supernumerary days each week to complete the management and administration work delegated to them.

The provider would be visiting the service on two days each week and ensure a more formalised approach to their management of the service. The deputy manager explained the provider was looking to introduce new formats for the care records and quality audits and would be updating the policies and procedures.

The deputy manager was 'hands on' throughout the day involved in the care of the people who used the service. It was apparent that she was well known to people and their visitors and had a good relationship with them. In discussions, staff told us they felt supported by the deputy manager and were able to raise concerns; they said they enjoyed working at the service. Regular meetings were held with staff and records of the meetings showed subjects such as teamwork, standards of care, records management and training were discussed. A care worker told us, "Yes, we have regular staff meetings. The deputy manager listens to us and we are able to discuss any issues. We have regular handovers and use a communication book to ensure nothing gets missed."

There was a range of processes in place which enabled the provider to receive feedback on the quality of care provided at the home, this included regular meetings and satisfaction surveys for people who lived within the home and their relatives. People who used the service and relatives considered the service was well-managed. One person said, "I think the home is well- managed, not sure who the manager is, always seeing different people." Another person told us they attended the resident's meetings once a month and had the opportunity to discuss if they were happy with everything. Comments from relatives included, "Never met the [Name of the manager], we regard [Name of the deputy manager] as the senior person and she is always responsive", "I have respect for the management" and "It's excellent here, really excellent. The atmosphere is so friendly and welcoming. It's all you want from a care home, it is their home."

The provider submitted statutory notifications to CQC in line with legal requirements. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used the service did not consistently have their needs assessed, care planned and met in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments and records of best interest decisions were not in place to support staff were acting lawfully in relation to aspects of people's care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems or processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated fully. There were shortfalls in recording systems.