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Eastcroft 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

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good in four of the five domains and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format for those domains because our overall rating of the service has not changed since our last inspection.

This inspection took place on 04 December 2018 and was unannounced. At our previous inspection in August 2016 we rated the service as Good.

Eastcroft Nursing Home is a 'care' home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to 21 older people. At the time of our inspection there were 18 people using the service the majority of whom were living with dementia.

The house people lived in had a homely feel, however certain aspects of the environment were required to better meet the needs of people living with dementia. Carpets in a number of the communal areas had a complex pattern. This can cause confusing or disorientation to people, as they can perceive the floor to not be flat. The registered manager said they were in the process of reviewing the flooring across the home as part of ongoing home improvements.

People told us they felt safe living at Eastcroft Nursing Home. Hazards to people's health and safety had been identified, and management plans produced to reduce the risk of harm. Staff understood their responsibilities around identifying and reporting suspected abuse. There was an ongoing safeguarding review taking place at the time of our inspection.

People's support needs were regularly reviewed to identify the safe levels of staff needed to meet those needs. Robust recruitment processes ensured that before new staff worked at the home, they were safe and suitable to do so.

Staff ensured that people received their medicines as prescribed, or when they needed them. Only those staff that were trained and competent were able to manage and give people their medicines.
People lived in a clean home. Infection control processes meant that the environment and equipment were routinely cleaned to keep people safe from the spread of infections. Staff followed good infection control practices, such as using gloves and aprons when handling food, and were seen to regularly wash their hands.

The staff team kept people safe by reviewing accidents and incidents and taking action to prevent reoccurrences.

A comprehensive assessment of people's needs was completed before they moved into the home. This ensured the staff had the skills suitable to meet those needs . Staff received training and supervision to keep them up to date with best practice. Nursing staff were supported to maintain their registration, and take part in additional training as necessary.

People had enough to eat and drink. We had positive feedback about the choice and quality of food that people ate.

There were good links with the local health care services, so people had access to GP's and other health care professionals when needed. Peoples health was seen to improve due to the care and support they received

People's rights under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were met. If a person could not make a specific decision for themselves people who had legal authority to make decisions for them where involved.

People were supported by staff that were caring, and respected their privacy and dignity. They felt involved in decisions on their day to day care, and staff knew the people they supported as individuals. People's faiths, culture and lifestyles were respected.

Care plans had a good level of detail to enable staff to give a responsive level of care. These were reviewed periodically or as people's needs change to ensure they reflected current support needs. People had access to activities that interested them, and they said they never felt bored as something was always going on.

There was a complaints policy in place and the registered manager said complaints were welcomed as it gave them the opportunity to improve.

Systems were in place to support people who were at the end of their lives. Staff knew their preferences and choices so people could be assured of a dignified, and as far as possible, pain free death.

The owner and management of Eastcroft Nursing Home set out to provide a friendly and family feel to the home. This is what we observed during the inspection, from the interactions between staff, their families and the staff, and the way the management spoke about people.

Quality assurance processes ensured that peoples feedback was obtained and acted on, and that staff provided a good standard of care to people. Notifications of incidents had been submitted to the CQC in accordance with the regulations.

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 felt safe living at the home. Staff understood their responsibilities around protecting people from harm.

The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk.

There were enough staff to meet the needs of the people. Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Infection control processes were robust.

Staff recruitment process ensured only suitable staff were employed at the home.

Is the service effective?

Good

The service was effective.

Adaptations to decoration had been considered around the home to make it more dementia friendly. We recommend the provider continue with their redecoration and review the suitability of the patterned carpet that is present in communal areas of the home.

Peoples needs had been assessed prior to coming to the home, to ensure those needs could be met.

Staff said they felt supported by the registered manager, and had access to training to enable them to support the people that lived there.

People had enough to eat and drink and had specialist diets where a need, or preference, had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health was seen to improve because of the care and support they received.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's liberty may be being restricted, appropriate applications for DoLS authorisations had been completed.

Is the service caring?

Good

The service was caring.

Staff were caring and we saw good interactions that showed respect and care. People were supported in a dignified way.

Staff knew the people they cared for as individuals. This included their preferences and how they wanted to live their lives.

People could have visits from friends and family whenever they wanted.

People's right to practice their faith was respected and supported by staff.

Is the service responsive?

Good

The service was responsive.

People were involved in their care plans and their reviews. Care given reflected that as detailed in the care plans.

There was a complaints procedure in place.

Staff offered activities that matched people's interests.

People were supported at the end of their lives to ensure their needs and preferences were met.

Is the service well-led?

Good

The service was well-led.

Quality assurance checks had been effective at ensuring that people had received a good standard of care and support.

Records management was good and the registered manager understood their responsibilities with regards to the regulations,

such as when to notify CQC of events.

Feedback was sought from people via key worker meetings and annual surveys.

Staff felt supported and able to discuss any issues with the registered manager.

Eastcroft 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was a routine comprehensive inspection. We were made aware prior to the inspection that there was an ongoing safeguarding investigation about the care and treatment of one person. This inspection examined those areas of concern to see if other people were affected.

This inspection took place on 04 December 2018 and was unannounced. The inspection team consisted of one inspector, an expert by experience and a specialist nurse advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held including notifications we received from the service of significant events. We had not asked the provider to send us an updated Provider Information Return as we were responding to concerns. The PIR 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. We review this information to see if we would need to focus on any particular areas at the service. We also contacted the local authority to seek their views on the care being provided.

We spoke with six people on a one-to-one or in small groups. We spoke with five relatives or visitors to the home. We also spoke with five staff which included the registered manager who was present on the day. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included four care plans and associated records, two medicine administration records, two staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted commissioners of the service to see if they had any information to share about the home. After the inspection the provider sent us with further information to show that they had responded to any issues we had raised.

Good

Is the service safe?

Our findings

People and most relatives we spoke with were positive about how safe they felt the home was. One person said, "We are looked after very well. I feel safe." A relative said, "I don't have to worry about her now, she's safe, happy, well looked after."

Staff understood their roles and responsibility about keeping people safe. This included understanding the signs of abuse, and the action they needed to take should they suspect it had taken place. One staff member said, "I have to tell the manager straight away. If they don't do anything I have to call the police or CQC." Policies in relation to safeguarding and whistleblowing reflected the local authority's procedures. Staff understood who to contact should they feel abuse had taken place, and appropriate referrals to the local authority safeguarding team had been made when appropriate.

People were kept safe because the hazards of harm related to their health and support needs had been well managed. Assessments of the risk of harm included areas such as not being able to use the call bell, falls, moving and handling, tissue viability and choking. When risks had been identified, the care plans contained clear guidance for staff on how to manage these. For example, one person had been assessed as having a high risk of falling. Safe working systems had been clearly documented, including the use of hoist and details of the specific sling to use. Risk assessments had been reviewed monthly, and the plans had been updated as people's needs changed. Where bed rails were used to help prevent people falling out of bed rails assessments had been completed and regular checks had been undertaken by staff to ensure the bed rails were being used safely. Where people were at risk of pressure wounds equipment such as pressure relieving cushions and mattresses where in place. Turn charts and cream charts had been completed and were up to date recording when people had received the care to minimise the risk of developing a pressure sore.

The registered manager reviewed accidents and incidents with a view to prevent reoccurrence. There had been very few accidents since our last inspection which demonstrated that risks to people were well managed. Where people had fallen a 'post fall assessment tool' had been used. This recorded the details of the fall and if there were any areas that needed to improve, such as trip hazards. Nursing staff also completed 24-48 hour observations on the person to ensure their vital signs remained within a healthy range, and there were no delayed reactions to the fall. The analysis of incidents had resulted in positive outcomes for people. One person had an increase in falls. This was attributed to a trial run of medicine they were on. This was reviewed with the GP and the medicine had been changed. The person had not fallen since.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that potential staff were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were sufficient staff deployed to keep people safe and support the health and welfare needs of people

living at the home. People and their families gave an overall positive answer when we asked if they felt there were enough staff. Staff were seen to be around all day in the sitting room where the people did activities and spent their day. We saw staff being available to help people who were in wheelchairs or using walking frames to get to the dining rooms for their lunch. We did receive feedback that at times there were not enough staff, and this was one of the areas that was under investigation with the safeguarding process. On the day of our inspection a meeting was to take place with commissioners of the service and health care professionals as part of this process. The registered manager had taken this into consideration when planning staffing for that day, as they knew they would be involved in the meeting. The registered manager used a tool that took into consideration the needs of people and identified the number of staff required. Staffing rotas confirmed that the number of staff calculated by the registered manager to give a safe standard of care had been present within the home during the previous three months.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the home and people took part in fire drills.

People were protected against the risk of infection because the home environment was kept clean. There was a cleaning schedule in place and staff ensured that the rooms and equipment were kept clean. Staff were observed to wear appropriate personal protective equipment such as gloves and aprons when needed, for example when serving food. Clinical areas were kept clean, and equipment such as mobility aids were routinely cleaned to make sure they were safe to use. There were no unpleasant odours in the home. This demonstrated that the people's needs with regards to continence management and support were met, and the risk of spread of infection was minimised.

Peoples medicines were managed and given safely as prescribed. Medicine was stored as per manufactures guidance, for example refrigerator temperatures were maintained at safe levels. Refrigerator temperatures were recorded regularly and staff had guidance on what to do in the event of the temperatures being outside of the recommended levels. The rooms where medicines were stored were free from clutter and maintained to a good standard. Staff were knowledgeable on safe storage practice. Medicines were stored safely in locked trolleys.

There were robust systems in place administer medicines so people received them at the times prescribed. We observed a lunchtime medication round carried out by a part time Registered Nurse and found this was completed in a safe way. Staff who gave medicines had received training and their competency assessed before they could do this. Staff were aware of good practice regarding providing support with medicines. For example, ensuring people had preferred fluids to help them swallow, or seeking alternative formats for medicine from the GP. Medicine administration records (MAR) charts had photographs of people using the service at the front and these had been dated to indicate they were still a true likeness of people. Medicine administration records (MAR) were clear and easy to read and had no signature gaps when medication had been administered. This ensured that the right people received the right medicine at the right time.

Good

Is the service effective?

Our findings

Consideration of the home environment and decoration to meet the needs of people living with dementia had taken place. The decoration of the walls was simple and uncomplicated to avoid overstimulation or confusion. The colours of the walls and surfaces were neutral and matt to avoid any shine or reflection. Reflective surfaces and busy patterns can cause anxiety for people living with dementia. The provider was aware of the effect the patterned carpet in on of the communal areas and corridors could have on people. The assured us this was in their plan of ongoing improvements and would be replaced with a plain carpet/surface to better suit peoples needs. one area where the provider was One relative said that the best thing about the home was, "The environment, it's homely." The house that people lived in was an old building that had been modified and extended over time. The home had a warm and homely appearance inside.

We recommend the provider continues to adapt the environment for people living with dementia. For example, by replacing the patterned carpet used in many areas around the home.

The registered manager assessed the needs of people before they moved into the home to ensure the environment and staff would be able to meet their needs. This also gave the opportunity to check if any special action was required to meet legal requirements. For example, use of specialist medicines, use of equipment that lifts people, or meeting the requirements of the Equalities Act (such as not discriminating against people). Assessments of people's needs included, amongst other things, people's support needs around behaviour, communication, continence, health and safety, hygiene and appearance, medication, mobility, nutrition, pressure Care, religion, and interests. This information was then integrated into care plans for staff to follow when the person came to live at the home.

Staff training and supervision ensured that people received effective care and support to meet their needs. Nursing staff said they had access to training and professional development and had support from the provider to maintain their registrations with their governing body, the nursing and midwifery council (NMC). Ongoing training and refresher training was well managed, and the registered manager ensured staff kept up to date with current best practice. Training specific to the needs of people had also been given. Staff had regular supervisions (one to one meetings with their manager) to discuss training needs, and give them the opportunity to discuss their role with their line manager.

People had effective support to protect them from malnutrition and dehydration. Feedback about the quality of food was all positive. One person said, "The food is really fine. They do give you some nice food." Another person said, "The food is lovely'. People were also offered choice at each meal. One person said, "For breakfast they give you choice – porridge, toast, egg – it's very nice." Where people were at risk of malnutrition or dehydration food and fluid charts were in place. These recorded their food and fluid intake to ensure they maintained good health. People's weights were monitored. Referrals to professionals and fortified meals were used where required, such is in helping people gain, or maintain a healthy weight. People were offered further helpings of food during lunch and the evening meal, and received these if they wished. Drinks and snacks were offered to people throughout the day of the inspection, with staff ensuring

people had enough to eat and drink.

The effectiveness of staff supporting people to eat was demonstrated when we overheard relatives talking to their family member who lived at the home. They said, "He never used to eat so much before he came here. You certainly don't struggle to eat now do you."

Staff teams worked well together so that people's needs were met. Staff meet during handover meetings to discuss how the day/night had gone, and if people had any additional needs, such as if they felt unwell.

People had good access to health care professionals to help keep them healthy. A relative said, "Before she [their family member] came here she had swollen ankles. The staff immediately put her legs on a stool - pretty on the ball. The staff were good with that. They kept at it to help her keep her feet up. Now her ankles are much better." People could see the GP if they felt unwell, and were supported to attend appointments at hospitals and specialist consultants when needed. Records showed when the GP had been called to review people's health, the reasons why a review had been requested and the outcome of the GP visit. Records also showed when other healthcare professionals such as the optician and the chiropodist saw people.

The 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. Consent to care and treatment was sought in line with legislation and guidance. Care plans contained mental capacity assessments for people and when people did not have the capacity to consent to their care, a best interests meeting had taken place. The notes from these meetings were held in the care plan and relatives (with the legal authority to make a decision for the person) had signed these to indicate their involvement and agreement. Examples we looked at included meetings with relatives to discuss people's personal hygiene needs, and the use of bed rails.

Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. Staff had an understanding of the Mental Capacity Act 2005 including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff asked for people's consent before giving care and support throughout the inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty was restricted to keep them safe, appropriate applications had been made to the DoLS Board. People were supported in accordance with these DoLS authorisations. Examples such as people not having the capacity to make a decision to live at the home had been addressed under the DoLS. The registered manager was also knowledgeable about the application of the DoLS. For example, even though no one currently receive covert medicines at the home, they were aware that this would require a DoLS application if the person did not have capacity to understand the need for the medicine.

Good

Is the service caring?

Our findings

People and their relatives where positive about the caring nature of staff. One person said, "We're looked after very well. The staff are very helpful. I enjoy staying here." A relative said, "The best thing of this place: it's a home. I feel like it's a family - they love my mum. They love all the residents."

People were treated with kindness and compassion by staff. During the inspection the team saw many positive interactions between people and staff. One staff member placed a gentle hand on a person's shoulder when trying to encourage them to eat. The staff member looked the person in the eyes when taking with them. They checked the person was swallowing each mouthful before offering the next one. Other staff were heard to give positive encouragement to people as they ate. Physical interactions were gentle and kind, such as holding people's hands when staff sat with them. An example of the caring nature was also shown by the registered manager. A person returned to the lounge after their lunch. The registered manager saw a person trying to get past them. He smiled at the person, gently placed a hand on their shoulder and said, "Hello my sunshine," at which point the persons face broke into a big smile and they started to sing, "You are my Sunshine," and the registered manager joined in.

People were involved in day to day decisions around their care and support. Staff asked people if they wanted dinner, and were given choice. Staff asked if people if they needed help, for example cutting up food, and didn't just assume or do it without asking. Information was given to people in a format they could understand. For example, there were display boards which showed the current season, day of the week, the month, the year, and a picture reflecting the weather condition of the day: This board was clear for everyone to understand and helped people living with dementia orientate themselves to the time of year.

Staff were knowledgeable about people they supported. This included the jobs they had earlier in their lives, hobbies and interests, as well as medical support needs. Care records recorded personal histories, likes and dislikes, and matched with what staff had told us.

Staff treated people with dignity and respect. Each person was encouraged to do as much for themselves as possible at a level they would be able to manage. Staff showed respect to people in many ways. This included telling them when visitors arrived at the home, and who they were and ensuing people were supported when items of clothing became loose, to protect their dignity. Personal care was discreetly given behind closed doors. Protecting people's privacy and confidentially were understood by staff. This was discussed at team meetings and was demonstrated during the inspection when the registered manager asked a relative if they were happy to share information with us.

People were supported to keep in touch with people that were important to them. Families could visit when they wanted. One person said, "'My niece always comes to see me whenever she's in Epsom." Another person said, "My son takes me out to Banstead.' A third person explained how they were supported at special times of the year, "For Christmas I'll be here and they put on a party for our relatives."

Where people had faiths or cultural needs these were seen to be met. People had access to a number of

religious centres in the local community. There were also regular visits by spiritual leaders to the home to carry out services for those that may not be able to attend faith services in the community.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans were person centred and gave good information about the whole life of the person. They included detailed personal histories, as well as the individual care and support needs of the individual. Preferences and choices were clearly recorded in a document called 'This is me.' and staff were seen to follow these during the day of the inspection. Care plans were reviewed on a regular basis with the person to check the care they received was still meeting their needs. Daily notes of care documented by staff recorded that care given had matched that as detailed in the care plans.

People had access to activities to stimulate their minds, keep mobile and offer opportunities to go into the local community. The home was decorated for Christmas and there was festive music playing in the activity/sitting room, one of the people told us, "We're going to have a party tonight." The activity co-ordinator and a number of care staff moved around the room paying attention to each person in turn and doing activities on an individual level. This was done according to the capacity or preferences of the individual. There was access to two large containers, one labelled 'memory box' and the other 'sensory box.' Both contained an array of items for activities. There were board/table games and activities like crosswords, puzzles, colouring, and musical bingo. We saw the activities co-ordinator held a book about Diana the Princess of Wales and sat with a person showing the pictures and enjoying the book together. One person said, "They do so much for us - get together, sing along, card games, there's always something going on all the time." Another person said, "I don't get bored. There's always something going on all the time. Sometimes they take us in a coach and take us round the country. When asked if there was anything the staff could do better for activities one person said, "No, we are lucky with the amount we have."

People were supported by staff that listened to and would respond to complaints or comments. One person said, "I have never needed to complain about anything." A family member said, "If I had any problem I would speak with the staff - but I've never had to." There was a complaints policy in place that was clearly displayed around the home. The policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government and Social Care Ombudsman. There had been one complaint since the last inspection. This was currently being dealt with under the local authority safeguarding process. We spoke with the relatives involved in this process during the inspection and via telephone after the inspection, to ensure we had covered the areas of concern as part of the inspection process.

People would be supported at the end of their lives. End of life plans were in place for those that had consented to have them completed. These covered people's faiths, type of funeral they would like, and where they would like to be if they became very ill, such as staying at the home or going to hospital. Where people were unable to give consent, the provider had followed the requirements of the Mental Capacity Act with regards to making best interests decisions, and involved families where appropriate.

Good

Is the service well-led?

Our findings

People lived in a home that was managed by a family with a clear vision for the service. The registered manager said, "It's about caring for our residents with love in your heart." A relative said, "It is a family run home and it has a lovely family feel when you go there." Another relative said, "This is the ideal place for us, it's just right. Mum's happy, and the staff are lovely. We have no complaints. The manager is great. Staff were seen to provide care in line with the vision of the owners, as detailed in the caring section of this report.

There was a positive, person focussed culture within the home, which was reflected in our findings across all the five key questions that we asked . Staff were also positive about their roles and enjoyed their work. Staff understood their roles and responsibilities and had a clear understanding of the values and visions of the service.

Staff felt supported by the registered manager. One staff member said, "The manager is always asking us if we need anything." During the inspection we listened to conversations between the registered manager and staff and heard professional and respectful conversations.

The providers quality assurance system ensured people received an overall good standard of care. Audits were completed on all aspects of the home. These covered areas such as infection control, health and safety, and medicines. These audits generated improvement plans which recorded the action needed, by whom and by when. Actions highlighted were addressed in a timely fashion.

People and those important to them continued to be involved in how the service was run. Due to people's support needs, group resident meetings did not take place. These were replaced by one to one meetings with their key worker. Topics such as food, activities and if they were happy were all discussed, which gave people the opportunity to raise any concerns, or offer suggestions to improve the service. Feedback was also sought from people's families, and health care professionals.

Staff were also involved in making improvements to the service people received. The provider and registered manager sought feedback via team meetings. These were also used as mini teaching sessions. Topics included responding to suspected strokes (F.A.S.T) and medicine processes, such as what to do if a tablet was found on the floor.

Learning from accidents and incidents that had happened at other services were also reviewed to ensure they risk of them happening here was minimised. Examples included the risks of choking, and how it was important to never leaving thickening agents where people could access them.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. They had also completed the Provider Information Return when it was requested, and the information they gave us matched with what we found when we carried out this inspection.